CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 18th May 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	*3*	*09.30*
Administration					
2.	Declarations of Interest	Information	Paul Burstow	*4*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 31 March 2023	Decision	Paul Burstow	✓ *5-12*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓ *13-16*	*09.35*
Chair's Update					
5.	Chair Update, incorporating: • Annual Fit and Proper Declaration	Information & Decision	Paul Burstow	✓ *17-19*	*09.40*
Executive Update					
6.	CEO Report, incorporating: • Data Security & Protection Toolkit (DSPT) pre-submission approval	Information & Decision	Dr Vivienne McVey	✓ *20-29*	*09.45*
Committee Assurance Reports					
7.	**Committee Updates (taken as read)**			*30*	*10.10*
	• Audit & Risk Committee (17/04), incorporating: ○ Reserves Policy ○ NHS England Annual Solvency Pre-Submission Approval ○ ToR Approval	Assurance & Decision	Rupert Perry	✓ *31-47*	
	• Quality & Safety Committee (25/04) Incorporating: ○ Quality Strategy update	Assurance	Steve Shrubb	✓ *48-58*	
	• Research Committee (03/05)	Assurance	Professor Stan Newman	✓ *59-65*	
	• People Committee (11/05)	Assurance	Dawn Brodrick	*verbal*	
Quality					
8.	CQC Inspection, Report and Actions Update	Assurance	Andy Brogan	✓ *66-68*	*10.35*

9.	Safer Staffing Report	Assurance	Andy Brogan	✓	*69-78*	*10.40*
Break 10.55 am to 11.05 am						
Operations						
10.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview • IT Security Overview • My Voice Update	Information & Assurance	Anna Williams, Dawn Chamberlain, Kevin Mulhearn & Sanjith Kamath	✓	*79-98*	*11.05*
Service and Patient Story						
11.	Dialectical Behaviour Therapy at St Andrew's – past, present, future (co-production with Patients and Carers)	Information	Dawn Chamberlain, Dr Emily Fox & Victoria Taylor (and patient)		*99*	*11.35*
Any Other Business						
12.	Questions from the Public	Information	Paul Burstow		*100*	*12.10*
13.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*101*	
14.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*102*	
15.	Date of Next Meetings: Thursday 8th June 2023 – Quality Account Approval Friday 21st July 2023 – Board of Directors Meeting in Public	Information	Paul Burstow		*103*	
Part One Meeting Closes at 12.15 pm						
Lunch 12.15 – 12.45 pm Conference Room, Main Building						
Strategy Session 12.45 – 13.45 pm Centre for Development and Complex Trauma, Main Building						
16.	Charity Strategic Milestones	Information	Dr Vivienne McVey	✓		*12.45*

Annexes - Items for information only	**Purpose**		
Annex A – Governance Oversight Group update	Information	✓	*104-105*
Annex B – Internal Audit Plan 2023-24	Information	✓	*106-114*
Annex C – Internal Audit Charter	Information	✓	*115-121*
Annex D – Local Counter Fraud Plan 2023-23	Information	✓	*122-125*
Annex E – Research Committee 2022-23 Publications List	Information	✓	*126-133*

Welcome & Apologies

(Paul Burstow – Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 31 March 2023

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

The Centre for Development & Complex Trauma, Main Building and Microsoft Teams
St Andrew's Healthcare, Northampton

Friday 31st March 2023 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Karen Turner (KT)	Non-Executive Director
Steve Shrubb (SS)	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
Anna Williams (AW)	Director of Performance
Alex Trigg (AT)	Director of Estates & Facilities
Duncan Long (DL)	Company Secretary
Jo York (JY) Item 13	Recovery College Peer Trainer
Liam Freestone (LF) Item 13	Specialist Practitioner
Melanie Duncan (MD) Minutes	Board Secretary
Apologies Received:	
Stanton Newman (SN)	Non-Executive Director
Dawn Brodrick (DB)	Non-Executive Director
Andrew Lee (AL)	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 Stanton Newman, Dawn Brodrick and Andrew Lee 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. The meeting was declared quorate.		
3.	**Minutes Of The Board Of Directors Meeting, held in public, on 24 January 2023** The minutes of the meeting held on the 24 January 2023 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: • **26.05.22 06 – Safer Staffing –** People Committee Assurance • **22.11.22 01 – QSC Update –** Operations Dashboard • **24.01.23 07 – Mental Health Bill -** Disproportionality All other actions on the log remained open, either in line with the agreed target dates or to return at a future Board.	**DECISION**	
CHAIR'S UPDATE			
5.	**Chair Update** PB gave a verbal update, firstly drawing attention to Appendix B of the pack, the Board Skills Matrix, which was for Board members to complete and would aid in the training and development plans of the Board. PB also updated on items that had been undertaken since the last meeting in January; notably, the evolution of the Thrive programme, along with a visit to Tabard Court in London which had aided in the development of the future business model for the Charity. PB noted that relationships with housing providers would be crucial to the success of this initiative. PB further noted two recent meetings, the first with Chris Dzikiti (CQC Director of Mental Health), with discussions on how the CQC were working with stakeholders and how the focus was on outcomes. With the second meeting with Professor Tim Kendall, NHSE National Clinical Director for Mental Health which gave the opportunity to re-introduce the Charity to him, as well as have discussions covering the landscapes for the future and commissioning. PB also noted his visit to CAMHS, commenting on the changes taking place, with particular note to the work being done by the College. Patients had commented negatively on the food, with PB following the comments up with AT. The ongoing demand and future purpose of CAMHS would be considered in the future. DC commented regarding Sitwell Ward within CAMHS, noting that a paper would be coming to Board. PB concluded that influencing and shaping the future for the Charity would now be key, with local and regional engagement important, along with the strategy regarding community services. AT agreed to address the food comments from the patients in CAMHS. The Board **NOTED** the update.	**DC**	**28.09.23**
EXECUTIVE UPDATE			
6.	**CEO's Report** VMc presented her report which was taken as read and noted a number of more recent additional items for discussion. The final meeting of the Buddy programme was held last week. It had been commented that this approach was ground-breaking and that the feedback was that all parties concerned found the programme to be useful, with two-way traffic regarding learnings. All workstreams had been supported during the process, however it was noted that two of the agreed exit criteria had not been met; Enhanced Observations and Standards of Care. VMc wished to note her thanks to Angela Hilary of NHFT, and highlighted the positive relationships which had been formed with the partners and that St Andrew's was seen as part of the system. AB added that increased reporting on low risk incidents had been noted from the exit meeting, as well as a full quality impact assessment for safer staffing had also been noted as required. AB confirmed that QIAs were completed and had been done on the staffing changes. AB confirmed that establishment figures had not reduced, however,		

	the impact of increase has been assessed, with no significant impact on quality had observed for those areas where establishment has been reduced. AB wished to note that there were no immediate concerns. VMc then noted her comments with regard to Operations, with DC updating the Board on the interim steps being taken with regard to management on night shifts. In the new operating model, the General Managers and Quality Matrons would be the out-of-hours managers on site. This would ensure 24/7 cover as opposed to being on-call. In addition to this, night visits by Executive would increase and the night culture would be addressed. KT asked if new staff would be rostered for both days and nights. DC confirmed that this would be the case. VMc then noted the upcoming Annual Awards which would be a bigger event than previously seen. Over 1,000 nominations had been received, with some also from patients and carers, this is a greater number than seen previously. VMc also highlighted that the final strategy workshop had been held in the previous week, with the MBA students now collating the information which would be received by Executives on the 19th April, and presented to Board in May, with many of the MBA students and staff involved in the co-production in attendance. SS asked about the call bells being installed, following the Essex CQC report, asking how compliant the solution was and if a permanent solution was being discussed. JC updated SS noting that he was the Executive accountable for the work and that Essex had now received the permanent solution for call bells. Further discussions covered other sites such as Birmingham (with a compliant temporary solution now in place), Broome Cottage and the timeframe for finalising the remaining Northampton wards. It was confirmed that further clarity over the compliance of the solutions as well as the need for them within Broome would be sought from the regulator prior to future work being carried out. JC would also furnish SS with a copy of the programme. Further discussions covered the recent reports from the regulator, along with how the strategy had been received by the staff across the three main hospital sites. The Board **NOTED** the update.	**JC**	**18.05.23**
COMMITTEE ASSURANCE REPORTS			
7.	**Audit & Risk Committee** RP introduced the report, which was taken as read, with PB enquiring regarding visibility of engagement with HSE. AT replied that close liaison was kept with HSE, with a good relationship in place and that nothing was expected at this stage. It was agreed that Health & Safety updates be given to the Chair of Quality & Safety Committee also. DL confirmed that following the committee wide review of Terms of References, Health and Safety oversight was returning to the QSC. The Board **NOTED** the report **People Committee** In DBs absence, SS introduced the report, which was taken as read with SS updating that the Lead the Change programme had now moved from the design phase to implementation. SS thanked everyone for their hard work on the programme. Items for escalation to the Board covered risks relating to the nursing fill rate and mandatory training completion rates. AW update that training figures had been observed as being far better in February, with the focus on non-nursing staff initially with plans for addressing training levels in nursing staff to be released. DC added that it was good to see the improvement in non-nursing completion, however the focus was on those need to be released from their rosters to enable them to	**AT**	**18.05.23**

	complete the training. DC confirmed that all bar one division had now exceeded 90% completion. RB asked if it was known which roles were more affected by mandatory training and which ones should be expected to be at 100%. DC replied that this was now known down to an individual level, with approaches to achieving compliance refined in order to gain better completion rates. PB indicated that a review of Charity trustee training would be welcome, with the involvement of Nominations & Remunerations Committee. MK suggested a trustee training passport approach using comparable training completed within the NHS. DL confirmed that this approach had commenced and had been used with a number of Non-Executives. The Board **NOTED** the update **Quality & Safety Committee** SS introduced the report, which was taken as read with SS noting the continued narrower and detailed focus for the Committee was working well. This approach would be continued for another 6 months, with a review on the approach completed at each future meeting. PB asked if risks were being reviewed as part of the revised focus and SS confirmed that they were being reviewed and highlighted that the Committee, and the Board should take a balanced and calculated risk approach whilst the Executive deal with the current challenges. RB agreed and noted the early warning benefits of the new Heatmap. The Board **NOTED** the update and the Quality Strategy Plan.	**RB, DL & SC**	**21.07.23**
QUALITY			
8.	**Safer Staffing Report** AB presented the report which was taken as read, and noted that Establishment would be subject to an annual review process in the future. The risks had been noted, particularly with regard to the reliance on Bank and Agency staff. AB highlighted that fill rates in the previous 6 months had improved with fewer issues being observed. AB also proposed that the detail from the report should be presented to Quality & Safety Committee in future, for assurance purposes ahead of providing the overview Safer Staffing Report to Board. RP noted that 31% of staff were leaving within 12 months, and asked how this was being managed. AB replied that nursing recruitment and retention was a national problem and that a quarter of qualified nurses do not go on to work within healthcare. AB added that preparing staff was important, along with retention. The St Andrew's 6 month preceptorship was low compared to the 2 years offered by other organisations. DC added that communication and retention was improving, with feedback indicating that staff were excited about the future. Further analysis would be done with regard to the permanent shifts on offer. KT asked if CAMHS should be considered separately in order to attract staff and therefore have more beds to offer. PB agreed and DC confirmed that the strategy for CAMHS would be to move away from a secure setting, and would be looked at separately. RB asked about the red and yellow categorisation within the report and asked AB to confirm the categorisations. AB confirmed, and added that there were extenuating circumstances. RB suggested that further narrative would be beneficial. Further discussion regarding the report format and content covered correlations with quality, and the inclusion of trend graphs on the use of action cards. AB agreed to include the suggestions. The Board **NOTED** the report	**AB**	**18.05.23**

9.	**Quality Workstreams Update** AB presented the paper which was taken as read and outlined that the buddy workstream work had now concluded, with remarkable progress, some of which was still to be recognised. There were two areas which required further work, however, they did not present themselves as of concern. AB wished to formally thank Julie Shepherd and Angela Hilary for their support during the process, which transpired to be a successful piece of work for all concerned. SS congratulated AB and noted that embedding and sustainability would be key for continued success. He cautioned that those exit criteria which had not been met did correlate with the recent report on Essex. AB acknowledged that there were areas of challenge, and that it was planned to address them. VMc noted that sustainability had been discussed extensively with Angela Hilary, and that changes at ward level would help a great deal. DC added that the e-observation work being done by Ash Roychowdhury would be key to this. The Board **NOTED** the report.		
OPERATIONS			
10.	**Integrated Quality & Performance Report** AW presented the report which was taken as read and each of the main topics were discussed: <u>Quality</u> AW noted that the Quality data indicated that improvements continued, with 69% of non-PICU patients transitioning to a lower level of security and just under half returning to their usual place of residence. My Voice positive responses were now at 72%, and the Quality strategy and framework continued to be implemented. Note: Post meeting it was confirmed that the My Voice figures were incorrect and should have read 76%, a further improvement on previous reported percentages. <u>People</u> AW highlighted that positive trends were being seen, with a vacancy rate of 15.4% which benchmarks favourably against peers. Turnover and sickness improvements were also being seen across all divisions and functions. PB acknowledged and welcomed the discharge information now included within the report. PB enquired if an indication on whether the process highlighted within the report required further review itself and whether an appropriate symbol could be added that highlighted where only a change in process would initiate an improvement in the reported metric. PB also asked what action was being taken to address the low levels of participation in the My Voice feedback. AW agreed to address the comments and suggested reporting updates. AW responded that a range of options regarding the My Voice submissions would be offered in order to increase uptake and engagement. SS suggested that Quality & Safety Committee could consider the My Voice submissions and process and that this was being arranged. KT asked if further information could be gained from looking at the discharges from ASD/LD as to where the patients went when they left the Charity. RB asked if there could be a reduction in inappropriately placed patients. SK responded that this was a good point to raise and the placements could be due to length of stay and the patient has completed their treatment, or due to no follow-on placement being available, with the vast majority relating to patients who should be leaving. PB suggested that it would be beneficial for the Board to	**AW** **DL**	**21.07.23** **21.07.23**

	have further discussions regarding tertiary service providers to better understand any inappropriate placements or what may impact the complexity of discharge. <u>Finance</u> KM presented the finance section of the IQPR and reported that full year forecast had projected a £5m loss, which was £60k more in February due to increased staff costs, partly due to an increase in acuity and enhanced support. Lower project costs had mitigated this slightly. The forecast however, is expected to be achieved. KM also wished to note that the Berkeley Close disposal would not fall within the current financial year. The impact of this will be offset by the positive movement in pension and investments. Redundancy costs would still have to be considered. KM also confirmed that there was no covenant risk. Occupancy levels sat at 590 in April 2022 with a forecast of 630 for March 2023, indicating a 7% increase which was following forecasted figures. SK added that there had been a lot of hard work spent on occupancy to raise it to these levels. SS noted concern regarding fragile staffing and the increase in acuity, against increasing occupancy. SK agreed that it was a balance, but that if a ward felt unsafe, it would not allow admissions, and outlined how each division mitigated this. KM outlined the growth aspects of occupancy and how staffing could be flexed accordingly, with DC adding that staffing challenges were being mitigated, and that TIs were being recruited to enhance the staffing on the wards. PB asked if the work of TIs could be presented to the next Court of Governors. <u>IT Security</u> JC gave the IT update and noted that the ISO Security Audit had been passed which allowed the Charity to maintain accreditation. RP asked about the patches being applied to the servers. JC replied that they were being done manually. The Board **NOTED** the report.	**DC**	**18.05.23**
GOVERNANCE			
11.	**Board Code of Conduct** PB introduced the Board Code of Conduct, outlining the process of development and requested the approval of the Board to adopt. SS asked if the document contained or referred to the Nolan Principles. DL and MD confirmed that the principles had been taken into consideration, but not explicitly quoted within the document. The Board **NOTED** the Code of Conduct and **AGREED** to its adoption.	**DECISION**	
12.	**Revised Charity Governance Structure** PB introduced the revised Charity Governance Structure Chart, and requested the approval of the Board to adopt and publish. The Board **NOTED** the structure and **AGREED** to its adoption and publication.	**DECISION**	
SERVICE & PATIENT STORY			
13.	**Oliver McGowan Training on Learning Disability & Autism** Liam Freestone and Jo York joined the meeting and gave presentations on the Oliver McGowan training and on Learning Disability and Autism. Liam provided further background and context to the Oliver McGowan training as well as the Ask, Listen Do approach and how the Charity was adopting it. Jo, provided a personal reflection on Making Autism Audible by sharing her experiences as a parent with a son who was diagnosed with ASD.		

	PB thanked both Liam and Jo and reflected on the anger felt regarding the system failures that had occurred. SS commented that it was important to hear the stories of what could be achieved and that they were powerful stories. KT added that she felt anger at the waiting times involved and how these affected opportunities. DC reflected on how this learning could be taken into the Charity's services, and how a consistent approach would help. PB commented on the use of psychotic medications and if there were any trends which should be reflected on. SK replied that this was a question which was asked repeatedly, and that the STOMP initiative was key. He suggested that a review be done by the Medicines Management Group and presented to Quality & Safety Committee for further consideration. He added that the use of medications could be beneficial via a collaborative approach and if used appropriately. The Board thanked Liam and Jo for their presentations and for sharing their stories.	**SK**	**21.07.23**
ANY OTHER BUSINESS			
14.	**Questions from the Public for the Board** No questions were received for the Board.		
15.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other business.		
16.	**What would our Patients and Staff think about Our Discussions Today?** • How the presentation on Autism was taken seriously • How frontline staff were being considered and were a main area of focus • How the Board were clear on follow-up and accountability • How the Board positively challenged each other, which indicated a maturity of the Board, and how it accepts that level of challenge. That the questions being asked were the right ones and would make a difference • How the presentation of information could be clearer for the Non-Execs. VMc indicated an appreciation of feedback on this topic.		
17.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Thursday 18th May 2023		

Approved – 18th May 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
26.07.22 **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. **18.05.23** - Remains open and due at July Board meeting.
22.11.22 **02**	**ARC Update – Functional resilience** VMc and DL to review resilience within the IA & Risk function and consider appropriate solutions to be shared with the ARC at the April committee meeting.	VMc & DL	17.04.23	Open	**18.05.23 –** Remains open with on-going discussions on department structure and function due to resignation of Head of IA & Risk.
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	**18.05.23 -** 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	**18.05.23 -** 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 (LC)	21.07.23	Closed	**18.05.23 –** IQPR now updated and includes plan targets. **Propose action is closed**
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	**18.05.23 -** 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	**18.05.23 -** MyVoice responses are increasing as per IQPR report. Propose that assurance of sustained increase be provided through QSC.
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	**18.05.23 -** The aggregated clinical outcomes and meaningful therapeutic activity dashboards are still being tested in some divisions. An update will be provided when this is complete and fully implemented.
31.03.23 **01**	**Chair Update - CAMHS** DC to provide a paper on Sitwell Ward within CAMHS to Board (via QSC) at a future meeting.	DC	28.09.23	Open	**18.05.23 –** The Sitwell paper will be coming to 28 September Board.
31.03.23 **02**	**CEO Report – Call Bells** DC to provide SS with a copy of the Call Bells programme	DC	18.05.23	Open	**18.05.23 –** Note – Action reallocated to DC. .
31.03.23 **03**	**ARC Update – Health & Safety reports** AT to ensure Health and Safety Updates are shared with the Chair of the QSC (SS) in-line with the change in reporting line for H&S to the QSC from People Committee.	AT (DC)	18.05.23	Open	**18.05.23 –** Note – Action reallocated to DC as of 2nd May.

31.03.23 **04**	**People Committee update – Non-Exec Mandatory Training** A review of Trustee related mandatory training to be undertaken, in conjunction with the Nomination and Remuneration Committee, that includes the consideration for a passport approach for using comparable training completed within the NHS.	RB, DL & SC	21.07.23	Open	**18.05.23 –** Due at July Board meeting.
31.03.23 **05**	**Safer Staffing – QSC Reporting** AB to ensure the detail information that supports the Board Safer Staffing Report is provided to the QSC for assurance purposes ahead of providing the overview report to Board.	AB	18.05.23	Open	**18.05.23 –** This will be reported as part of the Safer Staffing Reports that will be submitted to QSC going forward. **Propose Action is Closed.**
31.03.23 **06**	**IQPR – Process related symbol** AW to consider the addition of an appropriate symbol to the current IQPR that highlighted where only a change in process would initiate an improvement in the reported metric.	AW	21.07.23	Open	**18.05.23 –** The IQPR has been refreshed – feedback is welcomed from Board members.
31.03.23 **07**	**IQPR – Tertiary service providers** DL to liaise with PB and schedule a future Board agenda item on Tertiary Service Providers to better understand any inappropriate placements or what may impact the complexity of discharge.	DL	21.07.23	Open	**18.05.23 –** Due at July Board meeting.
31.03.23 **08**	**IQPR – TI presentation to Court of Governors** Presentation to be consider for the next Court of Governors that highlights the work of the Technical Instructors. Note: Next Court on 19th May 2023	DC	21.07.23	Open	**18.05.23 –** Due at July Board meeting.
31.03.23 **09**	**Oliver McGowan Training – Use of psychotic medications** Medicines Management Group to undertake a review of the use of psychotic medications and report to QSC ahead of Board.	SK	21.07.23	Open	**18.05.23 –** Due at July Board meeting.

Chair Update, incorporating: Annual Fit and Proper Declaration

(Paul Burstow)

Paper for Board of Directors

Topic	Annual Fit and Proper Persons Declaration
Date of meeting	Thursday, 18 May 2023
Agenda item	**05**
Author	Duncan Long, Company Secretary
Responsible Executive	Paul Burstow, Charity Chair
Discussed at previous Board meeting	27 May 2022
Patient and carer involvement	Not required for this process
Staff involvement	Not required for this process
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	None previously

Report summary and key points to note

All current Board members and those who have director level responsibility and regularly attend Board meetings have submitted annual declarations satisfying the requirements within the Fit and Proper Person Regulations 2014 (Regulation 5 of the Health and Social Care Act 2008), demonstrating that all are of good character and meet the requirements. The following checks have also been undertaken by the Company Secretary in accordance with the Charity's Annual Declarations process, from which no issues of note have emerged:

- Confirmation of all Directors in scope for the 2023 declaration process, incorporating Director Self-declaration of Interests; Related Party Transactions; Public Contract Regulations; Reportable Gifts; Audit Declaration and Self-declaration for other incidents or relevant matters.
- Review of appointment checks completed on any newly appointed Trustees/Directors that are in scope
- Individual insolvency register
- Disqualified directors register
- Companies House Director check
- Search of Charity Commission Register of Removed Trustees
- General internet search

The Chair has overall responsibility for ensuring the Charity discharges the requirements placed on it to ensure that all Directors meet the fitness test and do not meet any of the "unfit" criteria. No concerns about relevant Directors' fitness or ability to carry out their duties, or information about a Director not being of good character have been identified. The Chair therefore provides the Board with assurance that all relevant Board members and those Directors in scope continue to meet the Fit & Proper Persons requirements.

The Board is asked to accept the assurance that all Board members and Directors continue to meet the Fit & Proper Persons requirements.

Appendices

None

Paper for Board of Directors	
Topic	CEO Board Update
Date of Meeting	Thursday, 18 May 2023
Agenda Item	**06**
Author	Dr Vivienne McVey, CEO
Responsible Executive	Dr Vivienne McVey, CEO
Discussed at Previous Board Meeting	Updates have been discussed at the Executive meetings.
Patient and Carer Involvement	A number of these items would have been discussed with patients and carers
Staff Involvement	A number of these items would have been discussed with staff
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic 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 Internal audit on the DSPT 2022/23 concluded with substantial assurance. Will be presented at the next ARC

Report Summary and Key Points to Note

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

Appendices –

Information Governance Data Protection and Security Toolkit Annual Submission

CEO Report

During the last reporting period, the Executive Team has been focussing on three areas:

1. The first phase of the Thrive Programme aiming to achieve quality, workforce and financial sustainability across the Charity.

2. The co-production of our overarching five-year strategy, which will see us achieve our vision and mission to be a leader in supporting those with complex mental health need to transform their lives, and the creation of the Education, Research and Training (ERT) Business Unit.

3. Continuing to improve the delivery of our 'business as usual activities' in the highly regulated and complex system we operate in.

This CEO report to the Board of Directors provides an update on areas of focus within 'business as usual' for the Executive Committee and matters that are not dealt with under other agenda items, including an update from ERT.

1. **Quality**

- **The Quality Strategy:** has been disseminated and is being implemented across the Charity. A number of initial activities have been completed including the development of the policy oversight function and the allocation of all policies to governance groups. Engagement workshops have been held with different leadership groups as part of the implementation plan alongside workshops to identify quality priorities. The strengthened ward to Board governance templates have been trialled and will be rolled out across all Divisions in June. The programme is currently in the phase of building capability through recruitment of the Quality Matrons and General Managers (aligned to the Thrive programme) to support the next phase of implementation.

- **CQC**: Essex services were re-inspected 14–16 March 2023, we have received brief verbal and written feedback prior to their full report. Issues raised included cleanliness, and blanket rules. The feedback and thematic issues were discussed, and assurance provided to the Quality and Safety Committee.

- **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. The application for registering the Northampton site as a single CQC location has been approved. The COO will assume the responsibility as Registered Manager for the site.

- **Surveillance and inspection process**: A mock CQC inspection process has been implemented across the Charity. Birmingham, Essex, and Neuro Divisions have been part of the initial process, with the findings and issues placed on their individual Quality Improvement Plans (QIPs). The process is being developed following learning from the initial inspections, and a programme of targeted inspections based on surveillance and risk will be recommended to the Executive Team during May.

- **Quality Improvement Plans:** Each division has developed their own QIP, based on Commissioner Quality reviews, internal surveillance and CQC Inspections. These are monitored at the regular Performance meetings chaired by the Chief Operating Officer. A Charity wide QIP incorporating wider themes and specific organisation wide issues is monitored via bi-monthly meetings chaired by the Chief Nurse. Summaries of progress are reported to the Executive Team.

- **East Midlands Alliance/ NHSE Support**: The Buddy Support Programme was closed at the end of March, with the vast majority of the exit criteria met. Three areas required further assurance: Enhanced Observations/Fundamentals of Care, Increased Reporting of Near Miss and Low Harm Incidents, and a Quality Impact Assessment Process to Support Workforce Safeguards. We are developing digital support to ensure ease of reporting for near miss/low harm incidents, a Quality Impact Assessment has been developed and is awaiting final approval. The Fundamentals of Care/ Enhanced Observations remains a focus and will be greatly supported by the new Operating Model with the Associate Directors of Nursing and Quality Matrons having a key role in supporting this going forward.

2. **People and Culture**

- **Annette Greenwood**: Consultant Psychologist & Trauma Response Lead has been appointed as Chair of the Crisis, Disaster & Trauma section of the British Psychological Society for 2023-2024. This will form an important part in promoting the trauma education, training and service delivery of Education Research and Training, our Centre of Developmental and Complex Trauma and the Charity as a whole.

- **People:** the HR team has been supporting the structural changes in the phase 1 of the Thrive programme to both strengthen the divisional leadership and bring quality closer to the patient, and we are now working through a programme of development to support those in new roles.

- **Culture development:** The Alignment of Lead the Change activities to the Thrive Programme and our new strategic ambitions has now been undertaken, with each key change finding a 'home' in these programmes of work. 'Lead the Change' will conclude by September with activities/ deliverables moved into the responsible areas of delivery. The Change Leaders are currently being consulted on how their voice continues to have maximum impact across the Charity, possibly via Champion roles supporting a number of our strategic priorities. Improving communication throughout the whole Charity is a key priority and Change Leaders are currently working up and testing ideas in relation to this.

3. **Clinical Services Operations**

- **Operations Committee (OpComm):** OpComm has progressed a number of key commissions over the past two months:

    - Review of CCTV and bodycams to inform the Executive Team by the end of May on best security options going forward – progressed through Security sub-group
    - A New Standard Operating Procedure for Emergency Preparedness, Response and Resilience (EPRR)– progressed through EPRR sub-group

- Psychology leadership of improving the My Voice response (see agenda Item 10 – IQPR)
- Clarity on commissioning contractual expectations and response – progressed through Commissioning sub-group
- Progression of the temporary solution for call bells through Estates & Facilities and permanent solution through IT
- CQI project initiated to improve the Induction process

- **Staff Management Procedures:** A joint piece of work between HR and Operations to refresh all staff management procedures has been completed (bar grievance procedure) and published. This will improve the response to staff issues and ensure rapid conclusion for both individuals and the teams they work in.

- **Operational performance:** There has been a significant improvement in performance across many KPIs through stronger management and leadership at the Divisional IQPRs, chaired by the COO, and which include sharing of best practice and learning – as noted in the Board performance report

- **The Clinical Services Programme Board** has been established. Chaired by the COO, this progresses the new operating model with a number of critical work streams chaired by the Service Directors.

- **Nursing spend:** There has been a full review of nursing spend grip and control issues uncovering the following, with the ***solutions in bold below implemented from 2nd May***:

  - Lack of adequate data and reporting – ***new dashboard established to ensure shifts do not increase above 100% of need***
  - No nursing budget breakdown or nursing/HCA posts established – ***new nursing and HCA posts established for every ward for recruitment control purposes***
  - Rostering process flawed from end to end – ***new process map agreed and cascaded***
  - Allocate 'rules' turned off, misused or abused including additional shifts given even when not approved – ***new rules in Allocate to prevent addition of shifts, to control the Working Time Directive (WTD) and to ensure approvals at right level of authority***
  - Poor capability of nursing workforce on rostering principles leading to over allocation of paid annual leave – ***ongoing work to build capability and to refresh all training***

4. **Estates and Facilities**

- **Cleaning Standards**: We have commenced key initiatives to address cleaning standards across all sites. We have started the completion of quarterly peer reviews within the Housekeeping Audit cohort to ensure consistent audit standards are observed and maintained. Additionally, dialogue has commenced with the Nursing team to improve dialogue and the understanding that standards of ward cleanliness are shared between clinical and Estates teams, and to engender a greater sense of joint ownership to ensure standards are improved. We are also including the Infection Prevention and Control (IPC) team in the group discussion and action plan.

- **Workbridge retail**: demonstrated strong and sustained growth of 30% at the end of the financial year and is well on the way to meeting its two year target. There is more detail about the expansion plans in Part 2 of the CEO report.

5. **Communications and engagement**

- **Your Voice Snapshot Survey:** Following the launch of our Thrive Programme, and as we embark on our new strategy we want to check attitudes across the Charity and ensure that our staff are engaged. Therefore, on Thursday 1 June we're launching a Your Voice Snapshot Survey, which will ask six questions. We will communicate the results when we have them. Another full survey will take place in November.

- **St Andrew's 2023 Annual Awards:** Our Annual Awards will take place at the Park Inn on 18 May. We received a record number of nominations (more than 1,000) and the evening celebration will celebrate staff who go above and beyond in their roles.

- **Mental Health Awareness Week:** To mark Mental Health Awareness Week this May, we're launching a photo exhibition entitled "Hope" which features five people who have been in our care. The Hope roadshow will be showcased at Northampton train station, Northampton General Hospital and the shopping Centre in Northampton, the Grosvenor Centre, before moving to our Essex and Birmingham sites. We hope the exhibition will improve external awareness of our work.

- **BBC's Headfest:** Headfest, is a weeklong festival aimed at raising more awareness around mental health, and led by the BBC. This year, we're leading two key events in Northampton during the second week of May; the first a session on Personality Disorder and the second a craft and chat session at Workbridge.

- **Positive recovery story:** A former patient of ours has shared her story in national publication the Independent, where she has praised St Andrew's Healthcare staff for their care and treatment of her. Sedona, who has been in and out of mental health services for many years, said we "saved her life".

6. **Education, Research and Training (ERT) Update**

- **Governance**: The ERT Business Unit is now up and running led by Martin Kersey, team building events have taken place, and SLAs being agreed with Clinical services for training services provided. The TOR for the ERT Committee are in development. This committee will oversee the strategy and performance of the Business Unit, with the Research Committee becoming a more 'operational' committee.

- **Research Open Day**: Stanton Newman chaired our first Research Open Day on Friday 28 April with over 60 delegates and a mixture of internal and external speakers showcasing the research being undertaken along with a number of poster exhibitions.

- **The Lightbulb Programme:** Has been shortlisted and presented for the prestigious Pearson awards, known as the 'Oscars' of the teaching profession. The Headmistress of a local primary school talked about our 'build resilience programme' and how this has helped teachers and parents and she described the programme, as "All our Prayers are being answered".

7. **Data security and protection toolkit pre submission approval**

   We believe we have taken all reasonable steps to ensure compliance with the DSPT requirement and as a result of the detailed due diligence undertaken, internal audit assurance and the re-accreditation of ISO27001, we are confident that the DSPT requirements will be met.

   Therefore, the Board is asked to approve the submission to NHS Digital of the DSPT, which reflects a "Standards met" position however note that action continues to be taken through the IGG, to review, monitor, and ensure continual improvement in Information Governance within the organisation.

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

Dr Vivienne McVey
Chief Executive Officer

Information Governance Data Protection and Security Toolkit (DPST) Annual Submission

Executive Summary

St Andrew's must undertake an annual assessment, called the Data Security and Protection Toolkit (DSPT) to identify and evidence its current compliance against a set of recognised data protection and data security standards, which is then assessed by NHS Digital.

It is an annual assessment. As data security standards evolve, the requirements of the DSPT are reviewed and updated to ensure they are aligned with current best practice. Organisations with access to NHS patient data must therefore review and submit their annual assessment each year.

The Data Protection Officer has been co-ordinating this work over the last year through the Information Governance Group (IGG) with support from key staff including, the Senior Information Risk Owner (SIRO) (John Clarke), Caldicott Guardian (Andy Brogan), Head of Audit and the IT Security Team.

The DSPT does not have a score rating, instead, it identifies if a standard is met or not. The assessment of St Andrew's regarding the DSPT for this year, will be "Standards Met".

The assessment criteria have been ratified by Information Governance Group (IGG) during the period November 2022 to April 2023.

The DSPT requires Executive Team and the Board to be informed on Information Governance risks and to approve the annual submission.

Background

The toolkit allows organisations to measure their performance against the National Data Guardian's 10 data security standards and align with the General Data Protection Regulation (GDPR) and Data Protection Act 2018. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurances that they are practising good data security and that personal data is handled in line with data security standards. It also puts organisations in a position where they have the tools and processes to respond and deal with information governance incidents.

All organisations that have access to NHS patient information must provide assurances that they have the proper measures in place to ensure that this information is kept safe and secure. Completion of the DSPT is therefore a contractual requirement specified in the NHS England Standard Conditions contract and it remains Department of Health and Social Care policy that all bodies that process NHS patient information, for whatever purpose provide assurances via the DSPT.

DSPT assessments are to be submitted by 30th June annually.

Summary of Work Undertaken

In the last year a significant amount of work was undertaken to ensure St Andrew's meets the DSPT standards. This year work has included:

- Significant efforts to review and improve the Charity's register of personal data, which includes information regarding all of the personal data that the Charity holds. We have been working to ensure that divisions and departments are involved in the reviewing of the information that they hold and process to ensure the register is up to date.
- Working with Communications colleagues to ensure that the St Andrew's Healthcare websites are all complaint with the Privacy and Electronic Communications Regulations.
- Working to ensure that the Charity is now fully complaint with the NHS Data Opt Out rules, which applies to all health and social care organisations. This ensures that we check the NHS central opt-out database before using health records for anything other than the direct provision of that persons care.
- Implementing a programme of data protection audits and spot checks, with audits of CCTV requests, Subject access Requests, use of body-worn cameras and historic paper records completed during 2022/23.
- Developing a centralised list of all suppliers that process personal data on the Charity's behalf. Previously, this information was held by a number of teams and there was no standardised process in collating and holding the data processing agreement. Now, the Information Governance Team are keeping all data processing agreements and evidence items in one place which helps us in demonstrating our accountability requirements. We have developed a third party Information Governance Procedure which has gone out to all key contacts so they know what to do if they are thinking about working with a supplier or third party that will process personal data on behalf of the Charity.
- Updating key documentation so that they are fit for purpose, including the Information Security and Information Governance questionnaire for suppliers, the Data Processing Agreement, Information Sharing Agreement and the Data Protection Impact Assessment methodology/guidance has also been updated.
- Continued to ensure that privacy and data protection requirements are embedded into key projects across the Charity, from the early design stage through deployment, use and disposal.
- Further increasing governance controls for managing any risks related to IT software.
- Significant development of the Information Governance risk register which is much improved to ensure that we are capturing our risks consistently and that where required, they are escalated to the right people at the right time.
- The Information Security Team continuing to provide regular metrics to the Board and the Executive Performance meeting to aid the understanding of the information security landscape. The update includes vulnerability management, audits undertaken, security incidents, outstanding security updates, and blocked network attacks.

Internal Audit Assessment

It is mandated via the NHS Standard Contract and the DSPT requirement that organisations that handle NHS patient data must annually complete a DSPT audit/independent review.

The scope of this review was limited to the 13 assertions advised by NHS Digital in its 2022/23 guidance for auditors. The elements of these assertions that are non-mandatory or exempted by ISO 27001 accreditation were not been assessed.

The assessment considered whether the Charity meets the requirement of each evidence text, and also considered the broader maturity of the organisation's data security and

protection control environment. Results were based on interviews with key stakeholders as well as a review of key documents where necessary to attest controls/processes.

Based on the evidence obtained during the review, we received an overall opinion of Substantial Assurance

- The Charity's arrangements to complete the annual DSP Toolkit self-assessment continue to improve, with the IT Health Dashboard recently being implemented This tool provides increased visibility of network connected assets and enables organisations to export a series of reports which can be used to evidence compliance with the majority of DSPT assertions.

- The audit testing has identified that the Charity can support a reasonable level of compliance with all 13 Evidence items that were reviewed, and as a result no recommendations for improvement have been made.

Data Security and Toolkit Position

The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. The standards are outlined here:

People Ensure staff are equipped to handle information respectfully and safely	**Process** Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.	**Technology** Ensure technology is secure and up to date
1. All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form.	4. Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required.	8. No unsupported operating systems, software or internet browsers are used within the IT estate.
2. All staff understand their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches	5. Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses	9. A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials.
3. All staff complete appropriate annual data security training and pass a mandatory test	6. Cyber attacks against services are identified and resisted and CareCERT security advice is responded to	10. IT suppliers are held accountable via contracts for protecting the personal confidential data they process
	7. A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management	

One of the standards of the DSPT is ensuring that organisations meet a 95% completion rate of staff who work with personal data, undertaking their mandatory Information

Governance training. Our highest completion rate so far has been 89%. We are working with the senior management teams to reach the 95% target by the 30th June 2023.

As St Andrew's is certified to the information security management standard ISO27001:2013, we automatically meet some of the more technical IT requirements of the DSPT. ISO27001 accreditation involves an externally verified audit and this saves us considerable time in this annual assessment, and it should be noted that our DSPT accreditation is dependent on continued adherence to ISO27001, therefore the loss of this accreditation would pose a significant risk to achieving this key standard.

We believe we have taken all reasonable steps to ensure compliance with the DSPT requirement. We would like to acknowledge, that as part of the process to complete this work, we have captured some areas for improvement to ensure we continually assess and audit our data security and protection controls. This work will be overseen by the IGG, which is part of their remit.

Recommendation to the Board
As a result of the detailed due diligence undertaken, internal audit assurance and the recently re-accredited ISO27001, we are confident that the DSPT requirement will be met before we are required to submit the assessment to NHS Digital on 30th June 2023.

Therefore, the Board is asked to approve the submission to NHS Digital of the DSPT, which reflects a "Standards met" position, however noting that action continues to be taken through the IGG, to review, monitor, and ensure continual improvement in Information Governance within the organisation.

Committee Updates

Audit & Risk Committee

Incorporating:

- Reserves Policy,
- NHS England Annual Solvency Pre-Submission Approval
- ToR Approval

(Rupert Perry)

Quality & Safety Committee

Incorporating:

- Quality Strategy Update

(Steve Shrubb)

Research Committee

(Prof Stanton Newman)

People Committee

(Dawn Brodrick - *verbal*)

Committee Update Report to the Board of Directors

Name of Committee: Audit and Risk Committee

Date of Meeting: 17 April 2023

Chair of Meeting: Rupert Perry

Significant Risks/Issues for Escalation:

- New material risk proposed in relation to the Charity not meeting the requirements of the policy in terms of the level of reserves being held
- Adequate assurance agreed for both operational and material risks
- Adequate assurance for the Whistleblowing and speaking out processes

Key issues/matters discussed:

1. Grant Thornton

Grant Thornton presented the committee with an update on the progress against the external audit plan. Planning and interim visits had been completed and the audit is on track, with no weaknesses identified to date. GT highlighted that in line with ISA 315 now applicable, the relevant processes around significant controls had been completed and documented in more detail, which had enabled a more robust approach towards revenue, and a key focus for the year would be the interaction between information systems and business processes.

2. Accounting Policies

The Committee carried out its annual review of accounting polices applied to the financial statements and confirmed that there were no changes in accounting standards that become effective for the 2022/23 financial year.

3. Charity Reserves Policy

The final Charity Reserves Policy was presented to the Committee for approval. The policy had been amended to reflect changes requested by the Committee and had also been reviewed by GT, who were content with it and had no further suggested changes. The policy was approved, however it was noted that the Committee will incorporate an annual review of the new policy in alignment with its annual review of main accounting policies. Furthermore the Committee requested that a new material risk be proposed to reflect the risk of the Charity not meeting the requirements of the policy in terms of the level of reserves being held.

4. NHS England Annual Insolvency submission

The Committee carried out a review of the Charity's annual self-certification declaration in accordance with the requirements of the Charity being designated as a provider of Commissioner Requested Services. Following a review of the submission, the Committee approved the submission for Board approval at the May meeting, along with endorsing the CFO signing of the submission.

5. Risk Management

The Committee received a revised version of the Risk Management reports for both operational and material risks which followed the recent changes to reporting for the Executive Team. The Committee discussed updating how unacceptable risks were reported and highlighted within the reports, and were updated on the on-going changes to the risk policies and procedures, flowcharts and guidelines that were being consulted on at present. Adequate assurance was agreed for both operational and material risk management processes.

The Committee also reviewed the 6 monthly risk management self-evaluation that provides assurance over progress with the on-going development of the Charity's Risk Management System as well as the alignment of the planned work within the function with the Governance Project actions. Adequate assurance was agreed in respect of the overall progress made.

6. Whistleblowing and raising concerns report

The Committee received and considered an annual update on the Charity's Whistleblowing and Speaking Up processes. This covered the Charity's primary methods for employees' raising concerns of Safecall, Freedom to Speak up guardians and Line Management, as well as the other multiple ways in which our staff have a voice. The Committee were content that there was an adequate level of assurance from the paper and subsequent discussion.

7. Internal audit

The Committee reviewed the current internal audit update covering published reports, functional resource, audit actions dashboard and progress versus internal audit annual plan. The level of outstanding IA actions were discussed, noting the progress made since the last Committee update. The Committee were also updated on progress with the introduction of the new Integrated Assurance model and the work being undertaken by IA to improve the connections between the multiple 2nd line of assurance functions and their effectiveness.

The Committee approved the IA Annual Plan for 2023/24, noting the addition of a 60/40 split on audit assignments between those initiated and approved via the Internal Audit team using its audit universe, and the remainder nominated by the Executive Team for areas of concern that require an audit or review.

The Committee also approved the updated Internal Audit Charter. The Charter formally outlines the Internal Audit approach and is linked to the Internal Audit practice framework and standards, and represents an agreement between IA, ARC and Charity management as to what IA do and how they do it.

8. Counter fraud

The Committee received and reviewed the latest counter fraud activity update that included information on recent local proactive counter-fraud work, any referrals for potential fraudulent activity in the previous period and an update on wider horizon scanning for issues that may impact the Charity.

The Committee also received, reviewed and approved the Local Counter Fraud Specialist annual plan for 2023/24.

9. Audit & Risk Committee Terms of Reference

The Committee received and approved the updated Terms of Reference. This followed the Terms of Reference Workshop in March, whereby committee members reviewed the terms on a line-by-line basis, comparing to previous terms and taking into account the terms of other Board Committees.

Decisions made by the Committee:

- Approval of the Charity Reserves Policy
- Approved the submission of the NHSE CRS Licence Agreement Annual Declarations to Board for final approval ahead of signature and submission
- Approved the Internal Audit Plan for 2023/24
- Approved the Internal Audit Charter
- Approved the LCFS Annual Plan for 2023/24
- Approved the revised Terms of Reference for the Audit and Risk Committee

Implications for the Charity Risk Register or Board Assurance Framework:

The Committee discussed the Charity's Risk Appetite approach and confirmed that whilst the Risk Management systems within the Charity were improving and much progress had been made, there remained more to do on embedding and working with risk appetite. Further discussions were required on ensuring the agreed risk appetite aligned with the new Operating Model and the Charity's new Strategy.

Issues/Items for referral to other Committees:

None

Issues Escalated to the Board of Directors for Decision:

- Board approval of the Charity's Reserve Policy
- Board approval of the NHSE CRS Licence agreement
- Final approval of the revised Terms of Reference for the Audit and Risk Committee

Appendices:

- Charity Reserve Policy
- NHSE CRS Licence Agreement Annual Declarations to Board
- ARC Terms of Reference
- IA Annual Plan for 2023/24 (see Annex B of pack)
- IA Charter (see Annex C of pack)
- LCFS Annual Plan for 2023/24 (see Annex D of pack)

Appendix 1

St Andrew's Reserves Policy – April 2023

Purpose

The purpose of the Reserves Policy for St Andrew's Healthcare is to ensure financial stability and assurance in the ability of the Charity to continue to operate as a Going Concern, meeting all liabilities as they fall due.

The Charity Reserves are intended to provide a source of funds for circumstances including -

1. Sufficient short and medium term cash flow to meet all liabilities as they fall due – known as **Operating Reserve Fund.**
2. Sufficient cash flow to cover any material unbudgeted expenditure, unanticipated loss in funding, unexpected and extended material financial losses, strategic priorities and other unforeseen events creating longer term financial distress – known as **Unforeseen Reserve Fund.**
3. Sufficient cash flow to cover **Essential Maintenance,** including unexpected repairs to critical assets to maintain ongoing services.

Charity Reserves are not intended to replace a permanent loss of income or eliminate an ongoing budget gap. It is the intention of St Andrew's Reserves to be used and replenished within a reasonably short period of time and such Reserves are intended to support the strategic priorities of the Charity.

Definitions and Targets

- **The Operating Reserve Fund** is defined as a fund set aside and will be an amount sufficient to maintain ongoing operations and programmes for a set period of time, measured in months. The Operating Reserve Fund level will be reviewed and adjusted in response to internal and external changes and the Charity priority in bank loan facility repayments or strategic investment.

  The target minimum Operating Reserve Fund is equal to **one month of average operating costs**.

  The calculation of average monthly operating costs includes all recurring, predictable expenses such as all staff related costs, contractual expenditure, patient care and ongoing living costs, service costs, utilities, interest and charges, pension scheme costs, average annual project associated expenditure and one off non recurrent costs. **Depreciation and other non-cash expenses are not included in the calculation.**

- **Unforeseen Reserve Fund** is defined as a fund for unexpected circumstances causing short to medium term cashflow/financial challenge. The target minimum Unforeseen Reserve Fund will be set at **5% of annual income** and will be reviewed and adjusted in response to internal and external changes.

  The minimum Unforeseen and Operating Reserve Fund target value calculated each year after approval of the annual budget and reported to the Finance Committee in the regular financial reports. If the annual budgeted Reserve Fund levels (Operating and Unforeseen) are below that set out in the policy, this will be identified and reported to the Finance Committee, along with difference between target level (the policy target level) and the budget agreed level for the financial year.

- **Essential Maintenance** is a fund that identifies and plans for the capital expenditure and maintenance to maintain continuation of essential services of the Charity and beneficiaries. Will be set at 1.5**% of annual income**.

Reserve Fund = Operating Reserve + Unforeseen Reserve + Essential Maintenance Reserve

Accounting & Funding of Reserve Fund

- Cash balance (excluding Service Users' monies and restricted funds) will be allocated in the following sequence:
  1. Current liabilities (taxation, creditors etc)
  2. Bank loan minimum annual repayments
  3. Operating Reserve Fund
  4. Essential Maintenance Reserve Fund
  5. Unforeseen Reserve Fund
- The Investment Portfolio should only ever be allocated to the Unforeseen Reserve Fund.
- Cash balance and Investment Portfolio will be monitored to ensure sufficient Reserves Funds exist, along with consideration for repayment of the Charity loan balance or any strategic investments.
- Bank loan repayments above minimum requirements will be subject to cash generated from future trading operational activities.

The Charity has a high value of tangible fixed assets, most of which is property, but as it is not liquid enough to support the Reserves Policy these amounts have been excluded from the calculations.

If after the exclusion of tangible fixed assets (and restricted funds), the resultant figure for unrestricted funds is negative, it will not be possible to achieve the aims of the reserves policy.

Reporting and Monitoring

- The CFO is responsible for ensuring that all three elements of the Reserve Fund are maintained and used only as described in this Policy.
- Reporting of Reserve Fund Levels will be to the Finance Committee.
- Annual Reserve level targets will be agreed during the budget review process and reported on at each Finance Committee.
- Finance Committee to report to Board annually on Reserves Policy as part of annual budget review, advising Board on Charity position compared to desired policy.
- Board to review and approve the reserve policy targets levels of
  1. Operating Reserve – one month of operating costs
  2. Unforeseen Reserve – 5% of income
  3. Essential Maintenance Reserve – 2.5% of income

Relationship to Other Policies

None

Review of Policy

This Policy will be reviewed every two years as a minimum by the Finance Committee or sooner if warranted by internal or external events or changes. Changes to the Policy will be recommended by the Finance Committee to the Board of Directors.

Appendix - Example of Reserve Fund (as January 2023)

Annual Income - £176m	Financial Year 2022/23 (Budget)			
£m	Target (as per Policy)	Reserve Fund Allocation	Diff	
Operating Reserve	13.5	(2.0)	(15.5)	One Mth of operating costs
Essential Maintenance Reserve	2.6	0.0	(2.6)	1.5% of Annual Income
Unforeseen Reserve	8.8	11.6	2.8	5% of Annual Income
Reserve Fund	**22.3**	**9.6**	**(12.7)**	
Financial Accounts 31 March 2022				
Cash		4.9		
Investment Portfolio		11.6		
Bank Loan minimum annual repayment		(1.0)	Loan legal repayment requirement	
Charity Current Liabilities		(5.9)		
Net Asset/(Liabilities)		**9.6**		

£9.6m reserve fund exists (£12.7m below policy target).

Appendix 2

NHSE Commissioner Requested Services (CRS) License Agreement Annual Declarations

St Andrew's has been designated as a provider of Commissioner Requested Services (CRS) and consequently has to complete self certification declarations annually by 31 May (two months after year end). Required submissions are against the following CRS conditions:

- General Condition 3 (G3) – Fit and Proper Persons as Directors
- General Condition 5 (G5) - Systems for compliance with licence conditions and related obligations
- Continuity of Services Condition 7 (CoS7) – Availability of Resources

This paper outlines the requirements of each submission and St Andrew's submissions (in red)

General Condition 3 - Fit and Proper Persons as Directors

All independent sector providers of healthcare services who hold an NHS provider licence are required to submit an annual certificate of compliance against condition G3 of their licence. Each Licensee is required to certify annually that, following a review of condition G3 of the provider licence, the Directors of the Licensee are or are not satisfied, that in the Financial Year most recently ended, the Licensee was compliant with condition G3.

St Andrew's Self-Certification G3 Licence Condition

Following a review of licence condition G3, the Directors of the Licensee confirm that the Licensee has not, in the financial year most recently ended appointed or had in place any person as a Director who is not fit and proper, within the meaning of licence condition G3(3).

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

Signed by CFO on behalf of St Andrew's Healthcare:

General Condition 5 - Systems for compliance with licence conditions and related obligations

All independent providers of healthcare services who hold an NHS provider licence are required to submit an annual certificate against condition G5 of their licence. Each Licensee is required to certify annually that, following a review of the provider licence, the Directors of the Licensee **are or are not satisfied**, that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with condition G5.

The certificate must be approved by your Board of Directors, signed to that effect and submitted through your licensing portal within two months of the end of the relevant financial year, i.e. by 31 May 2023.

See appendix for General Condition 5

St Andrew's Self-Certification G5 Licence Condition

Following a review for the purpose of paragraph 2(b) of licence condition G5, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with condition G5.

Signed by CFO on behalf of St Andrew's Healthcare:

Self-certification of Continuity of Services Condition 7

Submit an availability of resources certificate within two months of the end of each financial year, in accordance with Condition CoS7 of your license. This must be accompanied by a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

St Andrew's Continuity of Services 7 Self-Certification

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

In making this statement the Executive Team have considered:

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

Signed by CFO on behalf of St Andrew's Healthcare:

Appendix - General Condition 5

1. The Licensee shall take all reasonable precautions against the risk of failure to:

    a. the Conditions of this Licence;
    b. any requirements imposed on it under the NHS Acts; and
    c. the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
3.
    a. the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
    b. regular review of whether those processes and systems have been implemented and of their effectiveness.

Terms of Reference
Audit and Risk Committee (ARC)
St Andrews Healthcare

1.0 Authority

The Audit and Risk Committee (ARC) is constituted as a Standing Committee of the St Andrew's Healthcare Board. Its constitution and terms of reference shall be as set out below, subject to amendment by the Board.

The ARC is authorised by the Board to request the attendance of individuals and authorities from within or outside of the Charity with relevant experience and expertise as it considers necessary at the cost of the Charity. The ARC is also authorised to investigate any activity within its duties under these terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee.

The ARC maintains a primarily assurance and advisory based role and is responsible for making recommendations to the Board for Board approval unless otherwise stipulated by these Terms of Reference.

2.0 Purpose

The principal functions of the Committee are to provide:

2.1 An audit assurance function, with a focus on assurance arrangements over governance, legal and regulatory compliance, internal control systems, financial reporting, annual reporting and accounts (including the governance statement) and performance of both the internal and external auditors.

2.2 A risk assurance function, with a focus on ensuring there is an adequate and effective risk management and assurance framework in place.

2.3 An advisory role to the Board and other Committees.

The Committee's responsibilities cover the Charity and its subsidiaries.

3.0 Duties

Internal Audit

The Committee shall:

3.1.1 Monitor and review the scope and effectiveness of the Charity's internal audit function.

3.1.2 Approve decisions regarding the appointment and/or removal of the Head of Internal Audit and their functional reporting lines.

3.1.3 Consider and approve the remit of the internal audit function and ensure it has adequate resources and appropriate access to information to enable it to perform its function effectively and in accordance with the relevant professional standards.

3.1.4 Review and recommend to the Board the internal audit strategy, IA Charter and annual internal audit plan and monitor such plan on a regular basis.

3.1.5 Review audit reports and consider the major findings of internal audit work (and management's response) and ensure co-ordination between the internal and external auditors to optimise audit resources.

3.1.6 Review and monitor management's responsiveness to the findings and recommendations of the internal auditor and their progress against agreed audit actions.

3.1.7 Meet the Head of Internal Audit at least once a year, without management being present to discuss their remit and any issues arising from the internal audits carried out. In addition, the Head of Internal Audit has the right of direct access to the Chair of the Board and to the Committee.

3.1.8 Initiate periodic reviews of the effectiveness of internal audit ensuring the function remains in line with the standards and attributes set out by the Chartered Institute of Internal Auditors, ensuring that an independent review is carried out at least every five years.

External Audit

The Committee shall:

3.2.1 Oversee the relationship with the Charity's external auditor;

3.2.2 Consider and make recommendations to the Board, to be put to Governors for approval at the Annual Court, in relation to the appointment, re-appointment and removal of the Charity's external auditor. The Committee shall oversee the selection process for a new auditor and if an auditor resigns the Committee shall investigate the issues leading to this and decide whether any action is required.

3.2.3 Approve the Terms of Engagement of the external auditor, including any engagement letter issued at the start of each audit and the scope of the audit.

3.2.4 Assess the independence and objectivity of the external auditor annually, taking into account relevant UK professional and regulatory requirements and the relationship with the auditor as a whole, including the provision of any non-audit services.

3.2.5 Meet regularly with the external auditor, including once at the planning stage before the audit and once after the audit at the reporting stage. The Committee shall meet the external auditor at least once a year, without management being present; to discuss the auditor's remit and any issues arising from the audit.

3.2.6 The Committee shall review and approve the annual audit plan and ensure that it is consistent with the scope of the audit engagement.

3.2.7 The Committee shall review the findings of the audit with the external auditor. This shall include but not be limited to, the following:

- a discussion of any major issues which arose during the audit;
- any accounting and audit judgements;
- levels of errors identified during the audit; and
- the effectiveness of the audit.

3.2.8 The Committee shall also:

- review any representation letter(s) requested by the external auditor before they are signed by the Executive Directors;
- review the management letter and management's response to the auditor's findings and recommendations; and
- develop and implement a policy on the supply of non-audit services by the external auditor, taking into account any relevant ethical guidance on the matter.

Other Assurance Activities

The Committee shall:

3.3.1 Review the adequacy and security of the Charity's arrangements for its employees, volunteers and contractors to raise concerns, in confidence, about possible wrongdoing and risk in financial reporting, clinical practice or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

3.3.2 Monitor the Charity's procedures for detecting and countering fraud, and assure the Charity that it has adequate systems in place and will review the outcomes of counter fraud work.

3.3.3 Monitor the Charity's systems and controls for the prevention of bribery, corruption and potential conflicts of interest.

3.3.4 In line with assurance received from the Internal Auditors, review and assess the process surrounding the NHS Data Security and Protection Toolkit submission prior to Board approval.

3.3.5 Review and assess the Caldicott Guardian and Senior Information Risk Owner Annual Report prior to Board approval.

3.3.6 Consider the work of other Committees and Groups in conjunction with their own work in order to provide assurance regarding the Committee's own scope of work.

Management

The Committee shall:

3.4.1 Request and review reports and positive assurances from management on the overall arrangements for governance, risk management and internal control as required.

3.4.2 Periodically assess the efficiency and adequacy of the Charity's corporate governance arrangements.

3.4.3 Monitor the integrity of the financial statements of the Charity, including its Annual Report, and any other formal announcement relating to its financial performance, reviewing significant financial reporting issues and judgements which they contain. In particular the Committee shall review and challenge where necessary:

3.4.3.1 The consistency of, and any changes to, significant accounting policies both on a year by year basis and across the Charity and its subsidiaries, including the Reserves Policy.

3.4.3.2 The methods used to account for significant and unusual transactions where different approaches are possible.

3.4.3.3 Whether the Charity has followed appropriate accounting standards and made appropriate estimates and judgements taking into account the views of the external auditor.

3.4.3.4 The clarity and completeness of disclosures in the Charity's financial reports and the context in which statements are made; the Charity's approach to impairment; and compliance with the financial and corporate governance reporting standards application to the Charity.

3.4.3.5 The adequacy and effectiveness of the Charity's internal control environment.

3.4.4 At the request of the Board, the Committee shall review the content of the annual report and accounts and advise the Board on whether it is accurate, fair, balanced and understandable and provides the information for stakeholders to assess the Charity's performance and strategy including the Public Benefit Statement.

3.5.5 At the request of the Board, the Committee shall review the NHS England Annual Solvency Commitment Certificate submission, and provide recommendation and assurance to the Board prior to submission.

Risk Management

The Committee shall support the Board in reviewing and assuring the Board of the effectiveness and adequacy of the process for risk identification and management, through:

3.5.1 Assessing the process for identifying, classifying, reporting and monitoring the risks to the Charity including the Board Assurance Framework (BAF).

3.5.2 Escalating to the Board for consideration and action any areas of actual or potential strategic or material risk which the Committee believes are not being adequately addressed.

3.5.3 Reviewing and approving the statements to be included in the annual report concerning risk and risk management.

3.5.4 Monitoring, reviewing and assessing the level of assurances from the Executive with regard to the EPRR and Business Continuity Plans in place.

3.5.5 Providing assurance to the Board prior to the annual EPRR submission.

4.0 Membership

4.1 All members of the ARC will be appointed by the Board upon the recommendation of the Nominations and Remunerations Committee from among the Non-Executive Directors and shall consist of no fewer than 4. Consideration should be given to those Non-Executives who are already members of People Committee, Quality & Safety Committee and Finance Committee. All members will collectively possess knowledge and skills in accounting, risk management, audit, financial governance and technical issues relevant to the business and strategic management of the Charity. At least one member will have a formally recognised accountancy qualification.

The membership of the ARC will be:

- Chair – Non-Executive Director
- Deputy Chair – Non-Executive Director
- Non-Executive Director
- Non-Executive Director

In attendance:

- Chief Executive Officer
- Chief Financial Officer
- Head of Internal Audit & Risk
- Company Secretary

Attendance as required:

- Chief Operating Officer
- Chief Information Officer
- External Auditors
- 2 x Governors

4.2 The Chief Executive should be invited to attend, at least annually, to discuss the process for assurance that supports the Statement on Internal Control. Other Non-Executive Directors who are not members of the ARC may attend with the agreement of the Chair of the ARC.

4.3 The Chair of the Board will not be a member of the ARC.

4.4 All members will have one vote. In the event of votes being equal, the Chair of the ARC will have the casting vote.

4.5 Appropriate Internal and External Audit representatives shall normally attend meetings, although are not entitled to vote. At least once a year the ARC should meet privately with the External and Internal Auditors.

4.6 Subject Matter Experts will attend the meeting to support specific agenda items as and when required.

4.7 Appointment to the ARC shall be for a period of up to three years, (other than for Executive members) which may be extended for further periods of up to three years, provided that the relevant criteria are met.

4.8 The Chair of the Board has the right to attend all assurance committee meetings of the Charity.

5 Quoracy

A quorum shall be two, which must include the following:

- Chair or Deputy Chair

6 Declaration of Interest

All members and attendees of the ARC must declare any relevant personal, non-personal, pecuniary or potential interests at the commencement of any meeting. These must be recorded in the minutes. Members must exclude themselves from any part of the meeting where a potential or actual conflict of interest may occur.

7 Meetings

7.1 Meetings shall be held not less than 3 times a year in order to complete the Committee's obligations. In addition a 4th meeting may be convened expressly for the purpose of considering the Annual Report and Financial Accounts. The External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary.

7.2 Meeting dates will be agreed in advance by members of the ARC and approved by the Board.

7.3 Notice of the meeting, confirming venue, time and date, together with the standing agenda will be circulated by email at least 4 weeks in advance of the meeting.

7.4 The final Agenda and the supporting papers will be circulated by email 1 week prior to the date of the meeting.

7.5 Meetings of the ARC may be conducted when the members are physically present together or virtually in whichever form is deemed fit for purpose at the time.

7.6 Extra-Ordinary meetings may be convened at the Chair's request, giving wherever possible 4 weeks' notice.

8 Administration

8.1 The Company Secretary will ensure there is appropriate secretarial and administrative support to the ARC.

8.2 All papers will be with the Company Secretary or nominated person at least two weeks before the date of the next meeting in line with clause 7.4 above.

8.3 An Action List and Minutes will be compiled during the meeting and submitted to the chair within ten working days of the meeting. Actions will be shared with appropriate management within three weeks of the meeting.

8.4 Any issues with the Action List or Minutes will be raised within seven calendar days of issue.

8.5 Draft minutes will be circulated to the members once approved by the Committee Chair and with the papers one week prior to the date of the next meeting.

9.0 Reporting and Relationships with Other Committees

9.1 The ARC Chair will provide an ARC Assurance report to the Board after each meeting and also formally report annually to the Board on how it has discharged its responsibilities. This will describe the major issues that were discussed by the ARC, and the level of assurance that was received through papers and oral testimony, as well as a report on the strength of internal controls.

9.2 The ARC will review its effectiveness on an annual basis, reporting the outcome of the review to the Board. Once every three years, the review may be externally facilitated.

9.3 The Chair of the Committee shall provide to the Chair of the Annual General Meeting an assurance report on how the Committee has discharged its duties in the preceding year.

9.4 These Terms of Reference shall be reviewed annually with any changes ratified by the Board of Directors.

2023-24 Audit & Risk Committee – Work Plan, Standing Agenda items and key items for discussion

ARC Duty	Agenda Topic	Frequency / Month
Financial Reporting	Agreement of Financial Accounts Timetable	Annually – April
	Review of accounting policies	Annually – April
	Annual Report Page turning session	Annually - September
	Review and approve the external (Annual) Financial Statements of the Charity (and any subsidiaries)	Annually – October
	Review and approve the Annual Report	Annually – October
Risk Management	Risk Management Update (progress on risk system, risk register status and material risk register review)	Each Meeting
	Strategic Risks update (via Board Assurance Framework update)	Each Meeting
	Whistle Blowing and Raising Concerns report	Annually – April
	Data Security & Protection Toolkit pre-submission discussion (June Board – via Internal Audit review and testing)	Annually – April
	NHS England Annual Solvency submission pre-board review (May Board)	Annually – April
	Identification and selection of Charity Principal Risks for inclusion in the Annual Report	Annually – July
	Reviewing and approving Risk Management statements within the Annual Report	Annually – July
	Caldicott Guardian and Senior Information Risk Owner Annual Report pre-Board submission review (July Board)	Annually – July
	EPRR / Business Continuity Plan – assurance report	Annually – October
	IT and Cyber Security Assurance Report	Annually – October
	Review of the effectiveness of the Charity's Risk Management process	Annually - January
	Review of Charity's Risk Appetite process	Annually - January
Counter Fraud	Counter Fraud Progress Report	Each Meeting
	Approve Local Counter Fraud Specialist Annual Plan	Annually – April
	Review Counter Fraud Annual Report	Annually – July
	Review Charity's Gifts and Hospitality Register	Annually – July

Internal Audit	Internal Audit Progress Report and latest audit reports	Each Meeting
	Internal Audit Actions Dashboard and Update	Each Meeting
	Draft IA Annual Plan	Annually – January
	Approval of IA Annual Audit Plan	Annually – April
	Review of IA Annual Report and Head of Audit Final Assurance Opinion	Annually – July
	Head of IA & Risk to attend ARC members private meeting	Bi-Annually – January & October
External Audit	External Audit Progress Update	Each Meeting
	Agreement of External Audit Plans and strategy	Annually – January
	Agreement of External Audit annual fees	Annually – January
	Consideration of AGM proposal to re-appoint external auditors	Annually / in-line with contract terms – July / October
	External Audit to attend ARC members private meeting	Annually - July
Governance / Assurance	Approval of Committee Annual Work Plan	Annually – January
	Review of Terms of Reference	Annually – April
	Annual review of ARC related Policies and Procedures	Annually – July
	Committee Effectiveness Review	Annually – October

Document Control

Document Description

Document Title	Terms of Reference for the Audit and Risk ARC of the Board of St Andrews Healthcare
Issuance/ Revision	0.1, 0.2, 0.3
Date of Board approval	May 2023
Owner	Company Secretariat
Authors	D Long / M J Duncan

The Board of Directors may recommend changes to this Terms of Reference provided that any such modification does not violate any application of laws, rules or the Charity's Articles of Association and further provided that any such modification is appropriately disclosed to concerned parties.

Approvals

Name	Role	Date
Audit and Risk ARC	Review	17 April 2023
Chair of Audit and Risk ARC	Recommend	
Board of Directors	Approve	18 May 2023 tbc

Document Change History

Date	Issuance/Revision	Author	Description of Change
23 June 2022	Draft v0.1	M J Duncan	First Draft
27 Sept 2022	Draft v0.2	M J Duncan	Draft following Chair amends.
02 Nov 2022	Draft v0.3	M J Duncan	Further amends to draft
Dec – March 23	Drafts v0.4 – 0.8	M J Duncan	Further amends to drafts
29 Mar 2023	Draft v0.9	M J Duncan	Further amends to drafts post workshop
17 Apr 2023	Draft v0.10	D Long	Edits pre ARC sign off
18 April 2023	Drafts v0.11& 12	D Long	Final edits post ARC Approval

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 25 April 2023

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- Safer staffing - Significant progress has been made in the following areas:
    - Identifying the number and grades of nursing staff (establishments) required to support safe quality care for each clinical area
    - A more flexible and sustainable approach to the use/deployment of overtime, agency staff and members of the broader multidisciplinary team, however

The Committee remain concerned about the Charity's ability to consistently employ and retain qualified nursing staff particularly in the areas of Child and Adolescent Mental Health (CAMHs) and during night shifts.

CAMHs and qualified staffing on night duty will be focused agenda items for the next QSC

- My Voice - Uptake is gradually increasing with most respondents indicating that their experience of care is either good or very good. However, it was recognised that the uptake needs to increase further to allow more meaningful conclusions to be drawn from the results. This will be aided by ensuring staff have sufficient time to support patients where required and encouraging patients to attend patient experience/feedback meetings.

At a strategic level there needs to be further work on a carer and patient strategy which allows using the results of MyVoice in making tangible improvements in patient experience on wards. This may go some way to motivating /incentivising involvement by achieving a "you said, we heard, we acted " approach.

The QSC asks the Board to consider identifying time to discuss the further development of patient and carer involvement across the Charity.

Key issues/matters discussed:

- **Essex CQC Inspection**

  The Committee received a paper outlining recent regulatory activity in the Charity's Essex Division, detailing the two warning notices received in 2022 and outlining the actions taken and completed following the publication of the CQC report following the inspections. The Committee discussed the improvements being made, as well as the remaining challenges within the division, and had a detailed discussion on how the new Quality Strategy underpinned the Charity's move from being a reactive organisation to proactively managing quality. It was noted that implementation of the Quality Strategy is linked with the changes involved in the Thrive project (eg: more Quality Matrons and General Managers).

- **Quality Strategy and New Operating Model – Implementation update**

  The Committee were provided with a presentation on the Thrive Programme that included the strengthening of divisional leadership, new establishments, new controls over rostering and divisional spend, as well as updates on the implementation of the Quality Strategy, supported by a Gantt chart of key activity and milestones.

  The Committee were also shown the accountabilities for the divisional triumvirates, outlining the Top 5 activities and how the accountabilities were allocated to the Clinical Director, Service Director or the Associate Director of Nursing. The accountabilities would be reviewed in 6 months' time to allow for changes following the initial implementation of the new operating model.

- **Safer Staffing**

  The Committee received the latest Safer Staffing report, that highlighted that generally across the Charity, staff fill rates were improving significantly on a day-to-day basis, but that qualified nursing remained a challenge, particularly at night.

  The Committee were advised that the format of the report was being amended to more accurately reflect the Charity's higher levels of enhanced support and to improve the assurance that the report could offer.

  Whilst the Committee acknowledged significant progress has been made in specific staffing areas (such as in setting establishments, and a more flexible and sustainable approach to the use/deployment of overtime), the Committee remain concerned about the Charity's ability to consistently employ and retain qualified nursing staff particularly in the areas of Child and Adolescent Mental Health (CAMHs) and during night shifts. The Committee confirmed that CAMHs and qualified staffing on night duty will be focused agenda items for the next QSC meeting.

- **My Voice – Patient and Carer feedback**

  The Committee received a paper on the Patient and Carer feedback process, My Voice, that detailed the range of mechanisms used to obtain feedback. It was recognised that uptake for My Voice was improving but this needed to increase further.

  The Committee recognised that on a practical level there are several challenges which need to be overcome, including more time for staff to support some patients to complete feedback, and promoting and prioritising patient attendance at patient experience/feedback meetings.

  The Committee also discussed how the soon to be finalised refreshed Charity-wide patient and carer strategy could demonstrate the value the Charity places not only on hearing patient and carer views, but also involving them meaningfully in transformation and strategy development.

- **Quality Improvement Plan**

  The Committee received a paper on the Charity QIP, including the detailed action plan, highlighting the improved progress being seen in effectively closing open and overdue actions. Assurance was received that the remaining overdue actions were now all on track and would be closed by the next QSC meeting. The Committee were also updated on the roll-out of the new KLOE based internal quality inspections that were being completed throughout the divisions and services.

- **Quality Risk Management**

  The Committee received a paper highlighting the continued progress and developments within the material and operational risk management processes relating to quality and operations. The Committee acknowledged the assurance being provided

by the revised approach and complimented the risk team, the Exec and the wider management team on their engagement with the risk management process and its significant improvement and continuing improvement story.

- **Safeguarding**

  The Committee received a paper the covered the completion of actions and recommendations from the Internal Audit of safeguarding processes, along with the positive results of the safeguarding training recovery plan. The recovery plan split the Level 3 training into e-learning and face-to-face modules, alongside targeted work with managers to identify staff who were out of date with their training.

  The QSC will arrange for further discussions regarding the frequency and content of safeguarding information received by the committee.

Decisions made by the Committee:

- None

Implications for the Charity Risk Register or Board Assurance Framework:

- Committee were assured regarding the continued development and improvements undertaken to improve Quality and Operational Risk management.

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- A - Quality Strategy Update

Appendix A - Quality Strategy Update

Thrive – Reset update for QSC

Strengthened divisional leadership

- Phase 1 Restructure on track to complete for 1st May – all ADN & SD (1 interim) posts filled. Half of QMs roles filled.
- Strong internal & external response to remaining GM & QM posts
- Tailored induction & development in plan

New establishments, rostering & spend controls

- New establishments & refreshed approach to care hours ready to go live 1st May
- New rostering & spend controls approach ready to go live 1st May
- New Ways of Working scope & timing being finalised

Clinical Services Programme Board is overseeing the totality of the operating model transition

Quality Strategy

- Building Capacity
- Developing competence, understanding and motivation
- Developing Quality Control and Assurance mechanisms
- Developing reinforcing cultures structures and processes

Quality Strategy Activity Gantt Chart

TASK	Apr-23	May-23	Jun-23	Jul-23
Building Capacity				
Refresh and update of JD's, Roles and Responsibilities for new & exisiting post inc;				
- Ward Managers,				
- Quality Matrons				
Recruitment of Service Directors				
Recruitment of Associate Directors of Nursing				
Recruitment of General Managers				
Recruitment of Quality Matrons				
Recruitment of KLOE inspections and surveilance 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				

Quality Strategy Activity Gantt Chart

TASK	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Create new ward to board governance templates and resources for different levels of staff explaining approach and their role (new and existing staff)			Wards to start using new CG				
Create short & long term term training plan for: ~ Development of incident investigation training inc Pt Safety Incidents, Safeguarding and Mortality Review							
Create process maps for key CQT functions e.g. MHA inspections and Transition handover to new roles of above key functions							
Implementation of training packages as part of a QM/GM/WM development programme							
~ L1 (basic; post incident review)							
~ L2 (intermediate; RCA, S42, Mortality)							
~ L3 (advanced; PSIRF incident review/ Complex Mortality Review/ SG quality assurance/ Thematic review)							PSIRF Policy and Plan
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)							

Quality Strategy Activity Gantt Chart

TASK	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
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:	Complete					
- policy structure and layout	Complete					
- policy allocation	Complete					
Policies in date 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	Complete					

Quality Strategy Activity Gantt Chart

TASK	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Developing Reinforcing Cultures, Structure and Processes							
Engagement workhops from EMD/ Chief Nurse/ COO and DMD regaridng the quality strategy	Complete						
Engagement workshops including with Patients and staff to identify quality priorities	Complete						
Create detdicated intranet resource site to collate key documents and FAQ's							
Finalise ToR for all second line assurance groups alligned with strategy							
Review performance, talent and reward systems to align with the strategy							
Create Leadership development to support focus on compassionate and improvement culture.							
Senior Leaders to engage with ward visits and to emphasise the quality approach and role model							

Top 5 Accountabilities for Divisional Triumvirates

	Clinical Director Setting, Monitoring & Improving	Service Director (plus Delivery against all CD & ADN accountabilities)	Associate Director of Nursing Setting, Monitoring & Improving
1	Setting the Clinical Vision and Strategy & Ensuring Clinical Governance is implemented in the wards and divisions	Business Development & Business Partnering	Setting the nursing Strategy and monitoring its implementation. Setting the Standards of nursing practice and monitoring these
2	Ensuring that every ward has a Clinical Treatment Model based on Evidence Based Practice. Setting and monitoring the standards of practice for medics, psychologists, AHPs in the division and social workers.	People management & experience (staff and patients)	Setting and monitoring Quality Standards of care delivery
3	Monitoring and Improving Clinical Effectiveness. Setting the appropriate Patient Outcomes in each clinical area	Performance Compliance & Ward Environment compliance	Setting, Monitoring and improving Patient Safety & Experience Standards
4	Quality Planning & CQI – ensuring each division implements the quality strategy and that there is a plan for embedding a culture of CQI through training and undertaking CQI projects.	Financial Accountability	Setting Safer Staffing levels and monitoring Workforce Safeguards
5	Bed Occupancy – To meet the forecasted levels of occupancy	Risk Registers	Setting and monitoring Quality Improvement Plans

Committee Escalation Report to the Board of Directors

Name of Committee: Research Committee

Date of Meeting: 3rd May 2023

Chair of Meeting: Stanton Newman

Significant Risks/Issues for Escalation:

- Committee's future, membership and constitution awaiting ToRs for ERT Board Sub-Committee and associate committee structure.

Key issues/matters discussed:

- **1**

  Martin Kersey introduced the Research Committee members to the new Charity structure and the new Education, Research & Training (ERT) arm of the Charity

- **2**

  Terms of Reference discussed along with new structure of Board and committees. Current Research Committee will change. Creation of new ERT assurance sub-committee of the Board. ERT will then have 3 sub-committees covering Education, Research and Training.

- **3**

  Research & Innovation Annual Report. Attached as a separate document and also available on our STAH website, along with all publications for the 2022/2023 year. Publication information includes a full portfolio of all our research dating back to 2013. Our research » St Andrew's Healthcare (stah.org)

  SharePoint links (for internal use):

  Research & Innovation - Research & Innovation Annual Report 2022 2023.pdf - All Documents (sharepoint.com)

  Publications by month April 2022-March 2023.pdf

- **4**

  Research Open Day verbal report. Great feedback from inaugural event. Approx. 50 participants including 10 online. 3 internal and 3 external speakers. Over 15 posters displayed showing breadth of STAH research. Meeting recorded and full (internal only) report created showing all presentations, Teams recording and all posters: Research Open Day - presentations and posters from the day (sharepoint.com). This will be shared across the Charity via email and Comms

Decisions made by the Committee:

- **1**
  Further meeting of Research Committee will take place to review Terms of Reference of ERT Board Assurance Committee and sub-committees. Date to be confirmed and reliant on work of all new TOR amendments taking place across the charity

- **2**
  Research Committee showed support for future research projects on patient head banging and commencement of Huntington's Disease Research Programme utilising donation to the Charity.

- **3**
  Committee reviewed Open Day and recommended that it should be an annual event.

Implications for the Charity Risk Register or Board Assurance Framework:

None

Issues/Items for referral to other Committees:

None

Appendices:

- Separate attachments of Annual Report
- Annex E - 2022/2023 publications list

Research & Innovation
Part of St Andrew's Healthcare

Research
& Innovation 2022/23

Transforming lives through research

Chair's introduction

As Chair of the Research Committee, I am delighted to present the 2022/23 Annual Report. It has been a period of significant change within St Andrew's and indeed the entire healthcare sector. The movement out of lockdown and the reduction in Covid infections began to change the way we met with others and this in turn influenced research conduct with more face-to-face interactions becoming possible again. Our research at St Andrew's has seamlessly adapted to these changing circumstances, as you will see in this report where we have a large number of high-quality projects that are being conducted by members of St Andrew's staff, as well as researchers from our partner organisations. In addition, the Research Committee has developed a research and innovation strategy which will form the focus of research at St Andrew's in the coming years. I want to express my thanks for the work of the Research Committee, as well as the Research & Innovation Team over the past 12 months.

Stanton Newman
Research & Innovation Chair,
St Andrew's Healthcare

A message from our CEO

Vivienne McVey
CEO, St Andrew's Healthcare

By 2028, our vision is to create a society in which everyone living with a mental health need is heard, valued and has hope for their future. Key to that is our ambition to be renowned for our charitable investment in research and education that improves the lives of those we serve.

It is well recognised that research-active hospitals have better patient outcomes. As the new CEO, it has been exciting to discover just how much research and innovation is already going on within the Charity. Of particular note are studies that support the development of new clinicians, translational projects that take research findings and turn them into practice to improve the wellbeing of our patients and service users, and innovative projects at the cutting edge of technology.

Our new strategy will build upon the strong research base that has been developed over the last few years – and I look forward to continued growth in this area and a meaningful future for St Andrew's.

CAMHS East Midlands Collaboration

East Midlands Alliance
for Mental Health and Learning Disabilities

The CAMHS East Midland Provider Collaborative aims to reduce the reliance on inpatient secure care and to enhance care in the community. An East Midlands partnership was established to work collaboratively to improve quality, efficiency and care outcomes of CAMHS services; this includes Nottinghamshire, Lincolnshire, Leicestershire and Derbyshire NHS, Chesterfield Royal Hospital, Shoen Clinic in Birmingham, as well as St Andrew's Healthcare and NHFT, who is at the heart of the Provider Collaborative.

The research team are currently evaluating the progress towards achieving the collaboration's aims, by completing and reporting back on a separate evaluation every six months, until December 2024. Funding received for the evaluation supported the employment of two research assistants in April 2022, Kristina and Sarrah; later joined by two part-time research assistants, Isobel and Esther.

Our evaluation team is engaging with clinical and senior management staff, as well as with patients and carers, in order to obtain a deeper understanding of the functioning of the Provider Collaborative. The research team has already produced two evaluation reports. These include a summary of various perspectives on the collaborative functioning, an analysis into its successes and current setbacks, as well as a list of recommendations to improve the new ways of working.

Sarrah Fatima
Research Assistant

Kristina Brenisin
Senior Research Assistant

> "The staff've been really caring, genuine with my son and really trying to help him and putting him on a right path. You know being away from family, being away from loved ones and staff became like an extended family."
>
> **Carer**

> "We set ourselves a target, which was to put children and young people at the heart of everything we do. And we're going to keep focusing on that."
>
> **NHFT Staff**

> "The CAMHS project is a wonderful example of translational research. I have had the opportunity to interview members of staff who have seen children and their families experience the benefits of service improvement on a daily basis. There is more work to be done and I am proud to work in a team that is dedicated and passionate about improving health outcomes."
>
> **Esther Gathii, Research Assistant**

Research Secondments

Consultant Clinical Psychologists, Dr Inga Stewart and Dr Charlie Staniforth are now 18 months into their 2 year clinical research secondments with the R&I Team. Priscilla Maziveyi has recently joined the team on secondment as a research assistant.

Dr Inga Stewart
Consultant Clinical Psychologist and Clinical Research Fellow

Dr Charlie Staniforth
Consultant Clinical Psychologist and Clinical Research Fellow

Inga is leading on a research programme, that seeks to co-produce research into care planning in partnership with the Alzheimer's Society. She has been working with a steering group that involves people who are living with dementia, to develop a new toolkit made up of Practice Standard Statements, a checklist and hints and tips to help care teams involve people with dementia in writing their own care plans.

Supported by the literature and existing evidence-base, and informed by their own experiences, the steering group have developed Practice Standard Statements, which underpin the values of co-production of care planning. These standards are inclusive and respectful of all those affected by dementia. They champion the partnership between the person living with dementia and all those involved in their care, and set the standard on what is expected from a genuinely co-produced care plan. The Checklist details the identifiers of co-production when used to demonstrate that the standards are being met and can also be used as a self-assessment or audit tool. The Hints and Tips can be used to help overcome any barriers when co-producing a care plan.

Find out more about people living with dementia as co-researchers in the co-production of care planning | Co-Production Collective (coproductioncollective.co.uk)

Over the last 18 months, Charlie has been working with a really enthusiastic group of young people and professionals and together they have developed a trauma-informed sexual health toolkit. The toolkit is now ready to be piloted in CAMHS inpatient units across the East Midlands CAMHS Provider Collaborative. This is really exciting as clinicians, in both St Andrew's and the NHS, will trial the toolkit with young people and all those involved will feedback their views regarding whether they found the toolkit helpful and if they recommend any improvements. As well as making sure the toolkit works effectively (validation), Charlie will analyse the information from the completed toolkits to better understand the sexual health and wellbeing needs of young people using inpatient services, with the aim of helping services to meet those needs.

Interviews have also been taking place with a range of clinicians across the East Midlands CAMHS Provider Collaborative asking them what they think are the barriers to sexual health assessment in CAMHS inpatient units. The data is being analysed for themes; this information will assist with how best to implement the toolkit for clinical use and how to try and overcome any barriers that have been identified.

A third stream of work, which informed the development of the toolkit, was an audit on the conduct and recording of CAMHS sexual health assessments on admission. The Adverse Childhood Experiences (ACEs) of admissions were also looked at to assess the levels and types of potential trauma present in young people using our services. This data has been analysed and is currently being written up into a paper that will be submitted to an academic journal.

Innovation and Technology

MeOmics™

The collaboration between MeOmics and St Andrew's Healthcare is already delivering results.

The MeOmics Vision

MeOmics is an innovative start-up company, recently spun out of Cardiff University, which is developing a platform to improve the process for identifying new mental healthcare drug therapies. Ultimately, it promises to provide clinicians with diagnostic support for mental illness through a blood sample. This could eventually be transformational for people who experience serious mental ill-health.

The Opportunity for Collaboration

We initiated conversations with MeOmics to identify areas for collaboration. The golden opportunity came with a joint application for a Biomedical Catalyst grant from Innovate UK. This involved proving and scaling up the MeOmic's technology to generate patient-specific nerve cell networks and assess responses to drug combinations using multi-electrode arrays. The ultimate aim is to improve drug discovery to achieve better patient outcomes.

Partnership Success

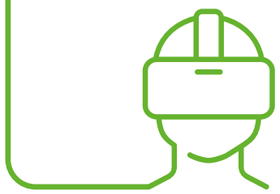
The partnership has been critical to the success of the Innovate UK project. Without the participation of patients and controls willing to provide a sample of blood and some medical history, there would be no project. The St Andrew's team have set about recruiting participants professionally and efficiently, so much so that we are now ahead of schedule. The combined team looks forward to seeing this project succeed and advancing our partnership as MeOmics develops.

Using Virtual Reality to Support Veterans

In veteran populations, research has predominantly focused solely on PTSD, despite its high co-morbidity with social anxiety. Few veteran studies have explored social anxiety treatment or veteran perceptions of virtual reality (VR) as a way of delivering treatment.

A study, led by Dr Louise Winter-Oakman (one of our Health Psychologists in our Community Services), looked at using a VR social engagement program, specially developed by OxfordVR to reduce social anxiety in a sample of ten veterans. The VR was able to create a safe space for veterans to practice social interactions and expose themselves to environments they would avoid in real life. We found that the VR social engagement program was an effective tool in facilitating exposure therapy for social anxiety in veterans. Whilst further research is recommended on treatment effectiveness, results showed that the program was well-received and perceived as beneficial – with reported improvement in social anxiety post-treatment.

This year, the Veterans Mental Health Complex Treatment Service launched a VR clinic for veterans presenting with social anxiety.



"I went to a concert recently with my girlfriend; I would never have done that before."

"Before I started I couldn't go in supermarkets and crowded places."

Physical Health

Move More Toolkit

Following completion of her PhD within our Children and Adolescent Mental Health Services (CAMHS) in 2022, Dr Justine Anthony, (Research Associate, Loughborough University) obtained funding to conduct a further research study. This follow-on project had the aim of improving both the physical and mental wellbeing of patients in our care by co-designing a physical activity toolkit with patients and staff.

Following a co-production process that involved multiple interviews with 19 staff and patients, informal conversations during community meetings in 10 different wards, including some from low secure, medium secure and our Birmingham site, two versions of the physical activity toolkit were produced: "Move More for Staff" and "Move More for Patients"

The booklets were launched in October 2022 and distributed across wards. The toolkit has been well received; especially the self-monitoring tools (the starchart and activity planner) which have been highlighted as supporting motivation to be active.

As a direct consequence of the launch of the toolkit and the associated media communication, other organisations nationwide have contacted Justine with a request for the toolkit to be used in their organisations. These include NHS trusts, and other mental health charities in England, Scotland and Ireland.

Justine has now completed her 'tenure' with the R&I team, having conducted research over a four-year period with us. She has been a valuable member of our Peer Review Team and we wish her well in her continued research journey at Loughborough University.

Dr Justine Anthony
Research Associate,
Loughborough University

Dr Poppy Gardiner
Researcher, Loughborough University

Sleep

Dr Poppy Gardiner has also now completed her PhD at Loughborough University. Her project with St Andrew's focussed on improving the quality of sleep for our patients as poor sleep has been identified as a significant clinical issue in secure psychiatric care.

21 patients from our Medium and Low Secure Divisions, along with 10 staff who took part in a focus group, were involved in Poppy's three-year study. Poppy used what she learned in these conversations to design a sleep improvement project that asked service users to increase their physical activity and spend less time sitting down and/or napping. Watches, similar to FitBits, were given out to monitor activity. Feedback from the study showed that patients were more active than usual, from doing more light physical activity to doing more moderate-vigorous physical activity; they also went to sleep earlier and woke up earlier!

Poppy has authored and published her systematic review in *The Journal of Forensic Psychiatry and Psychology* and presented a poster at the World Sleep Congress in Rome, March 2022, which won the best poster award.

Another exciting output from the project is an e-learning module called 'The Importance of Sleep'. This is available to St Andrew's staff and was co-produced with Dr Keith Jenkins, Consultant Clinical Neuropsychologist, and patients.

Poppy has now taken on a new research position in the USA; we will miss her at peer review and we wish her well as Dr Gardiner!

External Collaborations

UNIVERSITY OF BIRMINGHAM

Why Are We Stuck In Hospital?

This national study, which first featured in our 2021/22 Annual Report, has now completed. The project, which was led by the University of Birmingham and the rights-based organisation, Changing Our Lives, started in 2021. Entitled 'Why Are We Stuck In Hospital?', the research drew on the experiences of people with learning disabilities and/or autism who are in hospital, their families and front-line staff to understand how more people could be supported to lead more ordinary lives in the community.

Findings informed a national policy guide, which gives people's top ten tips for helping them to leave hospital. This guide, along with the other resources, such as a free training video for care staff, are available here: https://www.birmingham.ac.uk/schools/social-policy/departments/social-work-social-care/research/why-are-we-stuck-in-hospital.aspx; and the full research report will be out later in 2023.

The research team also linked up with Birmingham-based Ikon Gallery – to commission an original exhibition (7-19 March) that tried to amplify the voices of people in hospital and share their experiences with a wider audience.

The HaSB-IDD trial – exploring cognitive behavioural therapy (CBT) for men with intellectual and/or developmental disabilities and harmful sexual behaviour

Our Essex site is taking part in an NIHR-funded randomised controlled trial (RCT) led by the University of Kent. The trial will test whether a group cognitive behaviour therapy called SOTSEC-ID (Sex Offenders Treatment Service Collaboration- Intellectual Disabilities) works as a treatment for men with intellectual and/or developmental disabilities (IDD) and harmful sexual behaviour (HSB). Dr Eve Hepburn, Consultant Psychologist in Essex, is leading a team of assistant psychologists, who have been trained to conduct this specialised CBT therapy.

Men with learning disabilities and harmful sexual behaviour often get arrested and tried in court. They may then end up in secure hospital services, detained under the Mental Health Act, where they can get stuck for years without any help to change their behaviour. These men need a treatment that has been shown to work, in order to leave hospital, lead less restricted lives, and live safely in the community.

There has only been a small amount of research on this kind of group CBT for men who fall into this category. The research so far suggests the SOTSEC-ID treatment is promising but the research to date has only looked at men before and after this treatment. The treated men have not been compared to men who get different treatment (so-called 'treatment as usual'), which is an important comparison for showing that it was definitely the SOTSEC-ID treatment that made the difference (and not just the passage of time or standard treatment for example).

The study is just getting started and is due to be completed in the summer of 2025, so watch this space...

The Centre for Developmental and Complex Trauma

The Centre for Developmental and Complex Trauma (CDCT) also has a comprehensive research programme that supports the core aim to advance clinical practice to achieve better outcomes for people who have experienced repeated incidents of trauma. Highlights for 2022/23 include: publishing six journal papers and being awarded an international publishing award, establishing new conference and research partnerships with NHS, University and not for profit organisations in the US and UK and launching ten 'research skills for clinicians' workshops. Full details can be found in the CDCT's annual report, which can be accessed here: **Centre for Developmental and Complex Trauma » St Andrew's Healthcare (stah.org)**

Photographed by **Richard Durham**, Groundsman at St Andrew's
Used with permission

Research & Innovation Team

Dr Kieran Breen	Head of Research & Innovation
Dr Charlie Staniforth	Clinical Research Fellow
Dr Inga Stewart	Clinical Research Fellow
Louise Millard	Senior Project Manager
Kristina Brenisin	Senior Research Assistant
Sarrah Fatima	Research Assistant
Esther Gathii	Research Assistant
Isobel Doyle	Research Assistant
Priscilla Maziveyi	Research Assistant
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Research & Innovation
Part of St Andrew's Healthcare

Registered office: St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

Registered Charity Number 1104951

Paper for Board of Directors	
Topic	CQC Report and Action – Progress Update
Date of Meeting	Thursday, 18 May 2023
Agenda Item	**08**
Author	Andy Bogan, Chief Nurse
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Progress against CQC actions on the Quality Improvement Plan were discussed at the Board meeting on 29 September 2022.
Patient and Carer Involvement	Co-production activity across all three divisions has contributed to the closure of a number of actions within this reporting period.
Staff Involvement	Staff engagement and collaboration has been instrumental in the initiation and embedding of Quality Improvements across divisions.
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 fortnightly Quality Improvement meetings.

Report Summary and Key Points to Note

This report updates the Board on progress following previous CQC inspections of the Women's and Men's services at Northampton and the inspection of the Essex service in June 2022.

The Charity-wide Quality Improvement Plan (QIP) is being monitored on a fortnightly basis, with input from all divisions and support functions.

The East Midlands Alliance Quality Support Programme led by NHFT has now formally closed. Almost all the exit criteria have been met. Four areas received partial assurance and will be overseen by the Independent Provider Licence Team.

- Enhanced Observations
- Fundamentals of Care
- Increase in reporting of low harm and near miss incidents
- Quality impact Assessment process for workforce safeguards

CQC Report and Action – Progress Update

Previously the Board have received reports on the improvement in Men's and Women's services. Our Essex service was inspected in June 2022, with the final report being received in March this year.

The Women's Service overall rating in this inspection moved from Inadequate to Requires Improvement. The Men's service remained Requires Improvement but there were improvements in 15 of the individual domains. We are now rated as Good in the Caring and Responsive categories and Requires Improvement for Safe, Effective, and Well-Led.

The inspection of Essex resulted in warning notices being received regarding the failure to comply with requirements for a patient call system to be in place and concerns regarding activity and therapeutic interventions on Maldon Ward. The overall rating for Essex was Inadequate, primarily due to receiving two warning notices. We responded to the warning notices, and alarm bells have been installed. The clinical model has been reviewed and, as part of previously planned moves, Maldon Ward has moved to Tiptree.

Essex services were reinspected in March 2023, and we expect the final report in June this year.

The quarterly Divisional Integrated Quality and Performance Reviews continue, enabling a collective review of a range of leading and lagging indicators, combined with clinical judgement and oversight of actions on the Charity-wide QIP, attributable to the relevant division and the Divisional QIP. This is triangulated with staffing data and financial performance.

The regular fortnightly QIP meetings are well attended and include representation from all divisions and support functions. The targeted work has resulted in eight actions remaining open, against the previous 52 actions reported in the last Board report.

The reports relating to the conditions of registration continue to be submitted bi-weekly to the CQC; these relate to amount of Section 17 leave taken, incidents occurring on specific wards and enhanced observation compliance with policy. Although the weekly assurance meetings with the CQC were stood down by the CQC following discussions and informal feedback from the inspectors that the actions highlighted in their reports last year had been addressed, we re-introduced an informal meeting with them to continue to build a positive relationship, and these meetings continue, attended by the Director of Nursing and Chief Nurse.

The East Midlands Alliance Quality Support Programme led by NHFT has now formally closed. Almost all the exit criteria have been met. Four areas received partial assurance and will be overseen by the Independent Provider Licence Team.

- Enhanced Observation
- Fundamentals of Care
- Increase in reporting of low harm and near miss incidents
- Quality impact Assessment process for workforce safeguards

The New Operating Model, and the initial stage of the Thrive programme, is underway. This will strengthen local ownership and oversight of Quality at Divisional and Ward level. A new function of quality surveillance and internal inspections has commenced, and a full programme of targeted inspections are planned for the year ahead. The outcomes and actions from these will be reported to the Quality and Safety Committee, with assurance provided to the Board.

Paper for Board of Directors

Topic	Safer Staffing Report
Date of Meeting	Thursday, 18 May 2023
Agenda Item	**09**
Author	Chloe Annan, Deputy Director of Nursing, Workforce, Safeguarding
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Regular agenda item
Patient and Carer Involvement	Aspects of Safer Staffing have been discussed with patients, where appropriate to do so, within community meetings on the ward.
Staff Involvement	Divisions and ward clinical teams have been fully engaged with to complete our most recent nursing establishment review.
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	

Report Summary and Key Points to Note

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

Safer staffing levels and skill mix are an essential element of providing safe and high quality care for our patients. It is therefore important that the Board has oversight of our staffing, alongside the rationale for any changes to base establishments, in order to assure itself that our wards have sufficient staff to operate safely.

The three 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 three months 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. The HoNs 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. These roster groups will strengthen further from 1 May, with the introduction of new roles and increased capacity at the frontline.

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 Team 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

Safer Staffing Report

Fill Rates & Divisional Risk Summary:

The tables below show the fill rates by division, for the last three months (1 January – 31 March 2023) 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).

Birmingham

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Birmingham	**107.13 %**	**123.77 %**	**91.49 %**	**149.47 %**
Birmingham	**107.13 %**	**123.77 %**	**91.49 %**	**149.47 %**
MMH Edgbaston	124.28 %	98.37 %	56.56 %	209.84 %
MMH Hawkesley	87.79 %	118.94 %	150.23 %	103.87 %
MMH Hazelwell	115.41 %	132.38 %	107.65 %	142.74 %
MMH Hurst	107.36 %	123.12 %	98.48 %	137.31 %
MMH Lifford	106.02 %	134.17 %	100.16 %	181.28 %
MMH Northfield	97.20 %	137.21 %	100.10 %	139.74 %
MMH Speedwell	104.87 %	103.53 %	99.35 %	108.06 %
WMH Moor Green	123.77 %	154.69 %	72.89 %	252.20 %
Total	**107.13 %**	**123.77 %**	**91.49 %**	**149.47 %**

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 steadily improved within the last three months. 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

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Northampton	**101.01 %**	**112.14 %**	**75.24 %**	**124.43 %**
CAMHS	**101.01 %**	**112.14 %**	**75.24 %**	**124.43 %**
ALS Billing Lodge		44.59 %		45.45 %
ALS Seacole	196.89 %	96.85 %	90.53 %	96.82 %
ALS Sitwell	65.65 %	497.88 %	95.78 %	261.15 %
ALS Stowe	88.44 %	108.49 %	57.32 %	174.25 %
Total	**101.01 %**	**112.14 %**	**75.24 %**	**124.43 %**

CAMHS have been scheduling Billing Lodge HCAs as part of Sitwell, hence reduced fill rates both day and night, and Sitwell being over 400% in the day, and 200% at night, 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 was 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.

Night Q cover remains their biggest challenge and area of focus. Effective rostering has a significant part to play in this challenge, and our current eRostering & staffing lead is working intensively with the CAMHS NMs to improve understanding and provide support.

CAMHS are now part of a larger division – named LSC – which combines CAMHS with the Low Secure division, sharing skills, experience and resource to tackle some of these consistent challenges.

<u>Action cards:</u>

03/01/23 – Sitwell – No Q from 21:00.

- All Night Site Coordinators (NSC) 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 the 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 of the 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 of the 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 to 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.

09/03/23 – Sitwell – No Q after 00:00

- No Q cover on Prichard after 00:00. Contingency plan implemented and Sitwell Q redeployed to Prichard after being clinically risk assessed as being of higher acuity.
- All staff on Seacole ward were aware of the need to respond to Sitwell immediately to any physical health alerts or medical emergencies.
- Seacole NIC held medication keys and all staff on Sitwell were aware of that and how to reach NIC & NSC should any concerns arise.
- NSC increased visibility on the ward throughout the night.

27/03/23 – Night Q divisional shortage

- No long night Q scheduled within the CAMHS division.
- Q twilight scheduled on Sitwell redeployed to Stowe
- NSC covered Seacole all night, who also had no night Q scheduled. Also held keys for Sitwell.
- All wards teams within CAMHS division made aware of who to contact and escalate any Q nursing requirements too.

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:

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Essex	**66.20 %**	**120.28 %**	**86.35 %**	**107.58 %**
Essex	**66.20 %**	**120.28 %**	**86.35 %**	**107.58 %**
MMH Audley	60.40 %	201.22 %	88.63 %	107.57 %
MMH Benfleet	88.53 %	80.07 %	60.16 %	93.09 %
MMH Danbury	85.45 %	106.96 %	107.57 %	104.44 %
MMH Tiptree	43.25 %	80.72 %	103.55 %	96.04 %
WMH Frinton	62.63 %	229.82 %	92.78 %	134.45 %
Total	**66.20 %**	**120.28 %**	**86.35 %**	**107.58 %**

As a site, Essex have had a number of qualified 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 three month period, however the Q availability offered has been mostly at night (as it has across the Charity), with much less availability from agencies during the day. This has been mitigated by the presence of NMs, who are largely Q nurses and also NSCs.

Maldon closed as its own ward in April, and has now been combined with Benfleet. This takes Benfleet total occupancy from 16 to 22. All staff from now will be scheduled as part of Benfleet and the staffing requirements have been updated to reflect this change.

Essex have not used any action cards during this three month period, and all shifts both day and night have had provision of at least one Q nurse, with this on occasions being the NM.

LDA

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Northampton	**96.70 %**	**127.54 %**	**93.64 %**	**129.84 %**
LDA	**96.70 %**	**127.54 %**	**93.64 %**	**129.84 %**
ASD Acorn	54.23 %	68.31 %	100.00 %	63.42 %
ASD Berry	109.21 %	126.18 %	100.19 %	106.06 %
ASD Brook	117.54 %	102.56 %	100.24 %	103.41 %
ASD Fern	71.84 %	101.52 %	100.66 %	115.24 %
ASD Garden Cottage	100.15 %	107.68 %	99.35 %	79.27 %
ASD Marsh	103.56 %	132.20 %	101.68 %	162.23 %
ASD Meadow	84.20 %	151.76 %	101.51 %	163.53 %
ASD Wantage Gate House		237.82 %		214.99 %
LDD Church	126.87 %	166.55 %	117.94 %	165.89 %
LDD Hawkins	79.48 %	111.69 %	67.12 %	150.78 %
LDD Oak	109.98 %	131.29 %	71.42 %	123.62 %
LDD Sunley	106.26 %	142.15 %	101.90 %	144.74 %
LDD Sycamore	130.11 %	99.75 %	100.64 %	97.49 %
Total	**96.70 %**	**127.54 %**	**93.64 %**	**129.84 %**

Acorn are planned to have three Qs in the day however have been scheduling to two due to reduced clinical acuity and occupancy. Acorn have also been scheduling and working to below their planned number both day and night in light of this. This has been clinically manageable.

Both Oak and Hawkins are planned to have two Qs 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.

Action Cards:

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

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Northampton	**86.83 %**	**108.16 %**	**69.83 %**	**123.23 %**
Low Secure & Specialist Rehab	**86.83 %**	**108.16 %**	**69.83 %**	**123.23 %**
MMH Bayley	80.25 %	113.11 %	60.15 %	151.90 %
MMH Berkeley Lodge	88.77 %	96.01 %	97.92 %	95.85 %
MMH Heygate	56.16 %	142.87 %	55.11 %	157.12 %
MMH Naseby	101.05 %	83.09 %	57.40 %	112.52 %
MMH Spencer North	93.86 %	90.24 %	100.00 %	90.34 %
MMH Spencer South	103.51 %	89.09 %	98.02 %	90.79 %
WMH 37 Berkeley Close		74.99 %		68.24 %
WMH Lower Harlestone	71.31 %	198.74 %	68.57 %	213.24 %
WMH Silverstone	119.79 %	103.08 %	49.86 %	138.12 %
WMH Watkins House	92.92 %	101.96 %	99.10 %	93.91 %
Total	**86.83 %**	**108.16 %**	**69.83 %**	**123.23 %**

A number of the Low Secure wards are planned to have two Qs at night including Bayley, 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 Qs. If filled, this third Q has often been redeployed to support Q provision elsewhere.

37 Berkeley Close were scheduling to below their planned number both day and night for the month of October due to reduced clinical acuity.

Medium Secure:

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Northampton	**85.96 %**	**109.54 %**	**80.59 %**	**116.74 %**
Medium Secure	**85.96 %**	**109.54 %**	**80.59 %**	**116.74 %**
MMH 23a/23 The Avenue		93.94 %		96.54 %
MMH Cranford	57.49 %	129.38 %	82.45 %	112.53 %
MMH Fairbairn	86.15 %	99.58 %	98.03 %	102.44 %
MMH Mackaness	77.64 %	105.98 %	100.20 %	154.11 %
MMH Prichard	70.18 %	105.47 %	59.48 %	139.79 %
MMH Robinson	100.96 %	107.95 %	99.99 %	105.85 %
MMH Rose	118.89 %	137.39 %	101.27 %	123.84 %
WMH 21 The Avenue		91.05 %		89.95 %
WMH Bracken	84.91 %	109.92 %	58.81 %	109.04 %
WMH Maple	90.12 %	85.28 %	100.05 %	123.63 %
WMH Willow	93.78 %	106.21 %	70.97 %	112.10 %
Total	**85.96 %**	**109.54 %**	**80.59 %**	**116.74 %**

Bracken and Prichard are planned to have two Qs 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 Prichard are all planned to have 2.5 – 3Q per day shift, however again reduced fill rates reflect current Q establishment gap combined with need to redeploy.

Neuropsychiatry

	Q-RN Day	U-RN Day	Q-RN Night	U-RN Night
Northampton	**91.16 %**	**115.84 %**	**96.76 %**	**130.82 %**
Neuro	**91.16 %**	**115.84 %**	**96.76 %**	**130.82 %**
NPS 19 The Avenue	81.70 %	52.12 %	87.39 %	103.03 %
NPS 38 Berkeley Close	127.21 %	80.25 %	84.99 %	84.91 %
NPS Allitsen	90.68 %	155.84 %	99.97 %	173.54 %
NPS Aspen	94.42 %	156.81 %	99.54 %	169.19 %
NPS Cherry	87.97 %	112.81 %	104.02 %	142.65 %
NPS Elgar	104.71 %	151.84 %	93.05 %	145.49 %
NPS Elm	72.81 %	86.70 %	100.55 %	84.62 %
NPS Fenwick	79.46 %	106.24 %	101.02 %	130.39 %
NPS Redwood	78.92 %	131.41 %	98.58 %	146.31 %
NPS Tallis	80.83 %	129.08 %	90.63 %	148.70 %
NPS Tavener	116.04 %	79.91 %	92.86 %	97.40 %
NPS Walton HD	96.99 %	82.25 %	100.85 %	98.89 %
Total	**91.16 %**	**115.84 %**	**96.76 %**	**130.82 %**

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.

Elm, Fenwick and Redwood are planned to have two Qs 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. Elm also had a qualified Nurse Associate (NA) who provides Q support, but is not included within the Q fill rates (as they cannot take lone charge of a ward for an entire shift, however can do most other Q tasks).

Action cards

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.

Current '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. 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.

Establishment Implementation

It has been agreed that the new ward establishments and baseline planned numbers will begin to phase in from 1 May. Two phases have been agreed as part of this plan due to the significant increase in ward establishments compared to current requirements, and the risk of oversaturating the market with a number of wards recruiting for a number of positions all at the same time. There is also a significant piece of work currently being carried out in relation to our wider MDT, and mapping their experience and skills to wards to contribute to the Care Hours Per Patient Day provided and to form part of the ward establishments. In addition, although the Charity as a total is increasing our establishment, there are a number of wards who are reducing and therefore redeployments are required to other wards.

Phase 1 – May

- All wards across the Charity move to their new total planned number both day and night.
- Only phase 1 wards however can move to their new qualified requirement day and night.
- These phase 1 wards include wards that have; changed patient group, moved environment, recently opened/had no initial baseline, or had a reduction in total establishment.

Phase 2 – October

- All remaining wards move to their new qualified requirement day and night (14 wards).

Work is now underway with divisions to ensure that rosters from 1 May are built on these new planned numbers and factor in any required changes to the qualified requirement.

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 to effectively implement our new ward establishments as from 1 May, 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.

Paper for Board of Directors	
Topic	Integrated Quality & Performance Report
Date of Meeting	Thursday, 18 May 2023
Agenda Item	**10**
Author	Anna Williams, Director of Performance & Kevin Mulhearn, CFO – with input from the responsible Executives for the presented topics
Responsible Executive	Dr Vivienne McVey, CEO
Discussed at Previous Board Meeting	Routine paper
Patient and Carer Involvement	My Voice patient feedback included in the paper
Staff Involvement	This paper builds from ward governance, divisional governance, divisional IQPR, Exec IQPR to Board – varying staff groups are involved through from ward to Board.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S ☒ E ☒ C ☒ R ☒ W ☒**
Strategic 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	The relevant sections are assured via the aligned committees.

Report Summary and Key Points to Note

We are pleased to share a refreshed reporting approach. This approach marries the feedback from Board colleagues with the Executive desire to continually improve the way we report.

Feedback is welcomed. Should any members of the Board wish to be talked through the new reporting approach ahead of the meeting please don't hesitate to contact me.

Anna Williams, Director of Performance.

Appendices – My Voice review

St Andrew's Healthcare Integrated Quality Performance Report

May reviewing the period ending March 2023

Summary

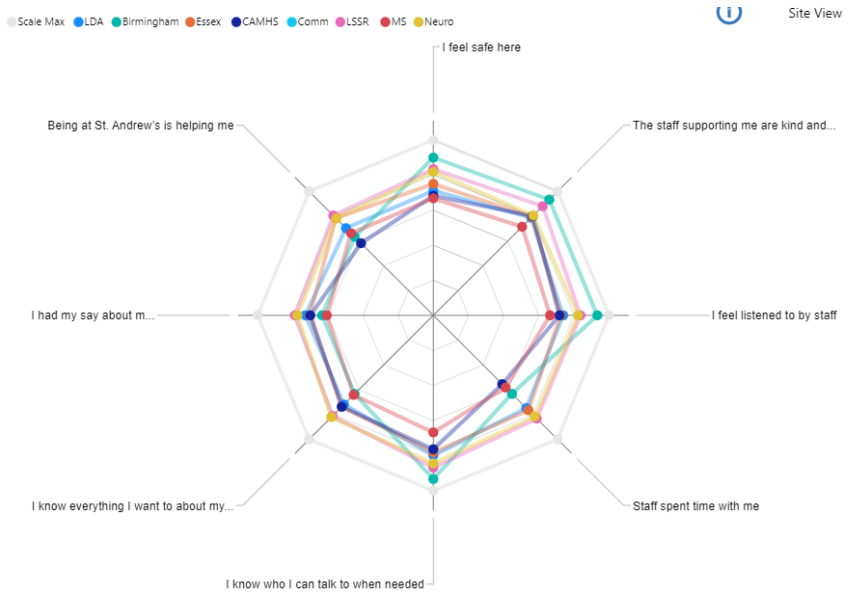
What has gone well

- **My Voice response** – the volume of patient feedback has significantly increased, with the March response being more than double the monthly average
- **My Voice result** – three quarters of patients rated their experience of care at St Andrew's as good or very good
- **Restraint** – at Charity levels and for Neuro specifically, levels of restraint show a statistically significant improvement
- **Workforce metrics** – significant progress at a time of challenge with the majority of staff management metrics showing improvement towards target across the last six months:
- **Training** (Charity level 89%) all divisions have improved (88%), with LSSR being the first to return favourable to target
    - Strong results for **Management Supervision** (94%) and healthy improvement towards target in **Clinical Supervision** (82%)
    - Divisional **Voluntary turnover** (15.2%) and overall **Vacancy rate** (13.2%) continue to improve, both benchmark favourably
    - Charity level **Sickness** is favourable to target, has been below the mean for the last three months and represents a special cause improvement - supported by reducing sickness levels in the divisions (also special cause improvement) following collaborative focus from HR and Operations
- **LSSR** – high performance across the board from the LSSR division, 84% of patients rate the care they receive as good or very good. largely favourable workforce metrics and closest to their budgeted net contribution. The remit of the LSSR leadership team has broadened to include CAMHS, who will in turn benefit from the increased support.

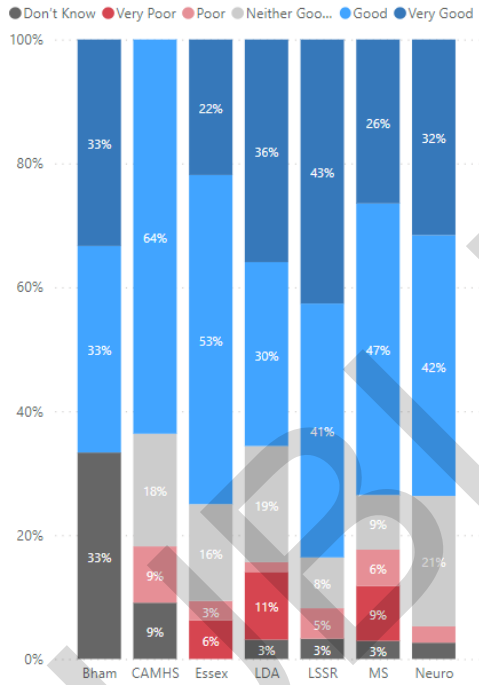
What is being focused on

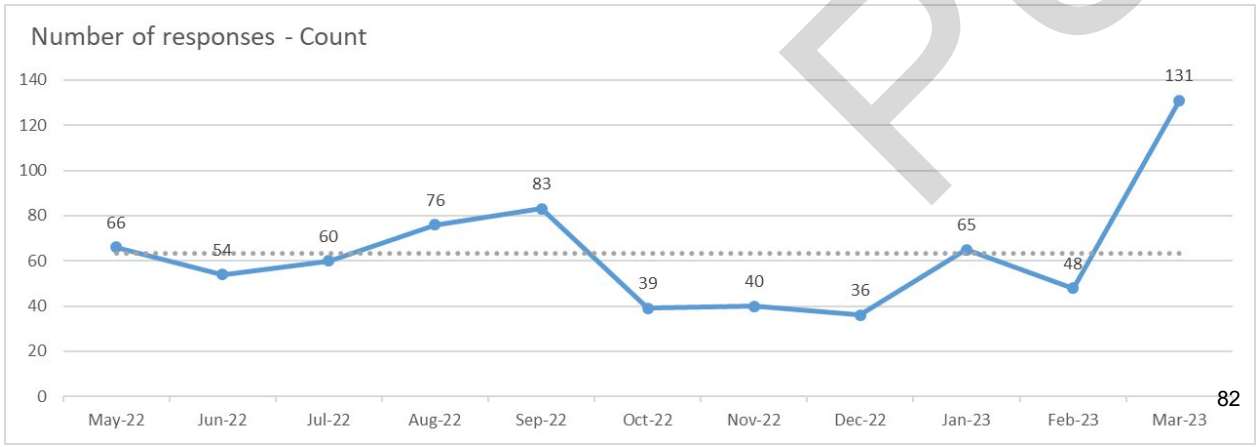
- **Delayed discharges** – most notably in LDA, whilst every effort is being made to secure appropriate next placements we continue to care for a number of patients for whom our services are no longer best suited. As a result, levels of long term segregation are close to the upper control limit (see quality narrative for further detail).
- **Enhanced support** – the above is a contributing factor to the volume of staffing needed to deliver enhanced support being above the upper control limit. Check and challenge of enhanced support levels is in place (see quality narrative for further detail).
- **Direct staffing spend** – spend has been above budget, driven by additional nursing requirements, compounded by backfill required due to non-patient facing shifts being in excess of the plan and utilising high levels of overtime, bank and agency to deliver this. This is being addressed through Thrive – in early May the refreshed ward establishment approach and complementary new rostering and approval controls went live. The enhanced rostering and leave management processes, supported by system improvements and data tools, enable budgetary alignment. A new monthly finance forum is being established to hold owners to account.
- **LDA** – whilst there are positive trends across people metrics, the LDA division is challenged clinically and financially. The improved people metrics plus the strengthened divisional leadership and addition of clinical and operational management via Thrive will enable improvements. See the divisional integrated performance summary for further detail.
- **IT security & forensics** – resignations from key personnel create a risk to the integrity of the service – plans are in place to mitigate and rectify.
- **Occupancy** – continued efforts to ensure occupancy is in line with budget

Quality – My Voice & Discharges



*Data period Jan 23 – Mar 23



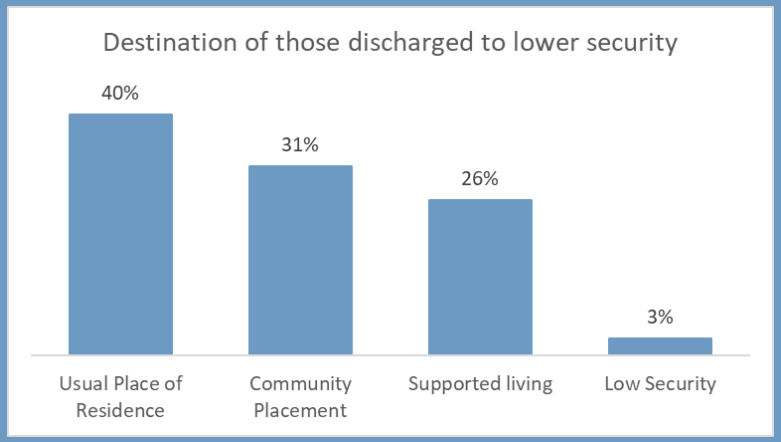


My Voice between January and March 76% of responding patients rated their experience of the care provided by St Andrew's as good or very good (75% across last 18mths). Response rates have improved significantly, following dedicated ownership chiefly from the Psychology team. Verbatim comments suggests varied experience, with positive themes focusing on treatment, support, kind and caring staff. Less positive feedback focuses on food, staff levels and behaviour, activities and their timing. Divisions utilise their community meetings to communicate how they are acting on feedback from patients. You said we did boards are being added to every service to help close the feedback loop. Charity wide themes are considered and resolved via OpCom.

Community Partnerships have a tailored My Voice typically returning c90% good or very good experience rating.

For more detailed analysis refer to the appended paper – reviewing 18mths

Discharges during February & March (excluding PICUs) 51 people moved on from St Andrew's. The majority, 69%, transitioning to a lower level of security, including 40% to their usual residence.



PICUs transitioned a further 16 people.

Quality – safety and outcome indicators

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	Seclusion Hours	LTS	LTS Days	Safegrd	Rapid Tranq	ES Episodes	ES WTE	Ptn Leave
StAndrews						↘	L	A H			B H				C H	

-	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		1 H														
CAMHS								2 H				↗			L	
Community Services							↗									
Essex			L							↘	↗		L			
LDA	7 H		8 H	9 H		↘				10 H	11 H		↗	12 H	13 H	14 L
Low Secure & Specialist Rehab			L							↗					3 H	
Medium Secure						↗						4 H		L		
Neuro	5 H		L				L	L							6 H	H

How to use the above table:

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

Statistical improvement

Improvements - at a Charity level, restraints have been below the mean since July 22. All divisions are within control, and Neuro have a March rate of almost half its OBD mean (16 compared to 29). Essex has seen improvements in Rapid Tranq use, and Neuro has seen a significant reduction in use of restraint and seclusion, increased patient leave, despite a rise in ES WTE use. Medium Secure: new episodes of ES has been below the mean since July 22, reflecting mainly improvements on Bracken female admissions ward.

Clinical Exceptions - Charity

A. Charity – Seclusion Events

Above upper control limit

The spike above the UCL was largely attributable to 1 patient in CAMHS who had over 50 brief episodes of seclusion (evidenced by seclusion hours being below average). This is back in control in April.

B. Charity – Days in Long Term Segregation

2 of 3 points close to upper control limit

This largely reflects long term issues with a cohort of delayed discharges in LDA, for which there is a weekly commissioner meeting and engagement with senior interveners from NHSE to plan discharge. For others, we are engaging in the national HOPE(S) programme to reduce use of LTS.

C. Charity – Enhanced Support WTE

Above upper control limit

Despite episodes and duration being within control, we have seen a rise in staffing use for ES in the last few months, mainly due to LDA (see LTS chart) and Neuro (the admission wards have seen a rise in acuity of referrals and we expect this to continue - wards working on revising clinical model)

Clinical Exceptions - Divisions

1. Birmingham - Incidents of Violence

2 of 3 points close to upper control limit

All wards in control, but a large proportion of the rise is due to Hurst, (16 of 39 episodes) which has been reconfigured and taken on a group of new admissions that are expected to stabilise with routine clinical management.

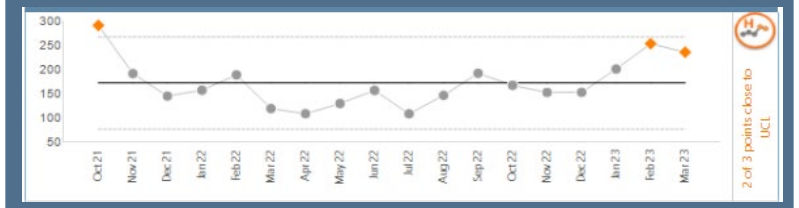
2. CAMHS - Seclusion Events

Above upper control limit

Due to multiple brief seclusion episodes for 1 patient that has reduced in April.

3. LSSR - Enhanced Support WTE

2 of 3 points close to upper control limit



Attributable to a rise of ES on Lower Harlestone due to patient admissions/ transfers of high acuity that is expected to stabilise in the next month.

Clinical Exceptions - Divisions

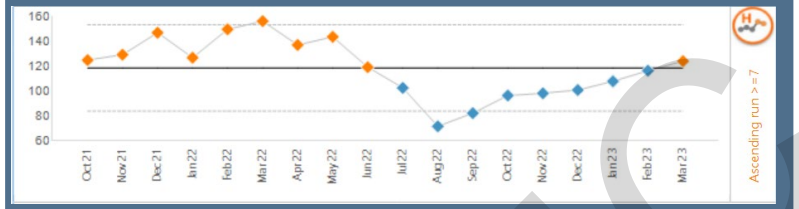
4. Medium Secure - Safeguarding

Above average for over 7 months

SPC trigger for 7 points above the mean. No wards out of control but includes the addition of Mackaness, admissions ward, that has seen a rise in SG from 0 in Feb to 3 in March, but L1/L2 harm and has reduced in April.

5. Neuro - Incidents

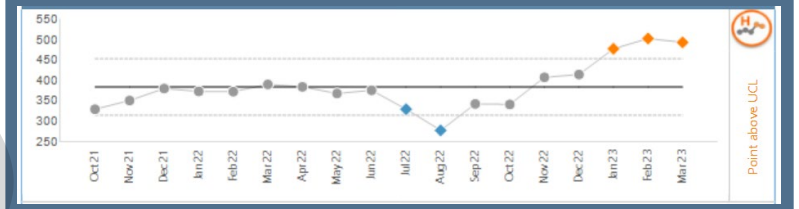
Ascending run of 7



Incidents above the mean after an improvement. All wards in control and 2 wards (Tallis and Walton) with statistical improvements in incidents. Has reduced below the mean in April so is back in a stable control pattern.

6. Neuro - Seclusion Events

Above upper control limit



Allitsen, Aspen and Elgar have seen a rise in referral acuity- this is likely to persist and the division is reviewing the clinical model and approach to ensure there is less reliance on ES. The current patients are expected to stabilise with routine clinical management

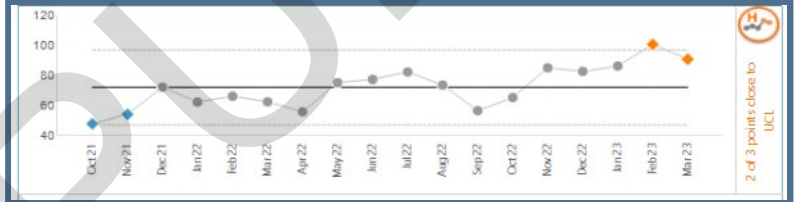
7. LDA - Incidents

2 of 3 points close to upper control limit

Church, Sunley and Hawkins have seen a rise in incidents of L1 and L2. Church is under the 9C's wards of concern process and has an action plan to address multiple quality concerns.

8. LDA - Incidents Level 1

2 of 3 points close to upper control limit



Sunley and Hawkins have seen a rise more acutely (over the last 2 months) in low harm incidents, whereas Church has had more medium term issues over the last 5 months.

9. LDA - Incidents Level 2

Above upper control limit

Level 3 incidents are *below* the mean and there is a trend down in SI's. A rise in low harm incidents does provide assurance that we are appropriately recording these and less are progressing to more serious harm incidents.

Clinical Exceptions - Divisions

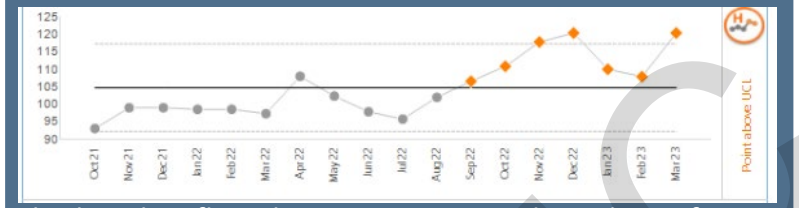
10. LDA - Long Term Segregation Episodes

2 of 3 points close to upper control limit

A mixture of Long term delayed discharges and a short term rise on Hawkins and Oak, which reflect specific patient issues, for which there are clear plans to end LTS within the next weeks.

11. LDA – Days in Long Term Segregation

Above upper control limit



This largely reflects long term issues with a cohort of delayed discharges in LDA, for which there is a weekly commissioner meeting and engagement with senior interveners from NHSE to plan discharge. For others, we are engaging in the national HOPE(S) programme to reduce use of LTS

12. LDA - Enhanced Support Episodes

Above average for over 7 months

This is an issue spread across multiple LDA wards. It reflects the need for longer term rebalancing across the LDA in-patient and community pathways and our CD is leading that work for the region, as well as a focus on QI to reduce reliance on ES such as increased activity, improved LDA training offer for staff, which are being progressed on the LDA QIP.

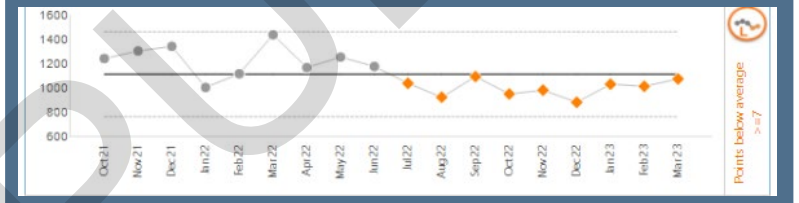
13. LDA - Enhanced Support WTE

Above upper control limit

As for ES episodes – this includes staff required for LTS.

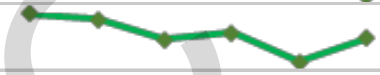
14. LDA - Episodes of Patient Leave

Below average for over 7 months



This is on Berry, Brook and Fern, with Meadow showing statistical improvements and other wards in control. The former wards have seen high acuity and now 3-4 months of reduced acuity – leave is rising month on month but not recovered to the mean. The expectation is that leave will continue to rise back to the mean reflecting the improvement in acuity and we would expect that to be reflected in patients being granted more leave.

People

Measure	Target	St Andrews		Divisions		Functions	
		Mar-23	Trend	Mar-23	Trend	Mar-23	Trend
Voluntary Turnover In Year	12%	14.0%		15.2%		11.1%	
Voluntary Turnover In Month	1%	1.3%		1.1%		1.7%	
Vacancy Rate		13.2%					
Mandatory Training	90%	89.0%		88.1%		92.7%	
Sickness % In Month	6%	5.5%		6.3%		3.8%	
RN Establishment Ratio	95%			82.6%			
HCA Establishment Ratio	95%			84.9%			
MDT Establishment Ratio				92.3%			
Agency Spend	5%			12.4%			
Non Patient Facing Shifts	25%			42.9%			

How to use above table chart:
Actual results are colour coded red for adverse to target, green for favourable to target or black where there is no target. This is complimented by a spark line that shows the actuals across the last six months and is colour coded based on the start and end position.

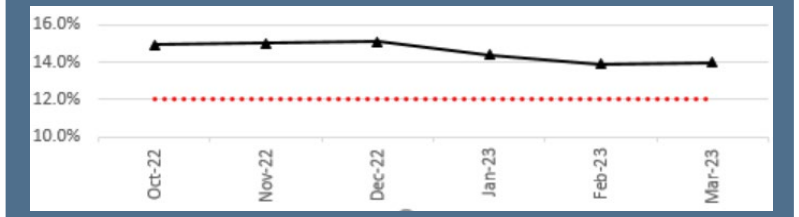
Adverse metrics are reviewed on the following page (trend line set against dotted target line), with the addition of vacancy rate due to increasing focus. RN and HCA establishment ratios are not reviewed in detail, as they have been rebased for 23/24. MDT establishment (plus the inclusion of locum support) largely correlates with 95.1% occupancy.

Please note, revised targets are being presented to the People Committee 11th May.

People

Voluntary Turnover

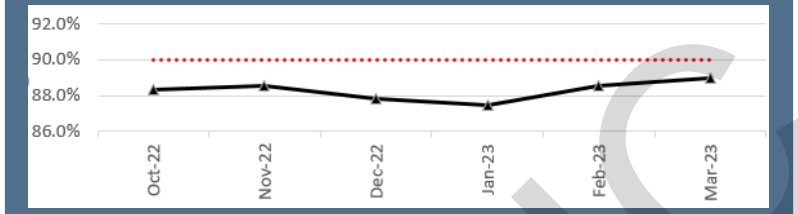
Positive trajectory towards target



Overall there has been an improving trajectory since Sept 2022 (a slight increase in March was rectified in April). Work - life balance remains top reason for leaving in year. The Charity Retention Framework and associated action plan provides a continued focus – recognising the challenges presented by a period of organisational change.

Mandatory Training

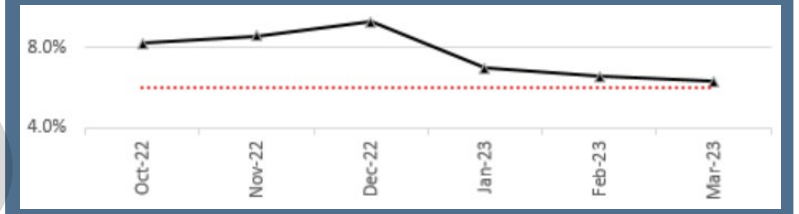
Positive trajectory towards target



Overall, further increase in compliance. For perm staff, all divisions are favourable to target. The Clinical Services plan is to achieve 90% divisional compliance by July – analysis confirms for perm staff (out of date / becoming out of date by July) there is sufficient training capacity and headroom for 100% compliance (noting Easter impacted April).

Sickness

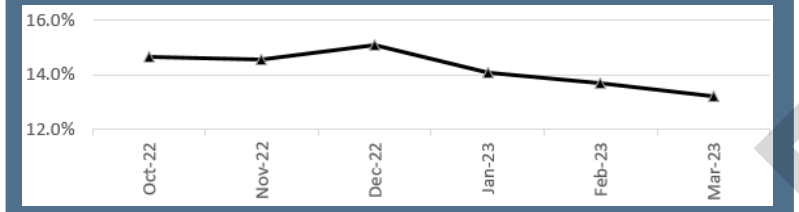
Divisional trend positive (Charity level favourable)



Remaining favourable to target at Charity level with a positive downward trend since Dec 22. Both Charity & division level showing special cause improvement. LTS reduced to 47 (56 Feb) – 73% Ward based staff. Updated Absence policy and related procedures will continue to support effective management of sickness.

Vacancy rate

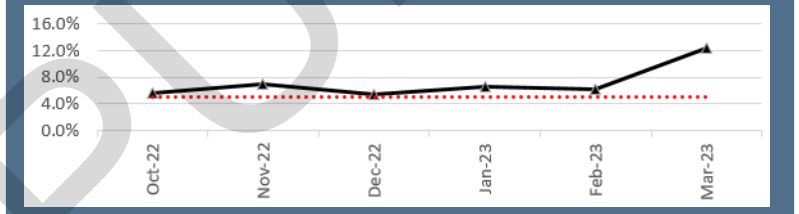
Positive trajectory (target from October 23)



An improving trajectory with a downward trend since Dec. Significant process on HCA recruitment in first quarter of year with recruitment exceeding monthly projection in March. Recruitment focus being reset to align with new ward establishment approach.

Agency spend

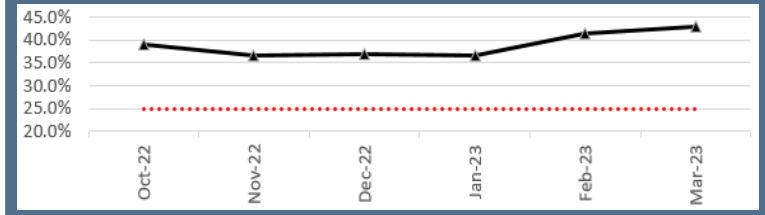
Adverse to (financial) target



Agency spend peaked in March and has since reduced. It will reduce further with the new resourcing approach for the revised ward establishments. Due to the challenging registered recruitment space, in the short to medium term agency use will continue for registered need, running in parallel with the Nursing Workforce plan. With agency spend only being approved for registered vacancies, via the recruitment panel.

Non-patient facing shifts

Adverse to target



Revised HR policies and procedures, alongside new roster build and leave approvals processes controlled by the General Managers will bring this metric in line with the budgeted expectation from June. We are rebasing the calculation from 1st May in order to focus on the elements of non-patient facing that are within operational management responsibilities.

Divisional integrated performance summary

	Measure	Birmingham	CAMHS	Essex	LDA	LSSR	Medium Secure	Neuro	Community Partnerships
Safety	Ward level SPC Concerns	2%	6%	0%	14%	3%	3%	3%	N/A
	Ward level SPC Improvements	2%	6%	3%	5%	2%	2%	6%	N/A
	Positive My Voice (Jan23 - Mar23)	66%	64%	75%	66%	84%	73%	74%	Being relaunched
Workforce	Voluntary Turnover In Year (12%)	9.6% Improvement	29.8%	15.0% Improvement	14.4% Improvement	15.6% Improvement	12.2% Improvement	15.2% Improvement	36.6%
	Voluntary Turnover in Month (1%)	0.7%	1.7% Improvement	0.6%	1.1% Improvement	0.7% Improvement	1.3%	1.3%	2.8%
	Training (90%)	87.9% Improvement	87.8% Improvement	85.7% Improvement	88.3% Improvement	91.0% Improvement	84.3% Improvement	89.6% Improvement	94.7% Improvement
	Sickness % In Month (6%)	7.5% Improvement	7.2% Improvement	5.0% Improvement	7.2% Improvement	4.0% Improvement	7.8% Improvement	5.8% Improvement	2.0% Improvement
	Non Patient Facing (25%)	38.7%	44.4%	38.2%	46.8%	38.4%	45.8%	42.4%	N/A
Finance	YTD Net contribution vs budget % (100%)	87%	90%	96%	79%	94%	90%	97%	110%
Focus wards	9C review wards	Moor Green	Seacole and Stowe	None	Church	None	Willow	Allitsen	N/A

There are many improvements across the workforce metrics. Overall LSSR's performance sets the standard for the other divisions, with comparatively very strong performance and progress in all areas - most notably patient feedback, training, sickness and finance. CAMHS will benefit from this leadership – having come under common oversight from 2nd May. The leadership team has instigated 9Cs quality reviews to understand where to focus their improvements. LDA is challenged across the key metrics, with strong improvement apparent for workforce. In addition to the strengthening leadership and clinical and operational management via Thrive there is further targeted leadership support for Church in order to support the dedicated Quality Improvement Plan. A separate monthly finance forum is being established where the Service Directors will be held to account by the COO and FD.

Financial Overview

Financial Year 2022/23 Actual Performance

- **Net deficit £5.9m** (£2.4m behind budget). **Significant improvement to 2021/22 £12.3m deficit**.
- March 2023 closing occupancy 627 – **7% increase over last 12mths** (+40 patients)
- Income was lower than budget due to lower avg occupancy throughout the year
- Non Operating exceeded budget due to the **one off cost of living payment** for staff (unbudgeted)
- Other material factors creating financial impact included Qtr4 higher staffing costs, Estates/IT overspend, higher interest rates, high cost inflation and reduction in the Investment Portfolio valuation.
- Cash held **March 2023 £8.3m** (£6.7m unrestricted cash) with £7m RCF headroom
- £4m less operational cash generated, offset by lower CAPEX & loan repayments.
- Significant improvement in EBITDA has strengthened bank covenants, with no current covenant risk.

Financial Year 2022/23 Actual Performance v Full Year Forecast (FYF Nov 2022)

- Operational staffing costs exceeded FYF in Qtr4, with factors identified and solutions imbedded within new staff establishment and Thrive Programme changes.
- £0.2m overspend on Corporate Services with Estates experiencing high repairs and maintenance costs in Qtr4
- Overall impact was **Operating Deficit £1.6m** worse than forecast
- Partially mitigated by lower OPEX Project Costs (non operating)
- **Net deficit £5.9m** (£0.9m behind November 2022 FYF).

2022/23 has seen reduction in net deficit, growth in occupancy and stronger covenants, whilst encountering challenging economical factors (cost of living, inflation etc). Secured new bank facility, and strengthened balance sheet (moved to net current assets of £0.6m).

Financial Performance 2022/23

	Full Year - Actual v FYF			Full Year - Actual v Budget		
Financial Performance - £m	**Actual**	**Forecast**	**Variance**	**Actual**	**Budget**	**Variance**
Income	172.7	171.5	1.2	172.7	176.1	(3.4)
Operational Costs	(129.6)	(126.9)	(2.6)	(129.6)	(130.4)	0.8
Net Contribution	**43.1**	**44.5**	**(1.4)**	**43.1**	**45.7**	**(2.5)**
Corporate Services	(32.4)	(32.3)	(0.2)	(32.4)	(31.9)	(0.5)
Depreciation	(10.7)	(10.7)	(0.0)	(10.7)	(11.3)	0.5
Operating Surplus/(Deficit)	**(0.1)**	**1.5**	**(1.6)**	**(0.1)**	**2.5**	**(2.6)**
Non Operating	(5.9)	(6.5)	0.7	(5.9)	(5.0)	(0.9)
Net Surplus/(Deficit)	**(5.9)**	**(5.0)**	**(0.9)**	**(5.9)**	**(2.4)**	**(3.5)**
Occupancy	**Actual**	**Forecast**	**Variance**	**Actual**	**Budget**	**Variance**
Available Beds	701	701	0	701	701	0
Avg Occupied Beds	602	604	(2)	602	637	(35)
Occupancy %	86%	86%	(0%)	86%	91%	(5%)
Investment/One Off Costs £m	**Actual**	**Forecast**	**Variance**	**Actual**	**Budget**	**Variance**
CAPEX Costs	3.3	4.5	1.2	3.3	5.9	2.6
OPEX Project Costs	2.3	2.9	0.5	2.3	3.3	1.0
Exceptional Costs	2.8	2.7	(0.2)	2.8	1.0	(1.8)
Total	**8.5**	**10.1**	**1.6**	**8.5**	**10.3**	**1.8**

Cashflow & Balance March 2023

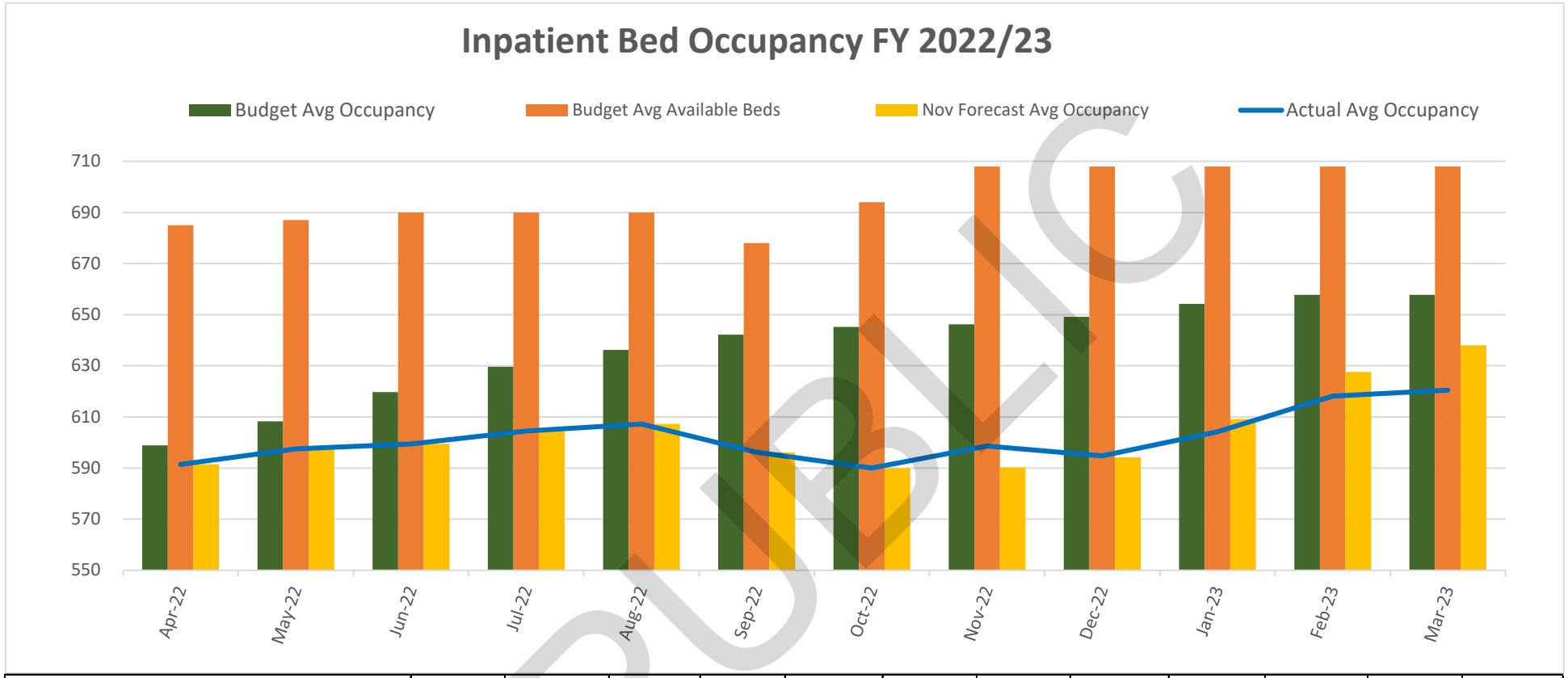
	Full Year - Actual v FYF			Full Year - Actual v Budget		
Cashflow £m	**Actual**	**Forecast**	**Variance**	**Actual**	**Budget**	**Variance**
Net Inflow / (Outflow) from Operations	5.1	6.1	(1.0)	5.1	9.1	(4.0)
Other Net Cash Inflow / (Outflows)	(2.8)	(8.4)	5.6	(2.8)	(11.2)	8.4
Total Cashflow Movement	**2.3**	**(2.3)**	**4.6**	**2.3**	**(2.1)**	**4.4**
Cash Held	**8.3**	**3.7**	**4.6**	**8.3**	**3.9**	**4.4**
Bank Loan Balance	(20.0)	(15.5)	(4.5)	(20.0)	(14.5)	(5.5)
RCF Headroom	**7.0**	**11.5**	**(4.5)**	**7.0**	**12.5**	**(5.5)**
Investment Portfolio	11.4	10.8	0.6	11.4	11.6	(0.2)
Covenant Risk	N	N		N	N	

Balance Sheet Summary £m	**Mar 22 Audited**	**June 22**	**Sept 22**	**Dec 22**	**Mar 23 Unaudited**
Fixed assets	196.6	193.9	191.9	190.5	189.0
Investments	17.3	17.4	17.4	16.5	17.1
Net Current Assets/(Liabilities)	(1.3)	(0.8)	0.7	0.0	0.6
Bank Loan Balance	(20.0)	(20.0)	(20.0)	(20.0)	(20.0)
Total Assets Employed	**192.0**	**189.9**	**189.4**	**186.4**	**186.1**

Note

- Other cashflow include – CAPEX, Property Disposals, Working Capital & Loan Movement
- Investments = Investment Property and Share Portfolio

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	638
Actual Avg Occupancy	591	597	599	604	607	596	590	599	595	604	618	621
Actual Closing Occupancy	594	602	601	608	605	592	587	600	594	619	626	629
Actual % Achievement of Budget	99%	98%	97%	96%	95%	93%	91%	93%	92%	92%	94%	94%
Avg Occupancy of Available	86%	87%	87%	88%	88%	88%	85%	85%	84%	85%	87%	88%

IT Integrated Quality Performance Pack

April 2023 (reviewing March)

IT Security

The team has continued their focused effort on remediating known vulnerabilities in line with agreed timelines, ensuring that St Andrews systems remain as protected as they can be from external vulnerabilities and exploits. The focus on security awareness within the charity has again seen an increased uptake of the IT Security eLearning module over the last few months. Network attacks have continued to decline and system patching levels are increasing.

IT Security Metrics (Jan – Mar 2023)

Legend: No Change | Trending Down | Trending Up

	JAN	FEB	MAR	RAG Rating	March – Causal	March – 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 September 2022. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: The network segregation penetration test was conducted in September 2022, one finding was immediately addressed.	**Remedial Actions:** None
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 0 P3 4	P1 0 P2 0 P3 1	P1 0 P2 1 P3 7		**Causal Analysis**: There have been 8 phishing incidents in March, one of which was a P2, indicating the staff member clicked on a malicious link. IT Security continue to proactively monitor for phishing threats.	**Remedial Actions:** IT Staff follow rigorous incident response procedures to investigate any incident. In this case no credentials were submitted. A Phishing simulation exercise is due in May to test selected staff's resolve and knowledge.
Blocked Network Attacks These are blocked network attacks directed at our external network edge	55929	37950	30550		**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)

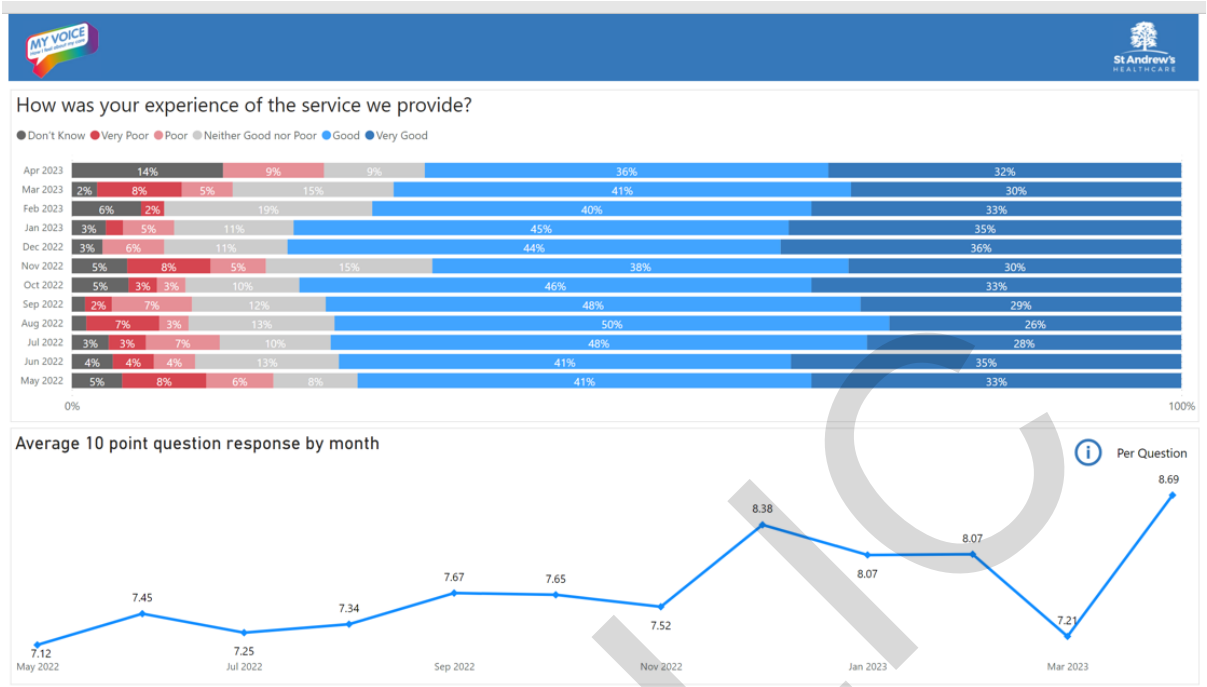
IT Integrated Quality Performance Pack

April 2023 (reviewing March)

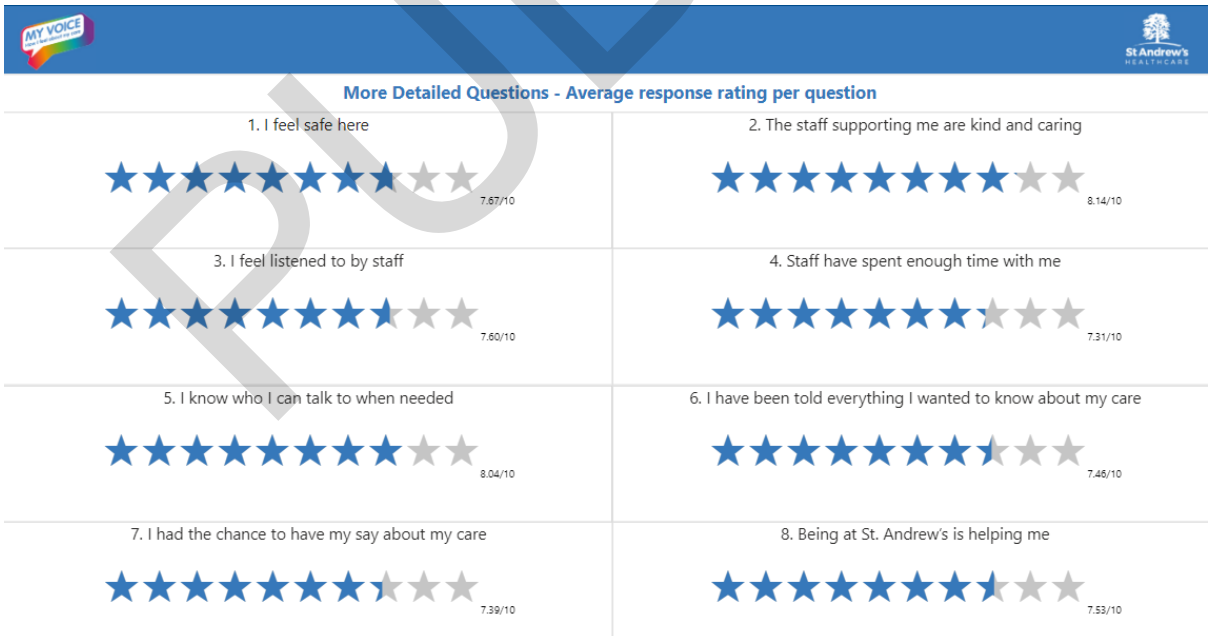
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	0	0	0		**Causal Analysis**: None to report.	**Remedial Actions:** Nothing to report.
% of Fully Patched Systems % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 89.43% Client = 94.4%	Servers = 88.2% Client = 91.6%	Servers = 89.61% Client = 92.5%		**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	96%	97%	95 %		**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.	22	8	18		**Causal Analysis**: There have been 18 high cases in March, 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	90%	91%	92%		**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.

My Voice – May 2022-April 2023

Overall there has been an increase in the average My Voice scores from May 2022 to April 2023:

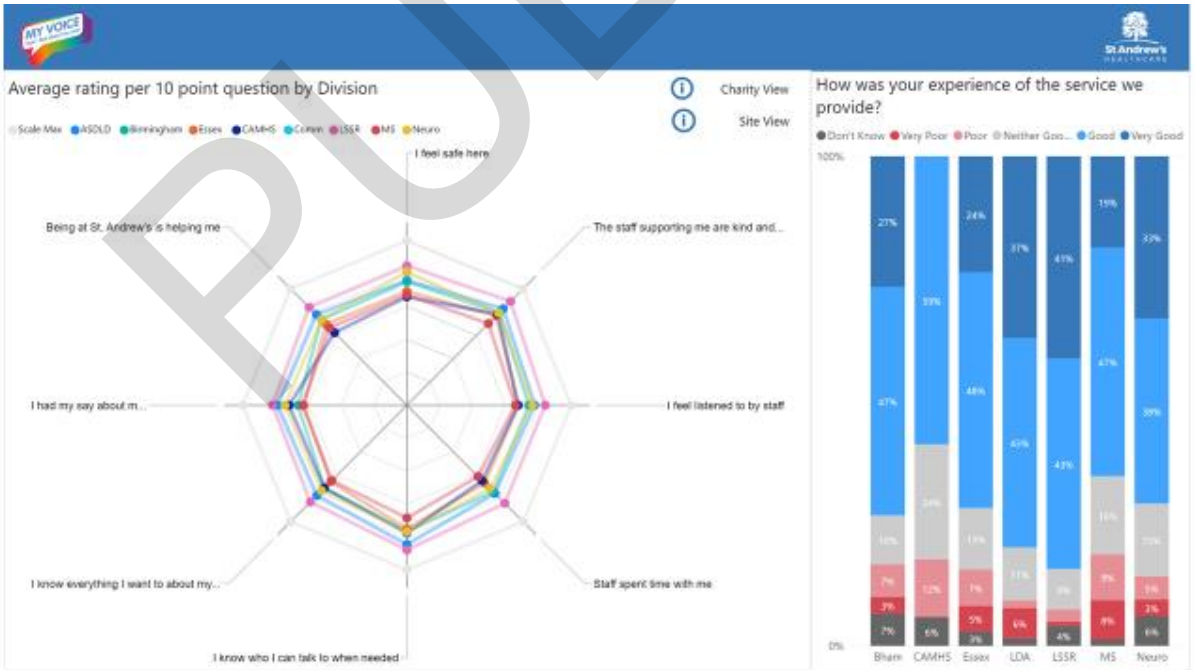


Across the questions there is a variation in the scores from the lowest ('Staff spend enough time with me' 7.31/10) to the highest score ('The staff supporting me are kind and caring' 8.14/10):

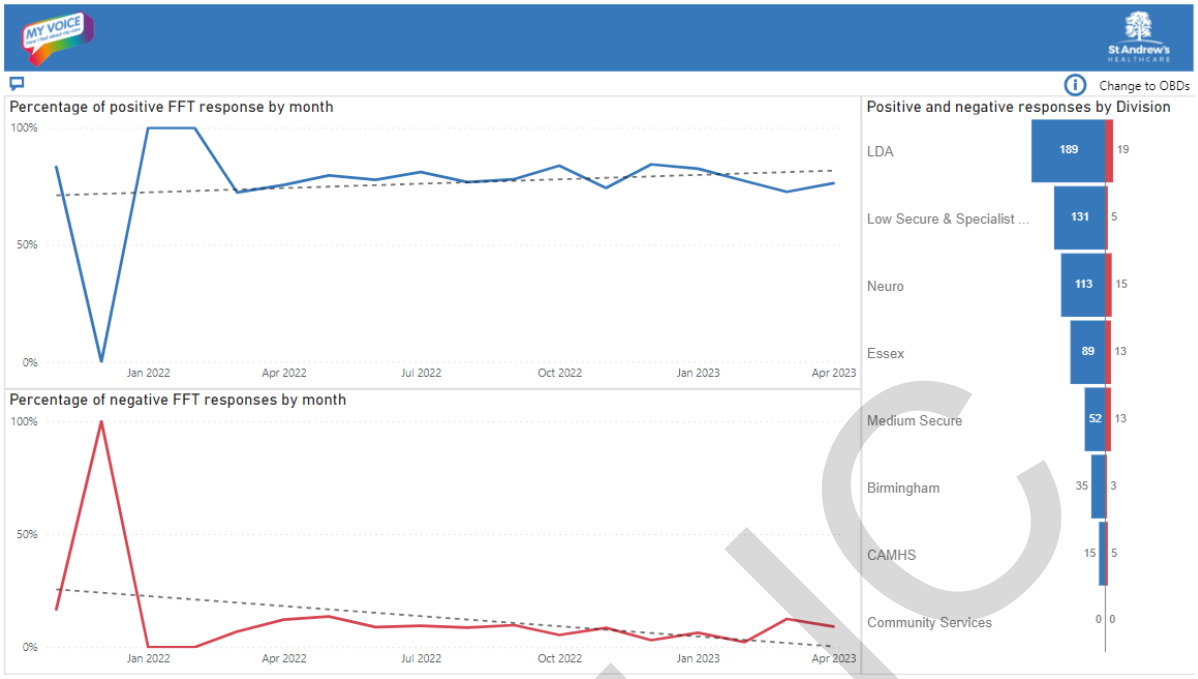


There is a variation in numbers of responses for each Division (this is a number count and so Divisions with a higher bed number are likely to get more responses). The NHS response rate for FFT is around 5-10%. In March 2023, 131 responses is around 22% response rate. This report was pulled for the TAG meeting in April and so there are likely to be more responses over the month:

Again there is variation across the Divisions in the ratings for the FFT. LSSR and LDA achieved the highest combined % score for 'Very Good' and 'Good' (84% and 80% respectively). Whilst CAMHS and MS achieved the lowest combined % score for 'Very Good' and 'Good' (59% and 66% respectively).



Finally, the trend line for the % of positive and negative scores across the Charity are moving in the right direction:



Decisions:

Divisions need to make a decision about how My Voice responses will be gathered. In some Divisions this has been done by Nursing and in others Psychology have taken a lead on this.

If a Division/Unit has decided that My Voice is not clinically indicated, another system for gathering the patients' voice needs to be agreed and signed off at the Divisional Governance meetings.

Once responses have been gathered, the results need to be discussed in the next ward Clinical Governance meeting. Feedback and actions from the clinical team needs to be taken to Community Meetings for further discussion and agreement.

This learning and feedback loop needs to continue with each time My Voice responses are gathered. The frequency of completing/reviewing My Voice needs to be agreed at a Ward/Divisional level to meet the needs of the patient group.

TAG will continue to review the Charity-wide and Divisional Scores on a monthly basis and flag any exceptions to the QSG – Compliance and Effectiveness.

Dr Emily Fox (Director of Psychological Therapies)

25th April 2023

Dialectical Behaviour Therapy at St Andrew's – past, present and future

(Dawn Chamberlain, Dr Emily Fox, Victoria Taylor & patient)

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 Meetings:

Quality Account Approval - Thursday 8th June 2023

Board Meeting in Public - Friday 21st July 2023 9.30am

(Paul Burstow - Verbal)

Annex A

Governance Oversight Group Update

Governance & Risk Project

Board Update May 2023

Project Headlines

- Project plan updated for final months prior to project completion in July 2023
- Board Code of Conduct – approved and issued to 14 Board members, with all bar two returned.
- Board Skills Matrix – approved and issued to 20 Board attendees, with all bar four returned. Follow-ups sent and results to be collated.
- Meetings templates remain under review.
- Governance Structure Chart – approved and published, along with supporting information document.
- ARC Terms of Reference approved, with NomRemCo, People Committee and QSC all close to finalising.

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)
- Skills Matrix format finalised ready for roll out after the annual declarations process (End of May 2023)
- Meetings Templates finalised for roll out in Q2 (July 2023)

Work in Progress

- New Board Terms of Reference being developed following review of Matters Reserved
- Board Matters Reserved aligned with Articles and updated Authority Matrix
- Skills Matrix – collation of results and drafting of initial development plan
- Meeting templates – revisions and benchmarking to comparable trusts currently being undertaken in readiness for review prior to adoption.
- Terms of Reference for QSC, People Committee, NomRemCo, FinCom and ERT.

Risk Summary

Risk ID	Risk Title	Brief Risk Description	Initial Risk Ratings			Existing Controls	Current Risk			Trajectory
			Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	
April/001	Project Scope	The project scope may not be well defined or incomplete resulting in poor effectiveness and potential project failure	Moderate	Possible	High	Development of Project Initiation Document outlining full scope of project taking into account E&Y review, and additional Charity requirements. [PE]	Insignificant	Rare	Low	⇔
April/002	Priorities	Lack of control of staff or charity priorities or unanticipated events may lead to project disruption, delay or non-delivery	Moderate	Possible	High	Clear communication with GOG and key stakeholders in order to mitigate any potential adverse occurances [PE]	Minor	Possible	Medium	⇧
April/003	Communication	Lack of effective communication and oversight could result in lack of confidence in the project by the Board and the Charity	Moderate	Possible	High	Regular project reporting and 1:1 meetings with key stakeholders. Regular GOG meetings [E]	Minor	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	Rare	Low	⇩
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]	Minor	Unlikely	Medium	⇔

Risks have been reassessed with two being re- rated:

- April002 – Priorities (increase in likelihood) – increase to medium
- April005 – Project Resourcing (decrease in likelihood) – decrease to low

Other risks remain stable with the same ratings as previously reported

Annex B

Internal Audit Plan 2023-24

St Andrew's Healthcare

Internal Audit Plan 2023/24

17 April 2023

Internal Audit Plan 2023/24

Introduction

Further to the discussion at the January 2023 ARC meeting, this paper outlines our approach to forming the Internal Audit Plan for 2023/24. The indicative plan shows the proposed internal audit topic areas for 2023/24 with the rationale for each review, the number of days allocated to each assignment, and the proposed audit timing.

Integrated Assurance Framework (IAF)

The Internal Audit Assurance Methodology provides a systematic approach to calculate the audit opinion for each assignment, based upon the aggregation of the risk ratings assigned to each of the control improvement recommendations included within an internal audit report. The total impact value of the recommendations is combined to determine the overall audit opinion, based upon a risk scoring matrix. In recent years, the trend of internal audit opinions has been towards limited assurance, with 10 of the last 14 patient-facing audits receiving a Limited assurance opinion based upon the Internal Audit Assurance Methodology. A consistent theme of recent internal audits has been that whilst the Charity has policies and procedures which define the key controls, the governance mechanisms to check that staff are applying them consistently require improvement.

The Internal Audit team is currently working on a project to develop an Integrated Assurance Framework (IAF) for the Charity, to improve the quality of assurance offered to the Board and its sub-committees via the introduction of:

1. Robust mechanisms to ensure that the 1st Lines of Assurance - LoA (ward and divisional managers) take responsibility for policy compliance and performance management, enabling the 2nd LoA to step back from providing operational support and focus on strategy development, control improvement, and audit and challenge.
2. Greater integration between the 1st and 2nd LoAs, to improve the flow of information from the operational functions that directly own and manage services to the oversight functions.
3. Enhanced integration between the existing functions which act as our 2nd LoAs (i.e. Risk Management, Clinical Audit, Quality Assurance, Health and Safety).

16 days have been included in the plan for on-boarding and overseeing the deployment of the “Phased”-Integrated Assurance Framework. The IAF will support and inform the production of the Head of Internal Audit annual opinion report for 2023/24, as it will enable us to provide an objective opinion on the overall adequacy and effectiveness of the Charity’s framework of governance, risk management and control. The introduction of the IAF will also help to increase Internal Audit coverage across the organisation, and ensure that all of the topic areas in the Audit Universe are covered within a five year timeframe.

Conclusion

In our opinion, the indicative 2023/24 Internal Audit Plan provides adequate coverage across key internal control areas to enable an end of year assurance opinion to be provided on the Charity’s internal control environment, especially in light of the core areas of control weaknesses identified in the recent years. It should be noted that the Internal Audit Plan is based upon our knowledge of current risks, and should be viewed as being indicative only and subject to change as other risks may emerge throughout the year.

The Committee is asked to review and approve the proposed 2023/24 Internal Audit Plan, ensuring that it addresses the Charity’s current key risks and the areas that should be covered as a priority.

Internal Audit Annual Plan 2023/24 - Indicative

Number	Audit Area	Risk Category	Rationale	Indicative Timing	Days
1	IPDR Process	Staff Governance	Cyclical review of a key internal control area	Q1 – 54 days	10
2	Procurement	Finance	Review of a key second line of defence		10
3	Legal and Insurance	Corporate	Review of a key second line of defence		10
4	Contingency 1 – Authority Matrix	Corporate	Agreed with CEO		10
5	Contingency 2 – MHA Review Process	Compliance	Agreed with CEO		10
6	Integrated Assurance Framework	Control Environment	Integrated Assurance Framework on-boarding		4
7	Infection Prevention and Control	Clinical Care	Review of a key second line of defence	Q2 – 55 days	10
8	Medical Devices	Clinical Care	Review of a key second line of defence		10
9	Key Financial Systems	Finance	Review of a key second line of defence		16
10	Contingency 3 – Divisional Governance	Corporate	Our suggestion		10
11	Follow up of Limited Audit Report	Control Environment	Sickness Absence Management		5
12	Integrated Assurance Framework	Control Environment	Integrated Assurance Framework on-boarding		4
13	THRIVE Programme Delivery	Corporate	Strategic risk area	Q3 – 44 days	10
14	Physical Healthcare	Clinical Care	Review of a key second line of defence		10
15	Contingency 4 – Whistleblowing / FTSU	Staff Governance	Agree with CEO		10
16	Follow up of Limited Audit Report	Control Environment	Safeguarding		5
17	Follow up of Partial Audit Report	Control Environment	Violence and Aggression		5
18	Integrated Assurance Framework	Control Environment	Integrated Assurance Framework on-boarding		4
19	EPRR Core Standards	Corporate	Annual review of the NHSE EPRR submission	Q4 – 51 days	4
20	DSP Toolkit	Corporate	Annual review of the DSP Toolkit		8
21	Patient and Carer Engagement	Corporate	Review of a key second line of defence		10
22	Contingency 5 – Fire Protection	Corporate	Our suggestion		10
23	Contingency 6 – Safe Staffing	Staff Governance	Our suggestion		10
24	Follow up of Partial Audit Report	Control Environment	Waste Management		5
25	Integrated Assurance Framework	Control Environment	Integrated Assurance Framework on-boarding		4
	TOTAL				204

Changes to the plan since the January 2023 ARC meeting

1. 60 contingency days have been added in line with the new draft Global Internal Audit Standards, which states that the internal audit plan must be dynamic and updated timely in response to changes in the organisation's business, risks, operations, programs, systems, controls, and organisational culture. We have included our current suggestions for audits which could be completed using these contingency days in the plan below, but we will be asking executive management to suggest the contingency audit topics, and our proposals will only be taken forward if no other audits have been requested. It should be noted that four contingency audits are planned to be completed by the Head of Internal Audit and Risk Management, so that if ERM and BAF activities require prioritisation, any or all of these may not be delivered.

2. Each quarter of the FY 2023/24 will have a dedicated time allocated towards the design, deployment and delivery of a fully Integrated Assurance Framework. This will entail monitoring of the results from the assurances offered by the 1st LoA, 2nd LoA, results of any functional reviews / audits conducted, design gaps or operational inefficiencies identified in the processes. Our plan has been carefully laid out taking into consideration the merits of preceding an independent Internal Audit ahead of socialising the IAF. Hence, further audits of 2nd LoA have been added to the plan (Legal and Insurance, Medical Devices, Patient and Carer Engagement, and Physical Healthcare).

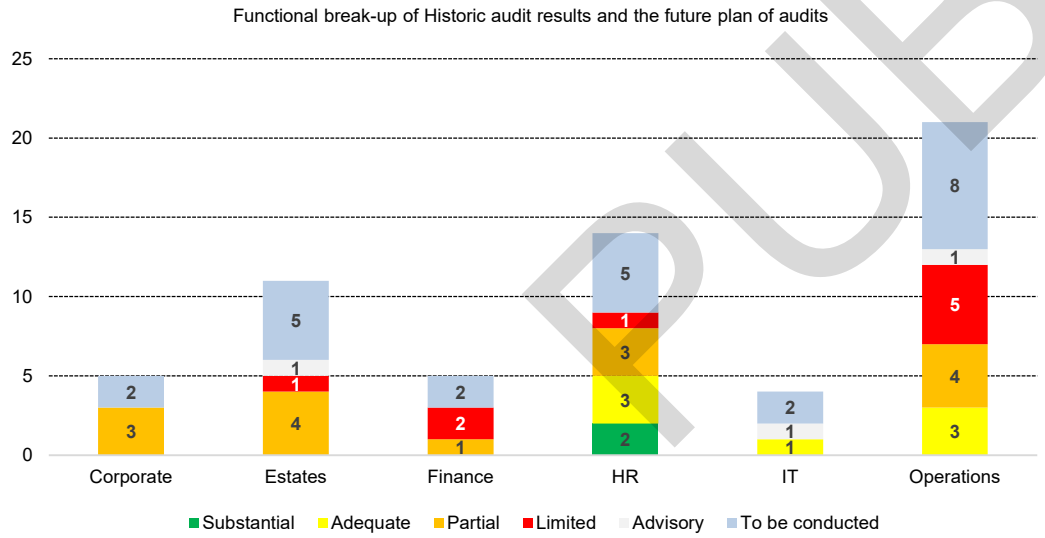
3. Reviews of the IPDR Process and the THRIVE Programme Delivery have replaced the reviews of Clinical Audit and Quality Compliance following our discussions with management.

Internal Audit Universe

Sl. No.	Auditable Area	Type	Last audit report Issued on	Assurance rating	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
1	Security Management	Estates	30/10/2017	Advisory			✓			
2	Stores and Stock Control	Estates	06/01/2022	Limited		✓				
3	Violence and aggression	Estates	11/07/2022	Partial	✓	✓				
4	Cleaning Services	Estates	15/02/2021	Partial	✓					
5	Health and Safety	Estates	11/01/2023	Partial			✓			
6	Waste Management	Estates	07/10/2022	Partial			✓			
7	Fire Protection	Estates						✓		
8	Planned Preventative Maintenance	Estates							✓	
9	Environmental Sustainability	Estates							✓	
10	Catering	Estates								✓
11	Control of Contractors	Estates								✓
12	Purchasing Cards	Finance	05/10/2017	Limited					✓	
13	Procurement	Finance	19/07/2019	Partial					✓	
14	Stores and Stock Control	Finance	06/01/2022	Limited		✓				
15	Key Financial Systems	Finance						✓		
16	Patient Monies and Property	Finance								✓
17	Well Led Framework	Corporate	09/05/2022	Partial	✓	✓				
18	NHS Contract Compliance	Corporate	14/10/2021	Partial	✓					
19	Risk Management	Corporate	16/11/2018	Partial						✓
20	Legal and Insurance incl. Claims Management	Corporate						✓		
21	Board Assurance Framework	Corporate							✓	
22	Pre-employment Checks	HR	07/09/2022	Adequate			✓			
23	Freedom to Speak Up / Whistleblowing	HR	10/10/2019	Adequate				✓		
24	Payroll Controls	HR	14/12/2017	Adequate					✓	
25	Sickness Absence Management	HR	09/05/2022	Limited		✓				
26	Fit and Proper Persons Requirements	HR	15/06/2021	Partial	✓					
27	Expenses	HR	08/05/2019	Partial					✓	
28	Workbridge	HR	05/09/2019	Partial					✓	
29	Pension Controls	HR	31/05/2018	Substantial						
30	Professional Registration	HR	06/06/2019	Substantial						
31	Statutory and Mandatory Training	HR							✓	
32	Agency and Temporary Staffing	HR								✓
33	Equality & Diversity	HR								✓
34	IPDR Process	HR						✓		
35	Recruitment and Retention	HR							✓	
36	NHS Data Protection and Security Toolkit	IT	04/10/2022	Adequate	✓	✓	✓	✓	✓	
37	ISO 27001	IT	25/10/2022	Advisory	✓	✓	✓			
38	Cyber Security	IT						✓		
39	Data Quality (incl MHSDS and SMH datasets)	IT							✓	
40	Advocacy service	Operations	26/01/2021	Adequate	✓					
41	Learning from deaths	Operations	09/10/2020	Adequate	✓					
42	Innovation & Research	Operations	05/06/2020	Adequate					✓	
43	Quality Account	Operations	07/06/2022	Advisory	✓	✓	✓			
44	EPRR	Operations	12/01/2023	Limited			✓	✓		
45	Physical Healthcare	Operations	07/06/2022	Limited		✓		✓		

Internal Audit Universe

Sl. No.	Auditable Area	Type	Last audit report Issued on	Assurance rating	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
46	Long-Term Segregation	Operations	05/01/2022	Limited		✓				
47	Safeguarding	Operations	07/10/2022	Limited			✓			
48	Infection Prevention and Control	Operations	01/11/2017	Limited				✓		
49	Patient and Carer Engagement	Operations	01/10/2021	Partial		✓				
50	Medical Devices	Operations	02/11/2018	Partial				✓		
51	Complaint Management	Operations	15/11/2018	Partial						
52	Serious Incident Management	Operations	06/11/2018	Partial						
53	Medicines Management	Operations					✓			
54	Safe Staffing	Operations							✓	
55	Clinical Audit	Operations							✓	
56	e-Rostering	Operations							✓	
57	Quality Compliance	Operations							✓	
58	Triumvirate Working	Operations						✓		
59	Admission and Discharge processes	Operations								✓
60	Divisional Governance	Operations							✓	



Notes:

1. Our audit universe is a collection of potential audit activities which we aim to perform through our function. It is a combination of functions, divisions, processes, and systems. The types of Internal audits we have considered for our audit universe span across operational audits, financial audits, and functional reviews. This is a live document, which is regularly reviewed and updated to incorporate and emerging risks across the strategy, operations, clinical / non-clinical exposures, legal and regulatory changes, etc.
2. Internal Audit function works very closely with the Risk Management function to oversee the potential risks, and the frequent results of control failures, or risk exposures. The on-going initiative of deploying an Integrated Assurance Framework across the various 2nd Lines of Assurance (which obtain assurances from the 1st lines and offer the assurances upwards) will significantly affect the possible areas for an independent evaluation i.e. conducting of Internal Audits.
3. The adjacent chart gives a pictorial representation of the various areas against which we have maintained our audit universe, the "as-is" results of the audits we have finalised, the level of assurances we have offered, and the number of areas which are pending conduct of an independent audit.

Appendix 1 – Audit Assurance & Priority Guidelines

The overall audit opinion is based on the following assurance ratings:

Assurance Level	Description
Substantial	There is substantial level of control over the key risks. The tested controls have been applied consistently and effectively. No significant improvements are required.
Adequate	Key risks are covered by adequate levels of control. Although there are some weaknesses in the application of control procedures, the weaknesses are not sufficiently critical to compromise the system of internal control. Some improvements are recommended to enhance existing controls.
Partial	Some key risks have inadequate levels of control or key controls are not being consistently applied. The weaknesses identified, taken together or individually, impair the system of internal control. Prompt corrective action is required by management to significantly improve the application of key controls.
Limited	Key risks are generally not covered by adequate levels of control. A widespread lack of application of key controls undermines the system of internal control. This failure of the control infrastructure has had, or is likely to have, significant implications for the business. Urgent management attention is recommended to implement effective controls.

Recommendations within the report are categorised as follows:

Priority	Description
High	A mission/ business critical fault has been identified. This is causing (or is likely to cause) the Charity a major breakdown in process or quality control to the extent that the Charity risks suffering major damage/ loss if the fault is not corrected.
Medium	There has been a significant breakdown in processes/ systems, resulting in inefficiencies and ineffectiveness. The Charity risks suffering damage/ loss if the fault is not corrected.
Low	Processes and/or policies are working moderately; however, improvements are required to optimise efficiency and effectiveness.

Appendix 2 – Internal Audit Assurance Methodology

Each internal audit assurance report includes recommendations for internal control improvements, and an overall assurance opinion, based on four levels of assurance rating as tabulated below.

Assurance Level	Description
Substantial	There is substantial level of control over the key risks. The tested controls have been applied consistently and effectively. No significant improvements are required.
Adequate	Key risks are covered by adequate levels of control. Although there are some weaknesses in the application of control procedures, the weaknesses are not sufficiently critical to compromise the system of internal control. Some improvements are recommended to enhance existing controls.
Partial	Some key risks have inadequate levels of control or key controls are not being consistently applied. The weaknesses identified, taken together or individually, impair the system of internal control. Prompt corrective action is required by management to significantly improve the application of key controls.
Limited	Key risks are generally not covered by adequate levels of control. A widespread lack of application of key controls undermines the system of internal control. This failure of the control infrastructure has had, or is likely to have, significant implications for the business. Urgent management attention is recommended to implement effective controls.

We appreciate that auditees and senior management may not always be clear regarding how we have reached the overall assurance opinion for each audit assignment. The Internal Audit team have therefore developed a systematic approach, which we propose to use to calculate the overall assurance opinion given for future internal audit assignments. The benefits of this approach are that:

- It reinforces the continuing integration of the Charity's Internal Audit and Risk Management functions, by linking the four internal audit assurance opinions with the risk scoring approach
- Internal audit opinions are more meaningful for senior management and the Audit and Risk Committee, as assurance levels are more comparable across different systems and processes
- Management is assured that audit opinions are unbiased, underpinning the independence of the Internal Audit team, which is essential to support robust challenge and effective and objective assurance to the Audit Committee and Board.
- This methodology (explained in the next section) will support and inform the production of the Head of Internal Audit annual opinion report for 2021/22 onwards, as it will enable us to provide an objective opinion on the overall adequacy and effectiveness of the Charity's framework of governance, risk management and control.

Methodology:

The methodology is based upon the aggregation of the risk ratings assigned to each of the control improvement recommendations included within an internal audit report. A weighted score is assigned to each of the recommendations, so that a 'High' impact rated recommendation is scored 3, a 'Medium' rated recommendation 2, and a 'Low' rated recommendation 1. The total impact value of the recommendations is then combined to determine the overall audit opinion, based upon the risk scoring matrix, as follows:

0 - 3 = Substantial	4 - 7 = Adequate	8 - 13 = Partial	14 - 25 = Limited

For instance, an audit report which includes 3 'Low' risk recommendations, 2 'Medium' risk recommendations and 1 'High' risk recommendation would result in a combined risk score of:
'Low' risks (3 x 1) + 'Medium' risks (2 x 2) + 'High' risks (1 x 3) = (3 + 4 + 3) = 10. This would therefore result in a Partial assurance opinion. An audit report containing 2 'Low' risk recommendations and 1 'Medium' risk recommendation would result in an "Adequate" assurance opinion (2 + 2 = 4). These rating ranges are consistent with the equivalent four levels of risk in the Charity's 5 x 5 risk scoring matrix, which correspond with those commonly used by NHS Trusts, whereby risks are graded as:

0 - 3 = Low	4 - 7 = Moderate	8 - 13 = High	14 - 25 = Major

Although audit reports can result in a score of **7, 13 or 14**, it is not possible for a risk to be scored this way using a 5 x 5 matrix. For the sake of fairness, an audit with a score of 7 is included in an "Adequate" opinion, a score of 13 would result in a Partial opinion, with a score of 14 resulting in a Limited opinion to ensure that the ratings are balanced. Although these calculations form the basis of the audit opinion, we do make a distinction to allow for the priority of the recommendations that are included in an audit report. Below are 3 noteworthy scenarios to be considered:

- It would not be appropriate to provide a Substantial assurance opinion if a 'High' or 'Medium' priority recommendation is included in the report (i.e. to achieve a Substantial opinion, a report must include 3 or fewer 'Low' risk recommendations).
- Equally we would not provide an Adequate assurance opinion if a 'High' priority recommendation is included in the report (i.e. to achieve an Adequate opinion, a report must contain a combination of 'Medium' and 'Low' priority recommendations only).
- Conversely, it would not be fair to provide a Partial or Limited assurance opinion if a report contains only 'Low' risk actions; in this instance an "Adequate" opinion would be provided.

Likelihood (Initial)	Consequence (Initial) 1 : Insignifica	2: Minor	3: Moderate	4: Major	5: Catastroph
(5) Almost Certain : Will undoubtedly happen	5	10	15	20	25
(4) Likely : Will probably happen	4	8	12	16	20
(3) Possible : Might happen occasionally	3	6	9	12	15
(2) Unlikely : Do not expect it to happen	2	4	6	8	10
(1) Rare : This will probably never happen	1	2	3	4	5

Thank You

Management – St Andrew's Healthcare

Annex C

Internal Audit Charter

Internal Audit Charter

This Audit Charter applies to all St Andrew's Healthcare's (StAH) Divisions, services, functions, and directorates, including (where agreed) StAH activities within Partnerships. This Charter establishes the purpose, authority, and responsibilities for the Internal Audit function at StAH. The establishment of a Charter is a requirement of the Internal Audit Standards and approval of the Charter is the responsibility of the Audit and Risk Committee.

1.1 Key Internal Audit Strategic Objectives

The purpose of the Internal Audit function is to provide independent, objective assurance and consulting services designed to add value and improve St Andrew's Healthcare's operations and internal control environment.

The key Internal Audit Strategic Objectives are based on the Definition of the Internal Auditing:

- To help the Charity to accomplish its strategic objectives
- To add value to the organisation
- To improve the Charity's operations.

Internal Audit will achieve its key objectives by using a systematic and disciplined approach to evaluate and improve the effectiveness of the Charity's risk management, internal control environment, and governance processes, thereby providing the Executive Team, Audit and Risk Committee and the Board of Directors with an independent and objective appraisal of the effectiveness of management's controls over these areas.

Internal auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations and internal control environment of StAH. We are required to work within the International Professional Practices Framework (IPPF) as published by the Institute of Internal Auditors (IIA) which includes the Institute's Definition of Internal Auditing, its Code of Ethics, Core Principles and Mandatory Standards (see Picture 2 below). Internal Audit also undertakes its work in accordance with the mandatory guidance within the IPPF. This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the Internal Audit function's performance. In line with these requirements, we complete audits and reviews in-line with a risk-based plan of work that has been agreed with management and approved by the Audit and Risk Committee.

1.2 Risks

The key risk to the achievement of the IA strategy is:

Failure to ensure that a systematic programme of Internal Audit is in place to provide independent and objective assurance over risk management, internal control and governance processes may result in control weaknesses going unidentified, increasing process inefficiencies, loss of resources to the organisation, eventually leading to an increased likelihood of the organisational objectives not being met.

The following scenarios may lead to an increase of the risk's likelihood and / or impact:

- Resilience of the Internal Audit function may be lower than required due to relatively low numbers of staff
- Inaccurate audit reports may damage the Internal Audit team's reputation with stakeholders
- The Head of Internal Audit and Risk Management's competing priorities
- Lack of permanent specialist IT audit knowledge within the Internal Audit team
- Budget constraints due to financial pressures on the Charity

1.3 Mission of Internal Audit

In keeping with the IIA's Standards, the Mission of the Internal Audit department is:

To enhance and protect StAH strategy, vision, mission, values, and targets by providing risk-based and objective assurance, advice and insight. This is Internal Audit's primary purpose and overarching goal and achievement of the Internal Audit Mission is supported by all elements of the International Professional Practice Framework.

1.4 Independence and objectivity

Internal Audit will remain free from interference by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to ensure a continued independent and objective approach is maintained. Internal Audit will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair their judgment. Exceptions to this must be justified, fully documented, and approved by the Audit and Risk Committee.

All members of Internal Audit must exhibit the highest level of professional objectivity in gathering, evaluating and communicating information about the activity or process being examined. They must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgements.

Conflicts of interest may arise due to the reporting lines outlined below in Picture 1 and the additional responsibilities of the Head of Internal Audit and Risk Management in respect of Risk Management, Counter fraud and wider assurance provision. The assurance engagements of areas that are under the control or direct influence of the Head of Internal Audit and Risk Management will be overseen by a party external to the Head of Internal Audit and Risk Management (to be agreed with the Audit and Risk Committee).

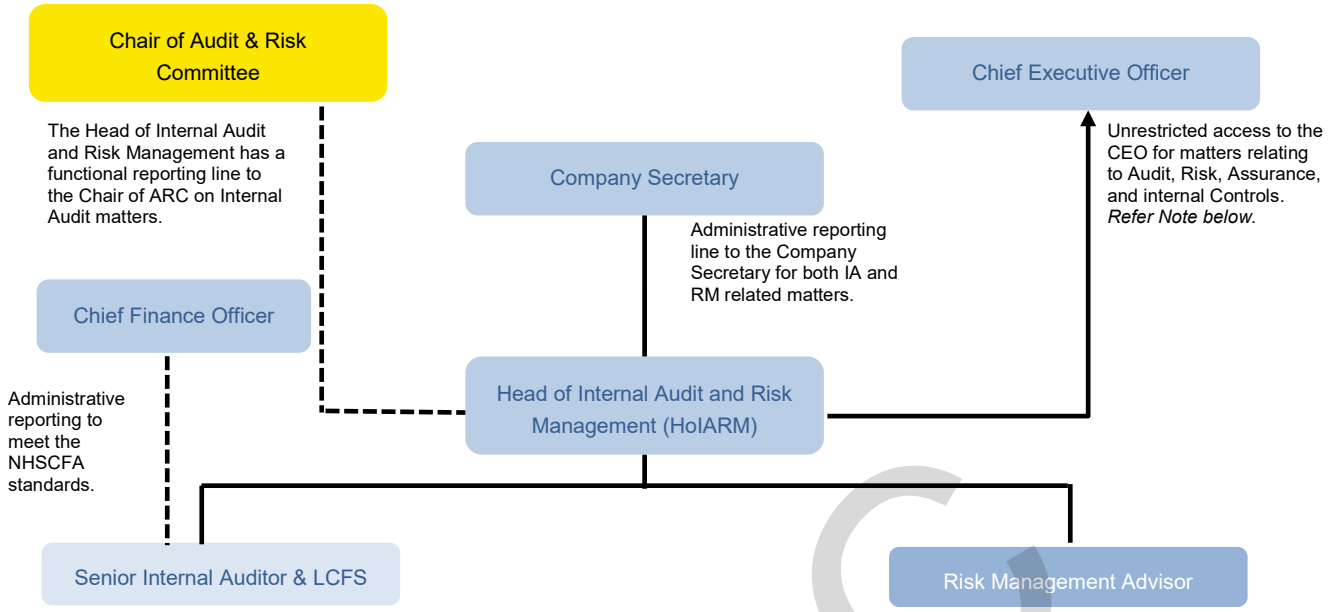
Any additional steps will be taken to avoid or manage transparently and openly, such conflicts of interest so that there is no real or perceived threat or impairment to independence in providing the Internal Audit service. If a potential conflict arises, disclosure will be reported to the Audit and Risk Committee. The nature of the disclosure will depend upon the potential impairment and it is important that the Internal Audit role does not appear to be compromised in any way when reporting the matter to the Audit and Risk Committee.

1.5 Authority & organisation

Internal Audit, with strict accountability for confidentiality and safeguarding records and information, is authorised full, free and unrestricted access to any and all of the Charity's records, physical properties, and personnel pertinent to carrying out any audit engagement. All employees are requested to assist Internal Audit in fulfilling its roles and responsibilities.

Internal Audit will also have free and unrestricted access to the Audit and Risk Committee , including in private meetings without management present.

The Head of Internal Audit and Risk Management will report functionally to the Chair of the Audit and Risk Committee and administratively to the Company Secretary (Line Manager). The Head of Internal Audit and Risk Management will communicate and interact directly with the Board/Audit and Risk Committee when necessary, including in executive sessions and between Committee meetings as appropriate.



Picture 1 Internal Audit Reporting Lines

Note: The reporting to the CEO is for administrative purposes, and is aimed to emphasize the unrestricted access the HoIARM has to the CEO. This shall, however, not be construed as an obstruction to his / her independence.

In addition to the team's permanent structure, the Head of Internal Audit and Risk Management will ensure that suitable outsourced support arrangements are in place where there is a requirement for specialist support, such as IT Assurance audits or additional support for the Local Counter Fraud Specialist for counter fraud activities and investigations. The Head of Internal Audit and Risk Management will confirm to the Audit and Risk Committee, at least annually as part of the Annual Internal Audit Report, the organisational independence of the Internal Audit Department.

1.6 Professionalism

The Internal Audit activity will govern itself by adherence to all mandatory guidance within the IPPF. This mandatory guidance constitutes principles of the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the Internal Audit function's performance. Where appropriate, the IIA's Implementation and Supplemental Guidance will also be adhered to, to guide day-to-day audit activities. In addition, Internal Audit will adhere to StAH relevant policies and procedures and the Internal Audit Manual.

Picture 2 International Professional Practice Framework

1.7 Internal Audit plan

At least annually, the Head of Internal Audit and Risk Management will submit to the Audit and Risk Committee an Internal Audit plan for review and approval, including risk assessment criteria. The Internal Audit plan will include indicative timings, as well as budget and resource requirements for the next fiscal year. The Head of Internal Audit will communicate the impact of any resource limitations and significant interim changes to the Audit and Risk Committee. The Internal Audit plan will be developed using risk based methodology, as well as input of senior management and the Audit & Risk Committee. Any significant deviation from the approved Internal Audit plan will be communicated through the quarterly Internal Audit reporting process.

1.8 Responsibility

The scope of internal auditing encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of StAH governance, risk management and internal control processes in relation to the Charity's defined strategic targets and objectives. The foundation of internal control involves competent personnel possessing integrity and ethics performing in an appropriate control-oriented environment. Internal control objectives considered by IA:

- Reliability and integrity of financial and operational information.
- Compliance with laws, regulations, policies, procedures, and contracts.
- Achievement of the organisation's strategic objectives.
- Effectiveness and efficiency of operations and programs.
- Safeguarding of assets.

Assurance engagements: Involve the examination and evaluation of evidence to provide an independent opinion regarding a process, function, operation or system. The nature and scope of assurance engagements will be determined by Internal Audit.

Consultancy and advisory engagements: Internal Audit may also perform consulting and advisory services, generally at the request of the Audit and Risk Committee or the Executive Team. Internal Audit will ensure that there are no conflicts of interest arising from undertaking the work, and not assume direct operational responsibility. These services may relate to governance, risk management and control as appropriate for StAH. It may also evaluate specific operations at the request of the Audit and Risk Committee or the Executive as appropriate. Based on its activity, Internal Audit is responsible for reporting significant risk exposures and control issues identified to the Audit and Risk Committee and to the Executive, including fraud risks, governance issues and other matters needed or requested by them.

Internal Audit will also assist the Board where required in evaluating the quality of performance of external auditors.

General Responsibilities – Internal Audit should examine the adequacy and effectiveness of internal control components and recommend improvements in such controls. Recommendations for improvement should be the result of informed judgements considering both the cost and the benefit of implementation and the impact on patients, carers and commissioners. Internal Audit should act as a communication catalyst throughout the Charity for the purpose of strengthening controls and improving quality, productivity and efficiency.

In order to accomplish the prescribed Internal Audit Mission, Internal Audit personnel should possess the necessary skills and be properly trained to carry out both general and specific responsibilities in a professional manner. Internal Audit may also engage (with the approval of the Audit and Risk Committee) outside third party auditors or consultants with specific skills if required. This may also require a process of internal approvals to be obtained from the Executive Management on the budgetary and financial feasibility front. Responsibilities to the Board and ARC:

- Focus on the Charity's system of internal controls to assure it is effective and functioning as intended
- Identification of risks within StAH and the identification of suitable mitigating controls
- Monitor adherence to the Charity's Code of Conduct, Ethics and Anti-Bribery Procedures to assure that matters of non-compliance are dealt with appropriately and that activities are being conducted with integrity
- Monitor adherence to key Charity policies (where applicable).

1.9 Counter Fraud

The Audit and Risk Committee recognises that StAH management is responsible for controls to reasonably prevent and detect fraud. Furthermore, the Committee recognises that IA is not responsible for identifying fraud; however Internal Audit will assess the risk of fraud and be aware of the risk of fraud when planning and undertaking any audit related work.

The Local Counter Fraud Specialist function (undertaken by the Senior Internal Auditor) will ensure the provision of counter fraud activities, advice and investigation support alongside Internal Audit.

1.10 Risk Management

The Audit and Risk Committee recognises that StAH management is responsible for the identification and implementation of an effective control environment.. Furthermore, the committee recognises that Internal Audit is not responsible for identifying all risks; however Internal Audit will assess the processes and controls in place to identify and mitigate risk. In addition, Internal Audit will consider and be aware of all relevant risks when planning and undertaking any Internal Audit work.

1.11 Reporting and monitoring

A written report will be prepared and issued by Internal Audit following the conclusion of each audit engagement and will be distributed as appropriate. Internal audit results will also be communicated to the Executives and the Audit and Risk Committee.

The audit report will include an associated Action Plan containing management's response and the agreed action taken or to be taken in regard to the specific findings and recommendations. Management's response, whether included within the original audit report or provided thereafter by management of the audited area, should include a timetable for anticipated completion of action to be taken and an explanation for any corrective action that will not be implemented.

Internal Audit will be responsible for appropriate follow-up on engagement findings and recommendations. All significant findings will remain in an open issues file until cleared.

Trends and statistics relating to Internal Audit activities will be maintained and reported to senior management on a periodic basis (as agreed). These will include the number of audits and consultancy activities (planned and completed); the ratings and gradings (where appropriate); number of action points raised and outstanding, as well as the number and status of any counter fraud or conduct activities undertaken.

1.12 Data Protection

Internal Audit files need to include sufficient, reliable, relevant and useful evidence in order to support Internal Audit's findings and conclusions. Personal data is not shared with unauthorised persons unless there is a valid and lawful requirement to do so. Personal data is not shared outside of StAH and Internal Audit adheres to the Charity's Data Protection Policy and linked procedures.

1.13 Benchmarking and sharing of leading Internal Audit practices.

The Head of Internal Audit and Risk Management is responsible for committing sufficient time and resources to participate in and communicate on benchmarking and leading Internal Audit practice activities. The Head of Internal Audit and Risk Management will identify and select relevant and meaningful benchmarks to gauge the performance of StAH Internal Audit, to include the following examples:

Internal - The Head of Internal Audit and Risk Management will maintain a schedule of regular meetings with Executive Directors and Directors/Heads of Departments from all functions and directorates to discuss key activities within Internal Audit and the respective function/directorate, share ideas, leading practices and methods. The Head of Internal Audit and Risk Management will also attend a selection of Charity committees and groups, such as the Quality Assurance & Safety Committee, People Committee, Operational Performance Committee, Integrated Quality Performance groups, Executive Committee and Information Governance Group.

Peer Groups - The Head of Internal Audit and Risk Management will periodically and informally meet with appropriate Internal Audit groups from public and non-public entities, as well as the External Auditors to discuss leading practices and benchmark department performance. Ensuring confidentiality (where required) is maintained at all times.

IIA and external bodies - The Head of Internal Audit and Risk Management will attend and participate in IIA seminars, meetings and events (and other suitable bodies) to facilitate the development of leading practices at StAH. In keeping with both the Internal Audit Standards and the relevant qualifications held by Internal Audit team members, the Head of Internal Audit and Risk Management will ensure all applicable Internal Audit team members maintain their knowledge, skills and other required competencies through Continuing Professional Development (CPD).

1.14 Quality assurance and improvement programme

The Head of Internal Audit and Risk Management will maintain a quality assurance and improvement programme that covers all aspects of the Internal Audit function. The programme will include an evaluation of Internal Audit's conformance with IIA Mandatory Guidance; the efficiency and effectiveness of Internal Audit and the identifying of opportunities for improvement; its consistency with the Internal Audit Charter and performance against its agreed strategic objectives and Internal Audit Plan.

The Head of Internal Audit and Risk Management will communicate to the Audit and Risk Committee on Internal Audit's quality assurance and improvement programme, including results of ongoing internal assessments and any external assessments that have been conducted.

Signed by:

Head of Internal Audit and Risk Management:

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Chair of the Audit and Risk Committee:

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Annex D

Local Counter Fraud Plan 2023-23

St Andrew's Healthcare

Counter Fraud Work Plan 2023/24

17 April 2023

1 - Developing the Counter Fraud Work Plan

This document sets out the approach taken to develop the St Andrew's Healthcare Counter Fraud Work Plan for 2023-24.

1.1 – Introduction

Under the NHS Standard Contract, all organisations providing NHS services must put in place and maintain appropriate counter fraud arrangements.

The NHS Counter Fraud Authority (NHSCFA) is charged with identifying, investigating and preventing fraud within the NHS and the wider health group.

From April 2021, the Government Functional Standard 013: Counter Fraud (Functional Standard) replaced the previous NHS specific Standards for Fraud, Bribery and Corruption (Standards). The Counter Fraud Work Plan has been developed in accordance with the Functional Standards, which consist of the following 12 components:

1. Accountable Individual	2. Counter fraud bribery and corruption strategy	3. Fraud, bribery and corruption risk assessment
4. Policy and response plan	5. Annual action plan	6. Outcome-based metrics
7. Reporting routes for staff, contractors and members of the public	8. Report identified loss	9. Access to trained investigators
10. Undertake detection activity	11. Access to and completion of training	12. Policies and registers for gifts and hospitality and Conflicts of Interest

1.2 – Work Plan

The Work Plan is indicative and will reflect the changes and trends (local or national) that may occur during the course of the year. Any proposed changes to the Work Plan will be discussed and agreed with the Head of Internal Audit and Risk Management and the Chief Finance Officer, and communicated to the Audit and Risk Committee.

The tasks to be delivered in the Work Plan include those priority areas for coverage based on the level of resources agreed with management and discussions with key personnel. Therefore not all of the tasks detailed in the standards will necessarily be covered in the Work Plan in any one year. Further detail of all of the activities planned can be found in **Appendix A**.

1.3 - Resources

For 2023/24, the total resource allocated to the Counter Fraud Work Plan remains at 36 days. If required, the Charity has the option to allocate additional days (derived from the Internal Audit resource or optional activities within this work plan) to ensure that any allegations of fraud are investigated fully.

Appendix A: Counter Fraud Work Plan 2023/24

Ref.	Task / Objective	Proposed Timing	Budget (Days)	Functional Standard components
Governance				
1	Preparation of reports for the Audit and Risk Committee, to report on progress against the tasks referred to within this Work Plan.	Every meeting	2	1.
2	Liaison with internal and external stakeholders, including Chief Finance Officer, HR, Procurement, Internal Audit and Risk Manager, TIAN Counter Fraud Managers Group and NHSCFA.	Throughout the year	8	1.
3	Continuously update the fraud risk assessment in line with GCFP fraud risk assessment methodology. Ensure that risks are recorded in line with the organisational risk management policy.	Throughout the year	1	3.
4	Completion of continuing professional development activities including training required by the NHSCFA.	Throughout the year	2	9. & 11.
5	Completion of submissions required by the NHSCFA; respond to any additional requests for assistance from LCFS's or external agencies; collation and submission of the 2023/24 Counter Fraud Functional Standard Return.	As required	3	8.
7	Production of the Annual Report 2023/24 and Counter Fraud Work Plan 2024/25.	Q4	1	5. & 6.
Fraud awareness				
1	Design, produce and distribute counter fraud newsletters.	Throughout the year	3	4. & 7.
2	Review and update fraud-related policies and procedures, intranet pages and e-learning material as appropriate.	As required	1	2., 4. & 12.
Proactive detection activity				
1	Completion of Local Proactive Exercise specifically focused on agreed areas of locally identified fraud risk.	Throughout the year	14	10.
Investigative activity				
1	Monitor the Datix incident reporting system to determine whether any potential frauds have been reported as incidents rather than through the proper fraud reporting channels.	Throughout the year	1	8.
2	Input information on the NHSCFA case management system.	As required	-	8.
3	Conduct investigations into all allegations of fraud, in line with national guidance and legislation.	As required	-	8.
4	Assist the NHSCFA with any regional or national investigations	As required	-	8.
5	Ongoing liaison and joint working with Human Resources throughout and upon conclusion of any investigation, with the commitment of pursuing all available sanctions and recovering monies where appropriate.	As required	-	8.

Annex E

Research Committee 2022-23 Publications List

Publications by month April 2022 to March 2023

#	Authors	Title	Publication	Month Published
5 (1)	Lewis, A, Conway, J, Middleton, J, Startup, C and **Wyatt, J**	Playing the harmonica with chronic obstructive pulmonary disease. A qualitative study	Chronic Respiratory Disease Vol 19: 1-9	April
6 (2)	Celentano, L, **Brenisin, K and Breen, K.C.**	A New Era in Psychiatry: The impacts of COVID-19 and the shift to telepsychiatry on clinical practice and clinician wellbeing	Journal of Enabling Technology	April
7 (3)	Crawford, M et al including **Anagnostakis, K and Millard, L**	The clinical effectiveness and cost effectiveness of clozapine for inpatients with borderline personality disorder (CALMED) study: a randomised placebo-controlled trial	Therapeutic Advances in Psychopharmacology	April
8 (4)	Trundle, G, Jones, K.A., Ropar, D. & Egan, V	Prevalence of Victimisation in Autistic Individuals: A Systematic Review and Meta-Analysis	Trauma, Violence & Abuse	May
9 (5)	Naughton-Doe, R., Moran, N., **Wakeman, E.,** Wilberforce, M., Bennett, L. and Webber, M	Interventions that support unpaid carers of adult mental health inpatients: a scoping review	Journal of Mental Health	May
10 (6)	Hartescu, I, Gardiner, P.M., **Girardi, A, Breen, K, Roychowdhury, A, Wallang, P** and Morgan, K	Sleep Quality and adverse incidents in secure mental health settings	The Journal of Forensic Psychiatry and Psychology	May
11 (7)	**Brenisin, K., Trumm, A., Akinwande, E and Breen K**	The experience of inequality and its impact on mental illness- thematic analysis of patients' lived experiences admitted to secure mental health hospital	The Journal of Forensic Practice	May
12 (8)	**Newman, C**	Tackling occupational deprivation during a pandemic	OT News	May
13 (1)	**Morris, D.J., Webb, E.L., Fox, E**. and Steen, S.	Extending the trauma lens in Forensic Mental Health Services	Symposia International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
14 (2)	**Morris, D.J., Webb, E.L., Umpunjun, P., Fox, E. and Beber, E.**	Addressing the trauma in the room: The differential trauma needs of women	Oral Paper	June

		with co morbid EUPD and Complex PTSD in secure services.	International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	
15 (3)	**Morris, D,J. and Webb, E.L.**	Reconsidering frameworks for trauma in healthcare professionals: The impact of exposure to violence and restrictive practices: theoretical and support implications.	Oral Paper International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
16 (4)	**Webb, E.L. and Morris, D.J.**	Re-traumatisation: The impacts of placement breakdowns in care for adolescents with developmental disorders	Oral Paper International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
17 (5)	**Steen, S., Morris, D.J., Hamilton, A**. and Law, G	The Prevalence and Clinical Impact of Moral Injury in UK Secure Care Settings	Oral Paper International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
18 (1)	**Umpunjun, P, Webb, E.L., Morris, D**	Exposure to Trauma in Childhood amongst Male Forensic Populations: A systematic review and Meta-Analysis	Poster International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
19 (2)	**Umpunjun, P, Webb, E.L., Morris, D**	Prevalence of Exposure to Trauma in male prisoners. A Systematic review and Meta-Analysis	Poster International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
20 (3)	**Webb, E.L., Morris, D.J.**	What are we really measuring with the HoNOS in forensic settings? Exploring its structure through confirmatory and exploratory factor analysis	Poster International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
21 (4)	**Webb, E.L., Ireland, J.L., Lewis, M. and Morris D.J.**	When you can't let your conscience be your guide: A Delphi study of morally injurious experiences in forensic mental healthcare	Poster International Annual Meeting & Conference, International Association of Forensic	June

			Mental Health Services (IAFMHS), Berlin, Germany	
22 (5)	**Webb, E.L., Ireland, J.L., Lewis, M. and Morris D.J.**	Potential sources of moral injury for healthcare staff in forensic and psychiatric settings: A systematic literature review and meta-ethnography	Poster International Annual Meeting & Conference, International Association of Forensic Mental Health Services (IAFMHS), Berlin, Germany	June
23 (6)	**Coxell, A and McAtamney, K**	An analysis of incidents involving both 'Leave not as planned' and non-suicidal self-injury and suicide	Poster Patient Safety Network Meeting of the East Midlands Health Sciences Network	June
24 (7)	**Coxell, A and McAtamney, K**	Review of Research on 'Leave Not as Planned' (Late-return, Abscond, Escape)	Poster Patient Safety Network Meeting of the East Midlands Health Sciences Network	June
25 (8)	**Coxell, A and McAtamney, K**	Expert by experience evaluation of proposed procedures for reduction of risk to self when on unplanned leave	Poster Patient Safety Network Meeting of the East Midlands Health Sciences Network	June
26 (9)	**Shaddel, F**	Beyond “Evidence-Based Medicine” in “Detained Patients”	BJPsych Open	June
27 (10)	Pakravan, A, Ghazirad, M and **Shaddel, F**	Development of the learning disability physical activity questionnaire (LDPAQ)	Tizard Learning Disability Review	June
28 (11)	**Anthony, J**, Johnson, W, Papathomas, A, **Breen, K** and Kinnafick, F-E	Differences in body mass index trajectories of adolescent psychiatric inpatients by sex, age, diagnosis and medication: an exploratory longitudinal, mixed effects analysis.	Child and Adolescent Mental Health	July
29 (12)	Karatzias, et al (including **Morris, D.L**,)	Borderline Personality Disorder (BPD) and Complex Post Traumatic Disorder (CPTSD): A network analysis in a highly traumatised clinical sample	Journal of Personality Disorders	FEB 2023
30 (13)	Morris, D.J., Webb, E.L., Trundle, G. and Caetano, G.	Moral injury in secure mental healthcare: part I: exploratory and confirmatory factor analysis of the Moral Injury Events Scale	Journal of Forensic Psychiatry and Psychology	August

31 (14)	Morris, D.J., Webb, E.L. and Devlin, P	Moral injury in secure mental healthcare: part II: experiences of potentially morally injurious events and their relationship to wellbeing in health professionals in secure services	Journal of Forensic Psychiatry and Psychology	August
32 (15)	Trundle, G, Jones, K.A., Ropar, D. & Egan, V	The forensic implications of camouflaging: a study into victimisation and offending associated with autism and pathological demand avoidance	Advances in Autism	August
33 (16)	Gardiner, P, Kinnafick, F-E, **Breen, K,** Girardi, A & Hartescu, I	Behavioural, medical & environmental interventions to improve sleep quality for mental health inpatients in secure settings: a systematic review & meta-analysis	Journal of Forensic Psychiatry & Psychology	August
34 (6)	**Morris, D.J. and Webb, E.L.**	Trauma and wellbeing profiles of healthcare professionals in psychiatric services in the UK: Implications and recommendations	Oral Paper 2nd International Trauma and Mental Health Conference Jerusalem, Israel	September
35 (9)	**Webb, E.L., Morris, D.J. and Fox, E.**	Elevated distress and risk, and reduced quality of life in women with comorbid Complex PTSD and Emotionally Unstable Personality Disorder	Poster 2nd International Trauma and Mental Health Conference Jerusalem, Israel	September
36 (7)	**Morris, D.J., Webb, E.L.**	Exploring inpatient admissions and clinical needs through an intersectional lens: The differential experiences of gendered ethnic groups	Oral Paper Division of Clinical Psychology (DCP) British Psychological Society (BPS) Annual Conference	October
37 (8)	**Morris, D.J.**	Moral injury in Healthcare: A focus on mental health services	Oral Presentation Austin Riggs & Erik Erikson Annual Fall Conference, Massachusetts' USA	October
38 (17)	**Campbell, L**	Journey to the Forensic Clinical Psychology Doctorate	BPS Forensic Update, No 142	October
39 (18)	**Webb, E.L., Girardi, A., Fox, E. and Wallang, P.**	An evaluation of value-based outcomes for women	Behavioural and Cognitive Psychotherapy	October

		admitted to a Dialectical Behaviour Therapy Integrated Practice Unit: A follow-up study	28 October, pp.1-6	
40 (10)	**Dagley, G., Roberts, B., Strazds, P.**	Improving the management of multiple outbreaks of Covid-19 within a mental health hospital using a multidisciplinary approach	Poster Infection Prevention Society 14th Annual Conference, 17-19 October 2022 Bournemouth	October
41 (19)	**Webb, E.L., Morris, D.J., Watson, E., Fox, E., Sibley, V. and Taylor, V**	Which complex PTSD symptoms predict functional impairment in females with comorbid personality disorder needs? Research and treatment implications.	European Journal of Trauma and Dissociation Vol 6, Issue 4, November 2022	November
42 (20)	Rato, M., **Kirkland, J.** and Kingston, A	Palliative care in non-malignant disease	Medicine	November
43 (11)	Loxley, G., Harding, V., Stewart, I., Beckles, K., Harris, G-M., Tinkler, C., & Mehta, S	The use of Person-centred Reminiscence Orientation and Sensory Experience (PROSE) as a therapeutic intervention for older adults living in an inpatient neuropsychiatric setting.	Poster The 16th UK Dementia Congress, Birmingham, 8-9 November 2022 AND St Andrew's Psychology Conference: Innovations in Patient Care and Service Delivery, Northampton, 11 November 2022	November
44 (12)	Loxley, G., Stewart., I., Harding, V., Beckles, K., Harris, G-M., Mehta, S., Tinkler, C., & Groucott, L.	Group reading sessions as a therapeutic intervention for inpatients living with dementia	Poster The 16th UK Dementia Congress, Birmingham, 8-9 November 2022 AND St Andrew's Psychology Conference: Innovations in Patient Care and Service Delivery, Northampton, 11 November 2022	November
45 (13)	Loxley, G., Stewart, I., Harding, V., Beckles, K., & Keavney, G	The use of Life Story Books as a narrative intervention for patients living with dementia and Huntington's	Poster	November

		disease in an inpatient neuropsychiatric setting.	The 16th UK Dementia Congress, Birmingham, 8-9 November 2022 AND St Andrew's Psychology Conference: Innovations in Patient Care and Service Delivery, Northampton, 11 November 2022	
46 (14)	Mehta, S., Tinkler, C., Beckles, K., Loxley, G., Stewart, I., & Harding, V.	Cognitive Stimulation Therapy in a locked inpatient setting for individuals with progressive neurological conditions	Poster The 16th UK Dementia Congress, Birmingham, 8-9 November 2022 AND St Andrew's Psychology Conference: Innovations in Patient Care and Service Delivery, Northampton, 11 November 2022	November
47 (15)	Webb, E.L., Worsfold, J., Morris, D.L. and Greenwood, A	The psychological impact of traumatic incidents in mental health workers: Levels of shame and guilt in referrals to a staff trauma support service	Poster 3rd International Trauma Informed Care in Practice – Trauma Frameworks: Evidence base and treatments. Disaster & Trauma Section of the British Psychological Society	November
48 (16)	Taylor, V., Campbell, L., Webb, E.L., Morris, D.J., Loxley, G., Mitchell, T., Reynolds, K., Holmes, J. & Lupattelli Gencarelli, B.	International trauma questionnaire (ITQ) and impact on service delivery: the first 18 months	Poster 3rd International Trauma Informed Care in Practice – Trauma Frameworks: Evidence base and treatments. Disaster & Trauma Section of the British Psychological Society	
49 (9)	Morris, D.J. and Trundle, G.	Trauma exposure: Frameworks, limitations and expansion	Oral Paper Trauma and Neurodiverse Populations: Evidence and Innovations, RADiANT network and CDCT Conference, December 2022	December

50 (1)	Deborah Morris and Elanor Webb	Social Identity Theories	Book Chapter Social Psychology in Forensic Practice. Eds: J Harvey & D Ambrose	December
1 (21)	E Webb, D Morris, E Sadler, S Macmillan, S Trowell, A Legister	Predictors of moral injury in secure mental healthcare workers: Examining a role for violence and restrictive practices through an intersectional lens.	Journal of Forensic Psychology Research and Practice	January
2 (22)	J Anthony, A Papathomas, A Annandale, K Breen & F-E Kinnafick	Experiences of physical activity for adolescents in secure psychiatric care: Staff and patient perspective	Mental Health and Physical Activity	February
3 (23)	F Shaddel & D Mayes	Considering capacity to use sex toys in secure care: two case reports	Progress in Neurology and Psychiatry. 2023 Jan;27(1):37-41	February
4 (24)	P Chadwick, P Strazds et al	Guidelines for the management of norovirus outbreaks in acute and community health and social care settings	The Journal of Hospital Infection	February
5 (25)	K Brenisin, M Padilla & K Breen	'"It's the discharge and what comes after that" - a phenomenological analysis of peer support workers' lived experiences of transitioning from psychiatric care	Journal of Forensic Practice 25(2), 139-151. https://doi.org/10.1108/JFP-10-2022-0055	March

Notes:

Journal Articles

Oral Presentations Book Chapters Posters

Orange for months to April (for reporting purposes)

Numbers on side to distinguish between articles, book chapters and symposiums/conferences and posters