CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Tuesday 22nd November 2022 at 9.30 am

Microsoft Teams and Conference Room, Main Building, Northampton, NN1 5DG

		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 29 September 2022	Decision	Paul Burstow	✓ *5-13*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓ *14-17*	*09.35*
Chair's Update					
5.	Chair Update	Information	Paul Burstow	*18*	*09.40*
Executive Update					
6.	CEO Report	Information	Dr Vivienne McVey	✓ *19-23*	*09.45*
Committee Assurance Reports					
7.	**Committee Updates**			*24-63*	*10.05*
	• Research Committee (14/11)	Assurance	Professor Stanton Newman	Verbal	
	• People Committee (10/11)	Assurance	Dawn Brodrick	✓	
	• Quality & Safety Committee (11/10)	Assurance	Steve Shrubb	✓	
	• Audit & Risk Committee (17/10), incorporating	Assurance	Elena Lokteva	✓	
	• Nomination & Remuneration Committee (07/11), incorporating: ○ Gender and Ethnicity Pay Reports	Assurance & Decision	Stuart Richmond-Watson	✓	
Quality					
8.	CQC Inspection, Report and Actions Update	Assurance	Andy Brogan	✓ *64-70*	*10.25*
9.	Safer Staffing Report	Assurance	Andy Brogan	✓ *71-75*	*10.35*

Matters Arising						
10.	National response to Panorama and mental health in patient services	Information	Dr Vivienne McVey	✓	*76-87*	*10.45*
Break 10.50 am to 11.00 am						
Operations						
11.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview • IT Security Overview	Assurance	Anna Williams, Kevin Mulhearn & John Clarke	✓	*88-96*	*11.00*
12.	Court, Board of Directors and Committee Calendar 2023-2024	Decision	Duncan Long	✓	*97-100*	*11.25*
Service and Patient Story						
13.	Divisional Presentation (including patient voice): Essex – co-production with Patients and Carers	Information	Dawn Chamberlain & Antony Miller (and patient)	✓	*101-118*	*11.30*
Any Other Business						
14.	Questions from the Public	Information	Paul Burstow		*119*	*11.55*
15.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*120*	
16.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*121*	
17.	Date of Next Meeting – Tuesday 24th January 2023	Information	Paul Burstow		*122*	
Meeting Closes at 12.00 pm						

Annexes - Items for information only	**Lead**		
Annex A – Governance Oversight Group update	Dr Vivienne McVey	✓	*123-124*

Welcome & Apologies

(Paul Burstow– Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 29 September 2022

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Meeting Room 17, The Braye Centre,
St Andrew's Healthcare, Northampton

Thursday 29 September 2022 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Dawn Brodrick (DB)	Non-Executive Director
Karen Turner (KT)	Non-Executive Director
Vivienne McVey (VMc)	Chief Executive Officer
Kevin Mulhearn (KM)	Chief Finance Officer
Sanjith Kamath (SK)	Executive Medical Director
Andy Brogan (AB)	Chief Nurse
Dawn Chamberlain (DC)	Chief Operating Officer
In Attendance:	
John Clarke (JC)	Chief Information Officer
Lindsey Holman (LH)	Executive – Organisational Development
Duncan Long (DL)	Company Secretary
Anna Williams (AW)	Director of Performance
Eddie Short (ES)	Director of Strategy & Business Development
Rupert Perry (RP)	Lead Governor
Holly Taylor (HT) Item 12	Director of Learning & Development
Ria Stanyer (observing)	Staff Governor
Melanie Duncan (observing)	Governance Review Project Manager
Kelly Sheridan (minutes)	Committee Secretary
Apologies Received:	
Martin Kersey (MK)	Executive HR Director
Elena Lokteva (EL)	Non-Executive Director
Oliver Shanley (OS)	Special Advisor to the Board
Alex Trigg (AT)	Director of Estates & Facilities
Julie Shepherd (JS)	Improvement 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 Elena Lokteva, Martin Kersey, Alex Trigg, Oliver Shanley and Julie Shepherd were noted. Vivienne McVey, Dawn Chamberlain, Karen Turner, Dawn Brodrick and Lindsey Holman were all welcomed to the Board for the first time.		
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 26 July 2022** The minutes of the meeting held on the 26 July 2022 were **AGREED** as an accurate reflection of the discussion. It was agreed to review the format of Board minutes and to bring a summarised version of the September Board minutes to the next meeting for review versus the existing format.	**DECISION** **DL & MD**	 **22.11.22**
4.	**Action Log & Matters Arising** It was agreed to **CLOSE** the following actions: • 24.03.22 **02** Governance update – Authority Matrix • 26.05.22 **02** Quality Improvement – QSC Assurance • 26.05.22 **03** Quality Improvement – People Committee Assurance • 26.05.22 **05** Safer staffing – QSC Assurance • 26.05.22 **06** Safer staffing – People Committee Assurance • 26.07.22 **05** Safer Staffing Report – Servery staff • 26.07.22 **07** Divisional Presentations – Looking ahead All other actions on the log remained open, either in line with the agreed target dates or to return at the November Board. Following discussions on a number of actions, PB requested that Board actions and actions from Board committees be brought together (using a Gantt chart) so that the timeline of all actions and how they align could be viewed.	**DECISION** **DL**	 **22.11.22**
CHAIR'S UPDATE			
5.	**Chair Update** PB gave a verbal update and extended thanks to Oliver Shanley for his time as Interim CEO and who facilitated a smooth hand over to VMc. PB then noted a number of visits he had made to various wards over the summer period, highlighting the work of staff, some of whom were operating within challenging circumstances. Three ward visits at William Wake House highlighted differing examples of these challenges, each of which would be subject to presentations in the future. Recruitment challenges within the Deaf Service that had been noted during ward visits would be discussed further at the People Committee. PB wished to particularly note the Nurse Manager on Mackaness Ward, who demonstrated a level of understanding of both the patient and the acuity of the patient during a difficult situation and had been seconded to work on nurse talent management. PB also outlined the recent meeting with the Charities Commission which was in response to the routine reporting of Commission related Reportable Serious Incidents. PB was joined by a number of trustees and JS, in her role as Quality Improvement Director. The meeting covered three areas; CAMHS, Men's and Women's Services, and how the Charity was progressing with the governance review. During the meeting we demonstrated how quality improvement was being embedded and were able to provide the assurance that this would be sustained. The Charity was making good progress in improving the services and was being transparent and fostering an open culture, including the holding of Boards in public. The Board **NOTED** the update.		

EXECUTIVE UPDATE			
6.	**CEO's Report** VMc presented the paper which was taken as read and reiterated the warm welcome she had received from both patients, staff, and Board colleagues alike. VMc also thanked OS for his assistance with the transition into the role. VMc outlined that this was a very interesting time to be joining the Charity, especially taking into consideration the developments around national policy on mental health, and the challenges currently being observed as a result of staffing, and cost of living. In addition to her report VMc wished to highlight the current focus on workforce challenges by the Executive Team. The challenges for the coming three months were outlined, especially regarding attraction and retention of staff. VMc announced that a leaflet was to be circulated to all staff in order to highlight everything that was being done in response to the cost of living crisis. Despite the financial impact of the above, the Charity remained operating to budget, with VMc extending thanks to KM and his team for their negotiations with the banks recently. VMc further outlined the meetings that had been held since taking up her position which included the East Midlands Alliance, the CQC and the Alliance partners. Of note was a recent meeting of all the anchor organisations of Northampton which had been organised by University of Northampton and included the local Police along with many of the large local employers. It was hoped that this would result in more collaboration with regard to jobs and support for young people within Northampton. St Andrew's had been reflected positively in the media as a result of the party held by Lowther Ward which had featured on BBC Look East News. Comments had been received regarding inviting the media to attend any future events held. SN asked if the proportion of patients within St Andrew's who had Learning Disabilities or Autism was known, and of them, how many were forensic patients, as he felt that the number of patients within this group would probably reduce over the coming years. SK replied that of 600, there were 110, and that 60 – 65% of these were within those criteria. SN asked how the remaining 30% would be supported. SK replied that it was exciting to be able to support these patients within a different environment, one which challenged us to be creative to meet their needs. RB asked how investigations into SIs would be handled in the future. AB replied that the aim was to have in-depth investigations and wider opportunities for learning across the system. AL asked about voluntary staff turnover, noting that 1.4% seemed low, and what the expectation should be. VMc replied that 1.4% was a monthly figure and that the annualised figure was 16%. This was at that level due to high turnover in specialities. There would be a focus on reversing this along with looking at nursing. LH added that a deep dive was conducted in August which indicated a level of 19% for the previous year. PB wanted to make sure that the Board was assured on this, and requested a report from the People Committee at the next meeting, adding that it was a central focus for the organisation. There were challenges and a lot of work had been done to clarify the variability among specialisms. PB asked that the Board consider this at the next meeting. SN asked if there was data from exit interviews. LH replied that the top reasons were better package at 20%, 17% for promotion, with health and training following closely. It was agreed that this would be covered within the deep dive and that the People Committee would scrutinise further. The Board **NOTED** the update.	**LH**	**22.11.22**

COMMITTEE ASSURANCE REPORTS			
7.	**People Committee, Incorporating: Diversity & Inclusion Annual Report** PB presented the report which was taken as read and noted the Diversity and Inclusion Annual Report which had been presented for approval. SN asked about the Change Leaders and how the culture change initiative was progressing. LH replied that the discovery phase was now finished, and that there were currently 95-100 Change Leaders across the Charity. The next stage was to develop an action plan for priorities which would link with the work being done by the Executive Team. More work was also being done to address retention within the Charity. The Charity-wide culture survey was also being progressed and was due to close shortly. This work would eventually, align with the priorities mentioned by VMc in her CEO report. There was a further discussion regarding the demographics of patients compared to the demographics of staff, with it be being confirmed that there was a section within the D&I Annual Report which indicated this and also showed comparisons to other organisations. VMc added that DC would be setting up a staffing programme meeting in order to address some of the challenges currently being experienced. The Board **APPROVED** the Diversity & Inclusion Annual Report **Quality and Safety Committee (16/08), Incorporating: Health & Safety Annual Report.** RB presented the report which was taken as read, noting that the issues regarding recruitment in CAMHS had been discussed, as well as the adoption and training in MHOST. PB wished to check with KM that the expenditure required for fire compliance was included in the budget. KM confirmed that it was. There were no further questions regarding the Health & Safety Annual Report. The Board **APPROVED** the Health & Safety Annual Report **Pension Trustees** RP gave a verbal update and noted that the three year valuation by PwC was currently being considered, along with discussions regarding discretionary awards for pensioners. AL asked RP what the impact of this would be. RP explained that there were two differing schemes in operation at the Charity and outlined that it was the one that had been closed to new employees since 2012. AL asked further what the impact would be, following the volatility of the markets in the previous days. RP replied that it was too early in the process to be able to evaluate at that stage. The Board briefly discussed the differences with the NHS pension offering. The Board **NOTED** the report	**DECISION** **DECISION**	
QUALITY2			
8.	**CQC Inspection, Report and Actions Update** AB presented the report which was taken as read and noted that good progress continued, and that assurance on this would be provided when the final reports were received. AB noted that a number of actions remained open, with work in progress. The buddy relationship was progressing well, with focus on lead the change and culture currently being undertaken. PB noted that the publication of the report on Women's Services was anticipated for the following week. Following a question from SN regarding what factors affected the closing of actions, there was a discussion regarding the timeline for the work being undertaken, particularly regarding data and electronic observations, with JC		

	noting that despite there being a wide range of variants, the priority parts would be undertaken first. The Board **NOTED** the report		
9.	**Safer Staffing Report** AB presented the report which was taken as read and noted the narrative and root causes which now accompanied the data within the report. He added that the full review of MHOST scheduled for December and January had been brought forward, along with a series of training events for staff. An update on the progress would be given at the next Board meeting. PB noted items within the report relating to Essex, CAMHS and Medium Secure, where the data indicated staffing concerns. Mitigating actions for the challenges were discussed, along with the contributory factors, especially over the Summer period. DC updated on the establishment reviews being undertaken, and the staffing programme team which was being developed which would give an oversight on quality and performance and support the Divisions to address the challenges around mandatory training, patient facing time and absence management. Senior Nursing support would also be included in this work. SN noted the requirement to increase occupancy and how this related to staffing challenges, with PB citing the inevitable risks involved in this. Transacting the admissions safely would be the challenge. SK and his colleagues were working closely on this. SN further enquired regarding when the information regarding the deliverables anticipated by the implementation of both MHOST and Allocate would be available for discussion at Board. DC replied that AB led MHOST whilst she would be leading on Allocate. She added that a review of the information entered into the system would indicate if it was being used to its full capability. Further scrutiny would see improvements. VMc noted that detailed discussions on this subject were ongoing as its success was critical for the organisation. A 3 month stabilisation programme would be required. Change was occurring on a daily basis with regard to occupancy and planning, with work being undertaken to ensure that the more accurate forecasting would be in place. VMc added that the second phase would not be in place until these initial stages had been completed, which she anticipated would take 3 months. PB replied that the Board would require clear visibility on the work in order to gain assurance regarding safer staffing. Trustees engaged in a wider discussion regarding the factors involved in staffing both locally and nationally, both on a recruitment and retention basis. PB noted that there were was a wide range of priorities which needed to be addressed, but that workforce was a key priority. RB asked if the challenges within CAMHS could have been predicted via the data provided, noting the risks of closing one ward in order to focus on the others. VMc replied that performance was being discussed at the Executive meetings, and that this key operational gap had been identified as was being managed by DC and her team. In order to identify challenges in advance, a new performance report was being developed by AW, which would focus on looking ahead as well as the current situation. This was clearly identified by the data from ASD/LD and Medium Secure. Softer forms of intelligence which were a critical source of information would also form a wider perspective. Risk Management was also being addressed, with more onus on being proactive rather than reactive. DC outlined the process that she wanted to introduce for the management of risks from Ward to Division to Operational meeting and then Executive and Board. SK added the pausing admissions to wards were only initiated in order to address the challenges presented at that time.		

	RB asked if the programme management for Allocate and MHOST were being reviewed in order to make sure that resources were being used correctly. JC confirmed that a review was being undertaken regarding the programme management of all of the linked projects. DC reflected that whilst the recruitment pipeline was good, there were skills issues present with there being 40% less experience being observed in ward teams as a result. Resourcing and skills mix issues often caused stress on the wards and had a direct impact on employee engagement which could then affect patient care. The two were intrinsically linked. PB concluded that further assurance on this subject would be required by the Board in the coming months. The Board **NOTED** the report		
REGULATORY			
10.	**Responsible Officer Regulations (Appraisal and Revalidation)** SK presented the report which was taken as read and noted that despite the restrictions over the last 12 months, appraisal and revalidation continued with no issues. Sufficient clinical resource continued to be a challenge however. The Annual report was **APPROVED** by the Board.	**DECISION**	
OPERATIONS			
11.	**Integrated Quality & Performance Report.** AW presented the report which was taken as read, noting that it reported on July data which indicated that 22 of the quality metrics showed sustained improvement at Divisional level. AW outlined the summary, highlighting those aspects which indicated Divisions with current challenges. The triangulation of information was noted as being a key aspect in the coming months in order to give a more holistic view. The data on agency staffing was noted by DB with AW responding that whilst the financial aspects were green against the KPIs, the staffing aspects were red. AW suggested that segmentation of the report and circulation to the relevant committees may be helpful in the future. PB reflected that the integrated view would be beneficial and that invitations could be extended to other Board members to dedicated People Committee meetings in order to have specific discussions on the issues highlighted in the report. KM presented the Finance Overview noting that August had continued the trend from the previous month, indicating lower income which was in turn offset by lower costs. As a result of this along with other contributory factors, July and August achieved an operating surplus, which indicated a significant milestone. A July high level forecast indicated that the figures were ahead by circa £0.3m. AL noted that there were concerns that the following 6 months would bring, with extra costs anticipated. KM replied that the assumptions had already been built into the trend. JC presented the IT Security Overview, with no further questions. The Board **NOTED** the report		
TOPICS FOR DISCUSSION			
12.	**Divisional Presentation (Including Patient Voice):** **REDS Academy and Peer Support Workers.** HT joined the meeting and introduced Cassandra Pollock and Roxy Rudkin from Peer Support, Steve Parker from the REDs Academy, and James, one of the learners who was working towards becoming a REDS trainer.		

	Cassandra and Roxy then outlined the work being done by Peer Support Workers, particularly noting the benefit that lived experience gave. In 2019 there were 5 Peer Support Workers, in 2022 there are 14 covering 11 wards in total. Steve gave a presentation on the REDs Academy, outlining the co-produced way they worked with all courses being attended by both staff and service users alike. Steve outlined the impact on culture that attending the courses can have. Some courses in particular were requested to be run directly on wards, whilst others were requested for medical students in Cambridge and Derbyshire. Steve highlighted that the focus was on what was strong, not wrong, with all courses being based on hope and opportunity, with learning from each other being paramount. James then outlined his journey from April 2021, and noted the compassionate staff and positive experience. James told the Board about his ambitions to be a trainer, and that REDs was the best thing that had happened. He added that co-delivering courses was inspirational. The Board thanked everyone for the extremely uplifting presentation given, and asked a wide range of questions regarding how Peer Support Work was seen as part of the wider team on wards, and how it was generally understood to be beneficial and empathetic. Ongoing training was also discussed with Roxy, outlining the training currently on offer both in the classroom and online. DC particularly wished to explore the co-production aspects of working with the team in the future. SK added that this offered the opportunity to involve more clinicians in this work in order to improve patient experience. LH asked how the network could be further supported by the Charity. Roxy replied that being able to attend training and to help the wider Charity understand who they were and what they did would be highly beneficial. HT added that there was a SAP awareness course for staff currently in development, as well as CPD training being considered.		
ANY OTHER BUSINESS			
13.	**Questions from the Public for the Board** No questions were received for the Board.		
14.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
15.	**What would our Patients and Staff think about Our Discussions Today?** PB began the discussion by noting that the centre of everything done by the Charity were the patients and how they felt. He highlighted the two common threads in the Boards discussions, with firstly workforce being the dominant part, stressing that not having right staff/skill mix, and the challenges this presented. Institutional solutions were not the future, and staff and patients wanted to know this. With regard to the second thread, quality, green shoots were being observed, but the intensity of external scrutiny risked having unintended consequence of taking Executive time away from the task of embedding quality improvement. The Peer Support discussion gave hope, with further thought required as to the optimum level for peer support in the organisation. As well as reflecting on the right mix of peer support which would materially affect the quality of patient experience. PB then added that culture, and what is meant by culture, was important as it was not just about the financial bottom line. AB felt that from a patient perspective, that a focus on what was being done to address challenges would be important to see. DB noted that leaders drove culture by being the change they wanted to see and not being defensive when talking about challenges faced.		

	VMc agreed with DB, noting that working as an Executive team could be challenging as it impacted both the current and the future and vision; that a balance between facing problems and keeping an eye on the future was required. SK commented that he wanted to make a positive difference to people's lives, and that the people the Charity looked after were all individuals. Despite being caught up in the problems it was great to know that we do make a difference to their lives.		
16.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Thursday 22nd November 2022		

Approved – 22nd November 2022

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
26.05.22 **01**	**Risk Appetite – Board Awareness** Following the approval of the Charity Risk Appetite, Board awareness sessions are to be scheduled on Therapeutic risk and compliance.	DL	04.11.22	Open	**22.11.22 –** Remains open and actual dates for sessions to be agreed with Chair in line with 2023/24 Board calendar and Board Development schedule
26.05.22 **04**	**Safer staffing – refusals data** AB to include data on refusals to deploy in future safer staffing reports.	AB	~~29.09.22~~ 22.11.22	Open	**22.11.22 -** This information not readily available and would require a significant manual process to identify and report. Proposed to deal with this at local level
26.05.22 **06**	**Safer staffing – People Committee Assurance** The People Committee are requested to review and provide assurance to the Board on actions being taken to address refusals to re-deploy, specifically in relation to the work being done on the Charity's culture.	PB & MK	~~29.09.22~~ 22.11.22	Open	**22.11.22 -**
26.05.22 **08**	**Integrated Performance Report – Registered Nurse levels** AW to look at how registered nurse levels could be overlaid on the bed occupancy graph within the IQPR in order to view potential correlations.	KM & AW	~~26.07.22~~ 22.11.22	Open	**22.11.22 –** Overlays have been completed and consideration to be given to the appropriate approach to reporting.
26.07.22 **01**	**QSC – Smoking cessation** Further discussions at QSC regarding smoking cessation to be scheduled, looking at how physical healthcare programmes could be used to assist with further reductions in patients smoking.	AB	13.12.22	Open	**22.11.22** – Executive Medical Director and Chief Nurse exploring the establishment of a group to proactively manage and support smoking cessation.

26.07.22 **02**	**QSC – Mental Health Bill** A Board session on the Mental Health Bill is to be scheduled once it has commenced its parliamentary passage.	DL	22.11.22	Open	**22.11.22 –** Remains open and actual dates for sessions to be agreed with Chair in line with 2023/24 Board calendar and Board Development schedule. Provisionally set for January 2023 Board.
26.07.22 **03**	**ARC – Committee Risk Oversight** To assist in the effective implementing and embedding of the BAF, Committees are to consider during the next round of committee effectiveness reviews how the review and oversight of the strategic risks allocated to them can be best accommodated in meeting agendas and annual work plans.	DL&MD	22.11.22	Open	**22.11.22** – Initial sessions held with committees to discuss inclusion of Strategic risks, further work to be completed during January BAF review at both Board and ARC, as well as finalising of revised ToRs for each committee. Remains open.
26.07.22 **04**	**Governance Oversight Group - ARC visibility over project risks** MD and JC to liaise with Sajid Ali to complete a review of the project risks and escalate any major concerns as required to the ARC, to enable a level of assurance to be developed with regard to progress against project objectives. It was agreed that ARC would review the project risks and that a full assurance report with revised timeline would be brought back to Board.	DL&MD	22.11.22	Open	**22.11.22** – MD has worked with MSA to formulate the project risk register, no risks are currently recorded as high, with risks either rated as low or medium and all are currently stable or decreasing. The full register and mitigations are proposed to be presented to ARC in January, with assurance provided thereafter at Board.
26.07.22 **06**	**BAF – Finance Risk** Following the approval of the initial proposed BAF Assurance Ratings, it was agreed that the Finance Committee would complete further reviews on the financial strategic risk.	KM & AL	22.11.22	Open	**22.11.22 -**
29.09.22 **01**	**Board Minutes** DL and MD to review the format of Board minutes and to bring a summarised version of the September Board minutes to the next meeting for review versus the existing format.	DL&MD	22.11.22	Open	**22.11.22 –** Action remains open and propose defer to January meeting.

29.09.22 **02**	**Board Action Log** Following discussions on a number of actions, PB requested that Board actions and actions from Board committees be brought together (using a Gantt chart) so that the timeline of all actions and how they align could be viewed.	DL&MD	22.11.22	Open	**22.11.22 –** Initial draft collated "Gantt" format of action log created and shared with Chair for feedback, ahead of further development and inclusion of actions from all committees.
29.09.22 **03**	**CEO's Report – staff turnover** In order to ensure the Board were assured on actions being taken to address staff turnover, as well as the challenges and variability among specialisms PB requested a report from the People Committee and for it to be considered at the next meeting.	LH	22.11.22	Open	**22.11.22 –** The Charity Retention Framework was reviewed and endorsed by the People Committee in November. This paper explored charity level turnover rates including tenure breakdowns and reasons for leaving with an action plan provided to support overall retention. The Our St Andrew's People Plan notes turnover as a key overall HR metric to measure progress. The People Committee will continue to review turnover including variability among specialisms.

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of Meeting	Tuesday, 22 November 2022
Agenda Item	**6**
Author	Vivienne McVey, CEO
Responsible Executive	Vivienne McVey, CEO
Discussed at Previous Board Meeting	Updates have been discussed at the Executive meetings.
Patient and Carer Involvement	A number of these items would have been discussed with patients and carers
Staff Involvement	A number of these items would have been discussed with staff
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☒ Finance & Sustainability ☒ Service Innovation ☒ Quality ☒ Research & Innovation ☒ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☒
Committee meetings where this item has been considered	Executive Meetings

Report Summary and Key Points to Note

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

Appendices – N/A

CEO Report

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

The key focus during the period since the last Board meeting has been all aspects of staffing, including remuneration, rostering, recruitment, retention, training and strengthening the operations of the Charity. Given the impact that staffing levels have on the quality of services, our CQC results have been a remarkable achievement. Continuing to improve in these two areas remain two of our top priorities.

1. **National update – Panorama**

   A recent BBC Panorama programme highlighted evidence of verbal and physical abuse towards patients at the Edenfield Centre run by Greater Manchester Mental Health NHS Foundation Trust. As a result of these serious concerns NHS England wrote to all providers asking for assurance regarding what steps services are taking to ensure similar abuse is not happening. They asked provider Boards to ensure that they have sufficient safeguarding processes in place. These processes include, but are not limited to, freedom to speak up arrangements, advocacy, complaints and monitoring of the use of restrictive practice. In response to the programme a number of actions have been taken and these are presented more fully later in the Board agenda. The Panorama programme raises important and fundamental questions about the quality of care across mental health in-patient services. We know that having robust oversight of quality and supporting clinical colleagues is an essential part of providing high standards of care. We also know that ensuring the voice of the patient is heard and responded to is imperative. Alongside our response we are also finalising our revised quality governance structure, a new quality strategy and our people strategy, all informed by our first ever co production strategy which will ensure the voice of the people we serve is embedded across all that we do.

2. **Quality**

   The CQC completed inspections of the Northampton Women's and Men's services and the Essex site in April and June. The CQC have published their inspection report for the Women's service with our overall rating improving from 'Inadequate' to 'Requires Improvement'. The Men's report has been received and published in the past few days and significant improvement has been noted although the overall rating remains Requires Improvement. We continue to wait for the draft report for the Essex service. In October the CQC undertook an unannounced responsive inspection of Fairbairn, Allitson and Heygate following whistleblowing concerns being raised about staff sleeping, management of the deteriorating physical health of a patient, staffing levels and management of aggression. Whilst this inspection did not result in a formal report or rating we were pleased to receive positive feedback from the visit; the CQC were assured that we were managing the patients and site appropriately. They also acknowledged that whilst staffing remains an issue for the organisation, staff on the wards were able to talk about the plans implemented to improve the situation. They also appreciated that our oversight and governance processes enabled us to demonstrate appropriate action taken when concerns had been highlighted, specifically the concerns of staff sleeping on duty which we had

already identified and HR processes had been implemented. We continue to focus on addressing further opportunities to improve for the benefit of our patients.

3. **Partnership working**

At the end of September we attended an event that brought together 'anchor institutions' from across Northamptonshire to begin to explore how working collaboratively and in partnership these organisations could help to address challenges such as poverty, inequalities, climate change and enhance economic growth and the health and wellbeing of the people of Northamptonshire. By the end of the year the intention is that the coalition of organisations will have developed a mission and set of commitments and as an anchor institution with a deep heritage in Northamptonshire we are continuing our involvement in this activity.

4. **People and Culture**

a. Cost of living and pay award
The cost of living payment has been really well received by colleagues, many noting that this will help them over the winter period. The pay review has brought us inline for qualified professional roles, we continue to be ahead for nursing and now ahead for entry level roles with our base hourly rating starting at £10.50.

b. Lead the Change Programme
The diagnostic phase of Lead the Change has now completed and the change leads have identified the priority themes for improvement from their workshop. The next phase includes designing the interventions that will be taken forward as part of the culture change programme for next calendar year.

c. Equality reporting and D&I Plan
The D&I Plan has been approved and sets out the Charity plans for the next 2 years. The plan was produced with involvement from the staff networks. The Gender and Ethnicity Pay Gap reports have been produced and presented to Nomination and Remuneration Committee.

d. Recruitment
- Recruitment 834 new joiners inducted so far this year (2022), including 144 in October
- 68 currently confirmed for the two November inductions
- 67 Nurses started so far this year
- Our first 10 International Nurses are going through their OSCE exams and all have now been allocated to wards
- A review of 'the time to hire' has commenced to deliver efficiencies in the hiring process and improve the candidate experience as well as reviewing the effectiveness of the on-boarding process.

e. Retention
A retention framework has been developed based on the feedback of our staff in terms of what creates a positive place to work and why they leave. Activity that will positively improve the staff experience is planned across executive portfolios and will be monitored through the usual Governance structure.

f. Allocate (e-rostering)
Allocate phase 1 went live for October pay run and through the hard work of the project team and payroll, the queries were minimised and actioned expediently. Key learnings and fixes will be actioned ahead of next month. We will begin

Phase 2 with a dummy auto-roster in Birmingham in January with the go-live of auto-roster for Birmingham in February followed by the rest of the Charity in March 2023.

5. **Operations**

The new monthly Operational Delivery Committee (OpCom) starts on 2 December and will follow the Divisional Quality and Performance Reviews; OpCom will cover a standing agenda of staffing and bed occupancy 'hot spots' (wards of concern), operational finance, sub-group highlight reports and the material operational risk register (quality, workforce, Estates & Facilities); OpCom will be supported by several sub-groups including the following:

a. *Operational Staffing Programme Board*
   - Allocate / auto-roster
   - Divisional structures
   - MHOST and MDT reviews
   - HR policy and staff management
   - Bank & Agency
   - Mandatory and statutory training; Learning and development

b. *Urgent response group*
   - Emergency response process
   - Staffing crisis response
   - Site coordination
   - On-call

c. *EPRR Steering Group*
d. *Policy Approval Group*
e. *Bed Occupancy Forum*
f. *Clinical Services Contractual Review Group*

The work on MHOST and our establishment continues at pace led by the Chief Nurse with the MDT reviews working in parallel. The divisional clinical leadership, operational management and quality improvement structures were shared at the Board Strategy day on 4 November and all of this work will be concluded by the end of November in first draft and costed with HR process plans in place for the strengthened divisions by end of December 2022.

6. **Finance**

a. *2022/23 Financial Performance – October YTD*

The Charity reported a £3.4m deficit October 2022 YTD and this is £1.4m behind budget. Operating performance YTD has been achieved but the one-off cost of living support payment in October 22 and negative movement in the Charity Investment Portfolio have created the YTD adverse performance against budget.

b. *2022/23 Financial Outlook*

The 2022/23 financial year budget net deficit was £2.4m. The ongoing risks continue to materialise, with lower occupancy, higher inflation and staff cost of living pressures providing considerable financial challenge. The Full year forecast will be discussed in Part 2 of the Board meeting.

7. **Communications and engagement**

It has been a busy few months in the communications team. Our focus internally has been on e-rostering with the team working hard to ensure that all staff received the correct information and training on the new system. We shared and celebrated news of the recent improvements in our Women's service following the release of the CQC report, but reminded everyone there was still work to be done. We communicated the positive news of our pay review. Following the Panorama documentary, Undercover Hospital, which highlighted areas of bad practice in secure care, we used it as an opportunity to highlight the importance of speaking up through a series of films and drop in sessions for our staff. Our revised Long Service Award ceremony on 8th November was a memorable event and an opportunity to say 'thank you' to two dedicated staff members who had devoted 40 years each to St Andrew's, alongside many others.

Externally we've been focussing on our upcoming Learning Disability and Autism Summit on 14 November. We have a number of high profile speakers attending and more than 200 guests have signed up. We also launched a new social media campaign called #EndTheEdit for World Mental Health Day. A woman in our care who has suffered all her life with body dysmorphic disorder (BDD) supported the campaign, which received coverage in local media. The campaign also did well on social with the main campaign video receiving up to 15,000 views.

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

Dr Vivienne McVey
Chief Executive Officer

Committee Updates

Research Committee
(verbal – Prof Stanton Newman)

People Committee
(Dawn Brodrick)

Quality & Safety Committee
(Steve Shrubb)

Audit & Risk Committee
(Elena Lokteva)

Nomination & Remuneration Committee
Incorporating Gender & Ethnicity Pay Reports
(Stuart Richmond-Watson)

Committee Escalation Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

10 November 2022

Chair of Meeting:

Dawn Brodrick

Significant Risks/Issues for Escalation:

Mandatory training is currently 88% and has declined since July. A compliance recovery plan is being reviewed by the Operational Staffing Programme Board to address this.

Key issues/matters discussed:

Our St Andrew's People Plan - Summary

Since the previous Committee the People Plan has been through various forums including a workshop with Change Leaders and the Executive Team. Subsequent updates have been made to the title, vision and guiding principles. A further review is taking place of the actions and associated timelines/measures. A summary version of the plan shown at appendix 1 was approved at the People Committee.

Diversity and Inclusion (D&I) Plan – Summary

The summary version shown at appendix 1 was approved at the People Committee.

Charity Retention Framework

A framework has been created to support the charity's focus on improving retention. This brings together influencers of employee experience sub categorised into:

- Individual personal factors (issues that people bring with them to work)
- The work environment (what they see, hear, perceive, and feel when they come to work every day)
- Values and behaviours (how they are treated and interactions with others)

The framework represents the voice of St Andrew's staff linking in feedback from various sources. This paper also explored charity level turnover rates including tenure breakdowns and reasons for leaving with an action plan provided to support overall retention.

Resourcing deep dive

The Committee were provided with a resourcing deep dive assessing a low, medium and high resourced ward reviewing any correlation between key people metrics. Although only three wards were reviewed, the assessment highlighted variations in outcomes within the sample and a correlation between increasing staffing levels and the level of experience on a ward. The Committee discussed the continued focus on skills mix and the development of a live dashboard heat map incorporating a number of the people metrics.

Culture programme – update on Lead the Change

- The Lead the Change programme forms one element of the overall approach to culture change within the charity.
- The discovery phase is now complete with Change Leaders completing 111 staff discussion groups, patient and carer focus groups, 13 Board interviews as well as 1440 responses to the charity wide culture survey. The themes from these data sets were shared with the Committee.
- During the Change Leader workshop in October the themes were prioritised as follows:

  - *Patient care*
  - *Wellbeing*
  - *Training and development*
  - *Behaviour and values*
  - *Leadership*
  - *Staffing (including ward moves and re-deployment)*
  - *Retention*
  - *Recognition*
  - *Communication*

- Nicola Bullock one of our Change Leaders and a Senior HCA updated the Committee on the Change Leaders role in influencing and supporting change in local areas.

Board Assurance Framework – Strategic Risk Committee Oversight

- The current process for strategic oversight was presented to the Committee for discussion and feedback.

Reporting groups

Updates were provided from the following:

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

Decisions made by the Committee:

- The summary versions of the Our St Andrew's People Plan and the D&I Plan were approved.
- The material risk deep dives for retention of key skills and recruiting required capabilities were deferred to the February Committee.

Implications for the Charity Risk Register or Board Assurance Framework:

- Mandatory training is currently 88% overall with Immediate Life Support (88%), BLS (71%) and Safety Intervention (69%). A compliance recovery plan is being reviewed by the Operational Staffing Programme Board focusing on these areas.

Issues/Items for referral to other Committees:

- None

Appendices: **Our St Andrew's People Plan - Summary and D&I Plan Summary**

Diversity and Inclusion Plan

2022-2024

Our People Vision

> A Charity where people have a sense of pride, belonging, can thrive and bring their whole selves to work.

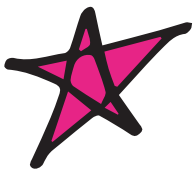
At St Andrew's Healthcare, we know that diversity is one of our greatest strengths, contributing positively to our success and, most importantly, to the care we provide for our patients.

There is significant evidence that when diversity practices and trust co-exist in an organisation, it increases employee engagement, staff feel valued and their wellbeing improves.

Our Diversity and Inclusion Plan is focused on achieving our Guiding Principle, as defined within our overarching Our St Andrew's People Plan to 'respect difference and treat people as individuals'.

Our CARE values are integral to how we operate

COMPASSION



ACCOUNTABILITY

RESPECT

EXCELLENCE

Our Guiding Principle for Inclusion

Respect difference and treat people as individuals

Our Inclusion Principles

Our underlying inclusion principles align closely with the NHS People Plan and strategic aims of the Northamptonshire Health and Care Partnership (where we attend the Integrated Care System People Board).

- Leadership diversity
- Tackling racism and any forms of discrimination
- Removing barriers to help staff speak up
- Leading with compassion
- Ensuring fair recruitment processes and progression opportunities
- Disciplinary and grievance processes free from bias
- Compassionate and inclusive health and welbeing.

Our Charity Action Pillars

See the St Andrew's intranet, The Hub, for the full version of our Diversity and Inclusion Plan outlining our progress and the actions being taken

Our St Andrew's - People Plan

This People Plan sets out our vision for and highlights how we will support the Charity's strategy to meet the needs of our staff, patients, carers and local communities.

Evolving to meet a changing world

Within mental healthcare there is a changing landscape, which is accelerating the need for change. Our St Andrew's People Plan acknowledges these trends noting the ways in which we will need to evolve to meet the changing nature of mental healthcare, and the changing expectations about the world of work.

Our People Vision

A Charity where people have a sense of pride, belonging, can thrive and bring their whole selves to work

How this plan has been developed - a co-produced approach

In 2020 we worked with staff from across the Charity, including our Employee Forum, to develop a People Promise, where staff expressed what is important to them and what they expect within the workplace. This work has helped inform our Guiding Principles.

Co-production is important to us and it has been shared with various forums including with our Change Leaders to ensure this plan connects with our people. We are committed to openness, being inclusive and will continue to seek staff views.

Our CARE values are integral to how we operate and underpin this People Plan

COMPASSION **ACCOUNTABILITY** **RESPECT** **EXCELLENCE**

Our Guiding Principles

Our 8 Guiding Principles highlight our promise to staff and must drive the decisions the Charity makes about our workforce.

Purpose and Belonging

Foster a sense of community and connection to the Charity

Wellbeing

Prioritise everyone's health and wellbeing

Diversity & Inclusion

Respect difference and treat people as individuals

Personal Development and Growth

Support people's careers and help them develop and grow in their role

Recognition

Praise our people and celebrate success

Reward

Reward all of our staff fairly

Innovation

Embrace innovation, and encourage new ways of working

Future workforce

Identify and grow the workforce fit for the future.

See the St Andrew's intranet, The Hub, for the full version of the Our St Andrew's People Plan outlining our progress and actions being taken

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 11 October 2022

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- The lack of emergency support was noted within CAMHS, with further assurance sought from the Committee.
- The Limited Assurance gained over CAMHS
- The staffing issues affecting the ability to admit within Neuro were noted
- Reviewing the priorities of the committee. Chair has initiated a review session, in order to stand back, review priorities and focus the capacity and capability of the committee and management on the most important items

Key issues/matters discussed:

- **CAMHS Update**

  Following the update, it was decided that frequency of reporting **should not** be stepped down as requested, as it was felt that the issues being faced regarding emergency support and recommencing admissions required further assurances. Written confirmation from the Commissioners was also requested prior to readmissions.

- **Stowe SI Report**

  The committee were provided with an update on the investigation into the death of the young person as a result of a ligature incident. The external reviews' recommendations were noted. The Committee requested a summary of the training support being put in place following the investigative report, along with how the administrative challenges would be addressed.

- **ASD/LD Divisional Deep Dive**

  The Committee received a deep dive on the current challenges, the divisional strategy and the top 3 priorities for the coming 12 to 24 months. It was noted that building quality and standards within the division was closely correlated to the recent published document from the CQC. Sustainable quality would be the basis for the division's long term aspirations.

- **Neuropsychiatry Divisional Deep Dive Update**

  The Committee received a divisional update following the deep dive presented at the previous meeting. It was noted that capability to admit had been compromised due to staffing challenges, however, the division remained at 90% occupancy. The estates work on updating the buildings was highlighted and would be central to the longer term strategy being formulated.

- **Executive Medical Director's report**

  The Committee noted the EMD's report which highlighted the concerns within Medium Secure which were being addressed with a heightened assurance process undertaken by NHSE.

- **Chief Nurse's Report**

  The Committee received the Chief Nurse's Report and noted the international recruitment update given. The Committee agreed that a joint meeting with People Committee would be beneficial from a staffing perspective.

- **Board Assurance Framework – Committee Oversight**

  The Committee discussed how it wanted to receive and scrutinise the BAF and assigned strategic risks in the future in order to provide assurance to the Board. The Committee felt that an annual review process was appropriate whilst maintaining a balance with operational and Executive responsibilities.

- **Quality Improvement Plan**

  The Committee noted the plan and the significant improvements observed since the previous iteration of the plan, along with the evidence based assurance process adopted. The aggregation of the rating process from the regulators was discussed with regard to Men's and Women's services along with the prospective rating for Essex. A target for completion of remaining actions before Christmas was confirmed.

- **IPC Update**

  The update was presented to the Committee with it being noted that more formalised reporting was expected in the future due to the prospect of the Winter Flu and Covid infections. Vaccinations for both Flu and Covid had already commenced.

- **Physical Healthcare Update**

  The Committee received the report and noted the points relating to head banging. The improvements and progress were acknowledged. Further assurance on the head banging data was requested from the next report. Health screening and its relation to mortality was discussed with the topic highlighted for discussion outside of the meeting.

- **Serious Incidents Update**

  The Committee received the Serious Incidents Update with the recurring themes being noted. It was requested that training be assessed in order to ensure that it remained fit for purpose along with its impact.

- **Integrated Performance Report**

  The report was presented with the concentration on quality aspects at ward and divisional level being noted. A re-focus was noted with regard to safeguarding and harm on enhanced observations as data suggested that this would be required.

- **Safer Staffing Report**

  The Committee received the report and received an update on the setting of establishment figures exercise currently being undertaken. The Committee agreed that a wider more informed discussion on the topic of staffing was required. This would be planned for the next Committee meeting in December and done in conjunction with the People Committee if possible.

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

  The Quality and Safety Group report was received and noted, highlighting the discussions had at both the Safety and Experience element and the Compliance and Effectiveness element of the meeting and that they covered all the areas brought to the committee. The Committee requested more information on the current shortfall in Clinical Audits versus the agreed plan.

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

  The Mental Health Law Steering Group report was received and noted. The Committee noted that the group was subject to a refresh due to recent staffing changes. The LPS reforms were considered with a task and finish group being formed to address the work required. The Committee requested a more detailed session at the next meeting to discuss the current state of play with regards to MHA compliance within the Charity.

Decisions made by the Committee:

- None for escalation

Implications for the Charity Risk Register or Board Assurance Framework:

- Committee proposed annual assurance reviews by the committee on committee assigned strategic risks.

Issues/Items for referral to other Committees:

- Request for collaboration with the People Committee on staffing concerns

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- None

Committee Update Report to the Board of Directors

Name of Committee: Audit and Risk Committee

Date of Meeting: 17 October 2022

Chair of Meeting: Elena Lokteva

Significant Risks/Issues for Escalation:

- Approval to sign off both the annual accounts for SAPML and St Andrew's Healthcare
- 2nd line of defence is incapable of keeping 1st line of assurance accountable
- The fragility of the Internal audit and risk management functions
- The committee offers the Board partial assurance over Charity's Emergency Preparedness, Resilience and Response.

Key issues/matters discussed:

1. Grant Thornton

Grant Thornton presented the committee with an update and noted that a clean audit opinion could be offered against the annual accounts process and had signed off on a going concern basis. ARC also agreed to recommend Grant Thornton reappointment for a further 12-month period at the upcoming AGM.

2. Annual Accounts

The committee considered and approved both the accounts for St Andrew's Property Management Ltd (SAPML) and St Andrew's Healthcare. This followed a robust page turning exercise in September and further review at the October meeting. Board to note the approval for signature of the annual accounts for SAPML and St Andrew's Healthcare as delegated to ARC.

3. Risk Management and Self-Evaluation

ARC received detailed risk updates which highlighted the committee's key focus areas within risk, including agreed risk KPIs, risk register review status, operational risks, on-going actions, risk resource and material risks. ARC noted the update and acknowledges the work management is doing in terms of moving risk management framework to the next level of maturity – "established". There was a good degree of engagement on material risks, however, focus was required on operations risks.

The Committee received the self-evaluation results and noted that some of the scores, particularly relating to culture had remained unchanged despite the ongoing work. ARC was assured with regard to progress as risk culture is being addressed separately with good operational management. After the discussion with management, the Committee accepts the offered level of assurance over Material Risks management is Adequate, and the level of assurance over Operational risks management is Partial.

4. Board Assurance Framework

The Committee discussed the oversight processes for the Charity's BAF, including timelines for providing assurance. An annual cycle of review cycle for both the BAF and material risk management would be discussed in detail at the January meeting, including the Board sub-committees work relating to the oversight over Material and Strategic risks.

5. Internal audit

The Committee reviewed the current internal audit update covering published reports, functional resource, audit actions dashboard, progress versus internal audit annual plan and a thematic review on the implementation of audit actions. Following an update from the Internal Audit Risk Manager (IARM), the Committee noted that there were 5 overdue actions (relating to two audits) at this point in time. These were all being addressed by the Responsible Executives in conjunction with the IARM. It was confirmed at the meeting that one action was now closed.

Four Internal Audit reports were published since the last meeting, with Safeguarding rated as "Limited", Waste Management as "Partial" and Pre-Employment Checks rated as "adequate" assurance. The forth report was an unrated advisory audit completed on the Charity's ISO27001 processes. The Committee were assured that the actions to address the Limited and Partial audits were in hand and under review, with follow-ups planned to review the implementation and embedding of the actions. The Committee were pleased to see that all audit reports relating to the remaining 2021/22 audit assignments have now been published.

Pre-Employment Checks audit report will come back to ARC Committee in January for ARC to obtain additional assurance that people do not "slip" into The Charity through third parties without pre-employment checks.

The Committee also noted the progress with the 2022/23 Internal Audit Annual Plan, with two audits from the plan also concluded, with reports published. Both were advisory engagements, and assurance ratings were not provided on this occasion.

6. Counter fraud

The Committee received and reviewed the latest counter fraud activity update that included information on local proactive counter-fraud work, referrals for potential fraudulent activity in the previous period and wider horizon scanning for issues that may impact the Charity. The Committee is satisfied with Local Counter Fraud Specialist work.

7. Emergency Preparedness, Resilience and Response (EPRR)

The Committee received an update on EPRR activity against the NHS framework, with partial compliance being noted. It was noted that standards had risen dramatically despite Claire Jones being the only person responsible for EPRR. A full review is due to be conducted by Internal Audit.

Based upon the presented report and the discussion with management, the committee offers the Board partial assurance over Charity's Emergency Preparedness, Resilience and Response. The Committee noted management's ambition to return to a position of "Substantial Compliance" at the 2023 review

8. Effectiveness Review

The Committee received the results of the recently conducted effectiveness review, and noted the findings and recommendations. The Committee concluded that the finalisation of the Terms of Reference would address many of the recommendations.

9. Governance Review Project Update & Terms of Reference

The Committee received an update regarding the progress of the project and the next steps. It was confirmed that the temporary Committee Secretary had now left the Charity and would not be replaced, with assurance given, that despite this, the timeline of the project and the milestones would remain unchanged.

Decisions made by the Committee:

- Agreed to recommend Grant Thornton for re-appointment to the AGM for a further 12 months.
- Approval to sign off both the annual accounts for year ending 31 March 2022 for SAPML and St Andrew's Healthcare
- To remove "Items for Governors" from its Standing Agenda

Implications for the Charity Risk Register or Board Assurance Framework:

The Committee discussed the differing review timelines and processes that could be adopted in order to give the best level of assurance. An annual review process was acceptable. Vivienne McVey outlined that under current processes, risks were not moving and that she was looking to streamline the way in which they were managed and use the Committee to challenge the risks.

The Committee agreed that the process was important, and felt that the question needed to be asked as to if the BAF helped the Board to do its job, and if not, what should be done in order to achieve that. This would be discussed further at the Board in January, at which point the BAF was to be reviewed having been in place for 9 months.

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- Appendix 1 – SAPML Annual Accounts – via Microsoft Teams
- Appendix 2 – St Andrew's Healthcare Annual Report & Accounts - via Microsoft Teams
- Appendix 3 – ARC Effectiveness Review

Paper for Audit and Risk Committee

Topic	Audit & Risk Committee Effectiveness Review
Date of Meeting	Monday, 17 October 2022
Agenda Item	**14**
Author	Duncan Long, Company Secretary
Responsible Executive	Elena Lokteva, Non-Executive Director
Discussed at Previous ARC Meeting	Discussed at each meeting of the Committee
Patient and Carer Involvement	Not specifically for the update.
Staff Involvement	Input to review survey
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☒ **C** ☐ **R** ☒ **W** ☒
Strategic Focus Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Previous Audit & Risk Committees only

Report Summary and Key Points to Note

This paper presents the results of the Audit & Risk Committee review of effectiveness for 2021/22 which was undertaken in September 2022, as well as highlighting potential action points for consideration by the Committee, based on the feedback received from the survey.

The results demonstrate improvements across the significant majority of questions, with all bar three ratings improving on the previous review.

The Committee is asked to:

1. Note the results from the Audit & Risk Committee Effectiveness Review 2021/22 and
2. Consider the identified areas for improvement as detailed within the detailed paper

Appendices: None.

ARC Effectiveness Review

October 2022

Transforming lives together

Introduction

Engagement

The following groups were invited to participate in the survey:

- Non-Executive Directors (NED) Committee members
- Governor Committee members
- Executive Directors
- Regular Committee attendees
- Internal and External Auditors

The response rate for this survey was 50%. The survey was sent to 14 people in total. 7 responses were received, achieving the minimum response rate for this survey of 50%. This compares with last years' uptake of 10 responses, or 67% uptake.

1. Purpose

This paper presents the results of the Audit & Risk Committee review of effectiveness for 2021/22 which was undertaken in September 2022 as well as highlighting potential action points for consideration by the Committee, based on the feedback received from the survey.

2. Background and Context

As part of good governance, it is appropriate to conduct annual effectiveness reviews on all Board Committees. The Committee Chair, on behalf of the Committee agreed the plans for undertaking this review. Responses to the survey were provided via Microsoft Forms. To ensure consistency where possible and to assist with a year on year comparison, the same survey questions were used on this occasion, as used in 2021, however during analysis it was established that the "unable to comment" responses had been included in last years average score per question and as such do not immediately reflect the accurate rating average. Based upon the scoring mechanism used within the survey, a lower average score indicates a favourable response, and the higher score indicates improvement is required.

Introduction

3. Conclusion and Summary

1. The results of the 2022 Committee Effectiveness survey demonstrate improvements across the significant majority of questions, with all bar three ratings improving on the previous review (taking into consideration the adjustment to remove the unable to comment scores from the 2021 responses). The three areas that are highlighted (based on average rating versus prior) that still require improvement are:

a) The size of the Committee packs
b) Appropriateness of the Committee Membership
c) Relationship between the Committee and the Board

In addition, one question, whilst improving on the prior year, was rated as an average of adequate and should also be considered an area for improvement, this related to the duration of meetings.

2. The main priorities for the next 12 months were highlighted as:

1. Continued focus on risk
2. Subject matter expert input
3. Improved committee papers
4. Reduction in agenda and length of meeting, however…
5. More time for discussion

4. Recommendation

The Committee is asked to:

1. Note the results from the Audit & Risk Committee Effectiveness Review 2021/22 and
2. Consider the identified areas for improvement

In line with some of the response suggestions, the Committee is asked to consider the following recommendations:

1. Development of committee based skills matrix and committee level additional training in areas identified within the survey and as identified as potential gaps within the skills matrix
2. Inclusion of Business Case reviews within agenda (taking into consideration role of FinCom)
3. Inclusion of Clinical Risk/Audit within Committee's remit (taking into consideration role of QSC)
4. Continued focus on risk within Committee agenda
5. Re-phasing of Committee Annual Plan in line with item's perceived risk and current level of assurance to reduce agenda items and overall meeting length
6. Introduction of SME's to present papers (supporting the relevant Executive)

Key Findings

Overall Effectiveness

Whilst the response rate was lower than last year and lower than ideal to establish an accurate view on the Committee's effectiveness, the results of the 2022 survey are favourable and indicate a general improvement across the range of areas covered and that the committee is on the whole operating effectively.

There remain areas which require work to be undertaken to improve them and whilst the polarity within responses is less this year, there remains a wide range of opinions in some areas within those that responded.

Overall however the individual scores are aligned with the overall averages and ratings recorded. One respondent indicates the effectiveness overall is between adequate and requires improvement, with two respondents indicating it is between good and excellent.

Summary of Findings

Out of 21 questions asked:
3 were rated as between "good and excellent"
1 was rated as "good"
9 were rated as between "good and adequate"
6 were rated as between "adequate and good"
1 was rated as "adequate"
1 was rated as "adequate to requires improvement"

No questions were rated overall as poor or requires improvement. Of the 147 total responses across all 21 questions, only 4 were marked as poor (2.7%) and 23 as requires improvement (15.6%), whereas there were 22 individual response of excellent (15%) and 61 of good (41.5%).

Good to Excellent – The frequency of ARC meetings; the management of agendas for meetings and the timeliness of the issue of committee packs.

Good - The relationship and communication between the ARC and the CFO

Adequate – The duration of meetings

Adequate to Requires Improvement – The volume (size) of committee packs. This was also highlighted in last years' survey as requiring improvement.

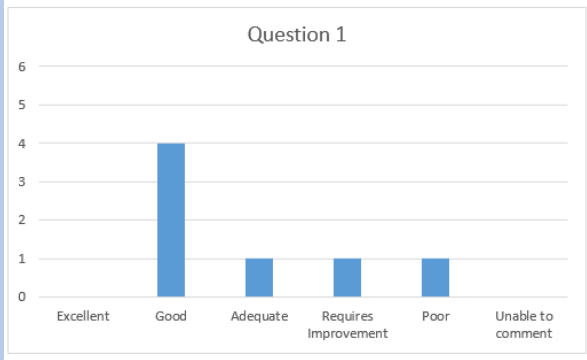
Summary of Responses

Area	Response Summary

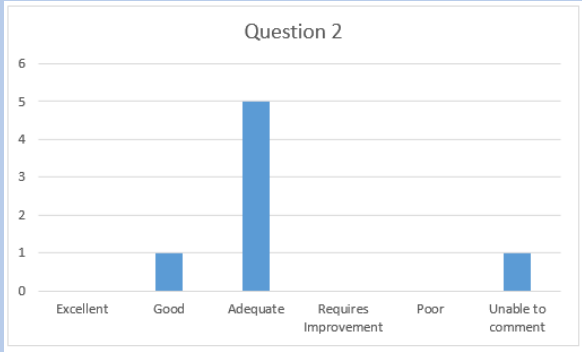
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Committee Membership

Question 1
The appropriateness of the Committee Membership was rated on average as between “adequate to good”, scoring an average of 2.9, with 4 of the 7 responses indicating that the Committee's composition was good (score of 2), with 3 responses indicating adequate (score of 3)



Question 2
The level of involvement of Committee members in the affairs of the Charity outside of Committee meetings was rated on average as between “adequate to good”, scoring an average of 2.85, with 5 of the 6 responses indicating the involvement was adequate (score of 3), one rated as good (score of 2), and one unable to comment (score removed from analysis).



Summary of Responses

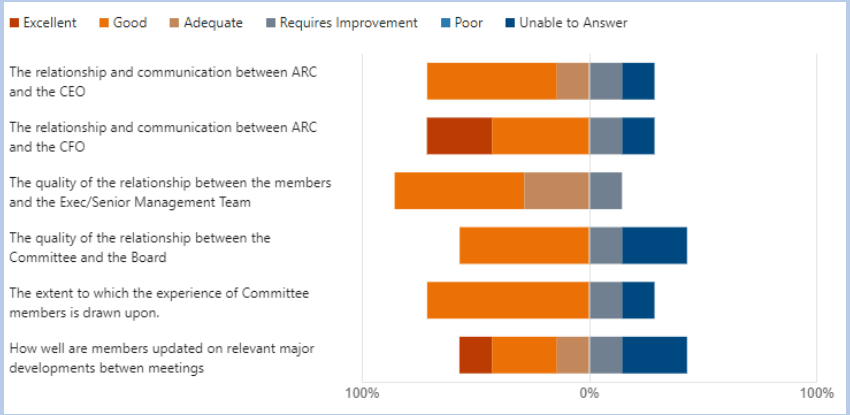
Area	Response Summary

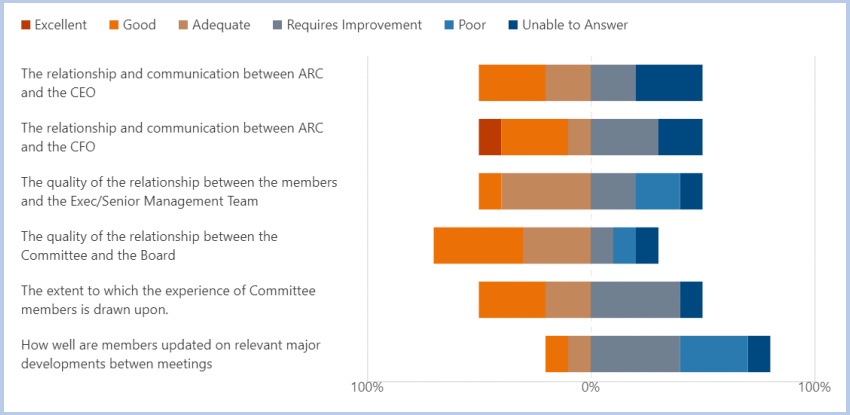
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Committee Effectiveness

Questions 3 to 8

The results for questions 3 to 8 on committee effectiveness demonstrate an improvement on those seen in the 2021 survey (bottom table), with a clear shift to an overall average rating of between “good to adequate”, scoring an average of 2.4, with elements rated as excellent





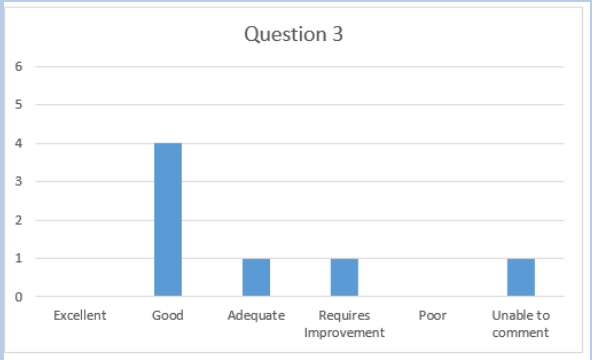
Summary of Responses

Area	Response Summary

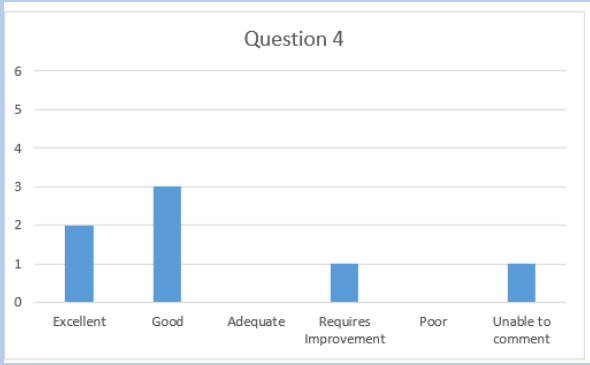
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Committee Effectiveness

Question 3
The relationship and communication between ARC and the CEO was rated on average as between “good to adequate”, scoring an average of 2.5, with 4 of the 6 responses indicating that this was good (score of 2)



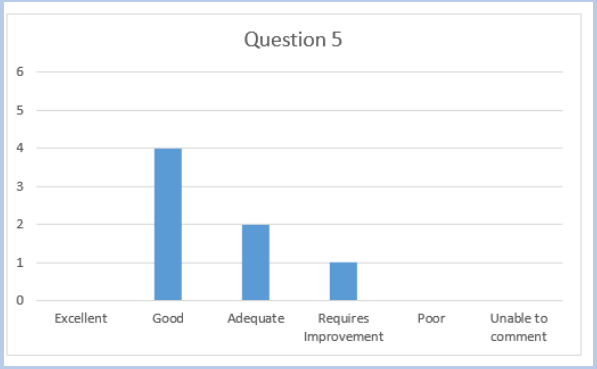
Question 4
The relationship and communication between ARC and the CFO was rated on average as “good”, scoring an average of 2.0, with 2 responses indicating that this was excellent (score of 1) and 3 responses as good (score of 2)

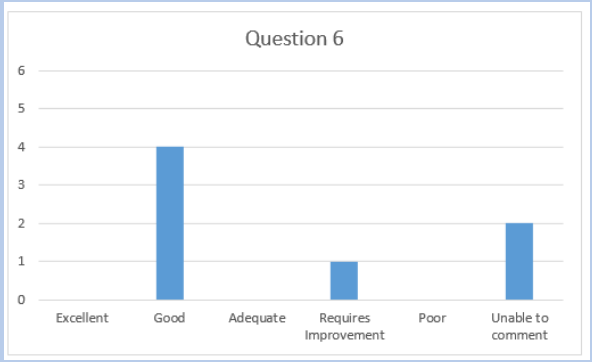


Summary of Responses

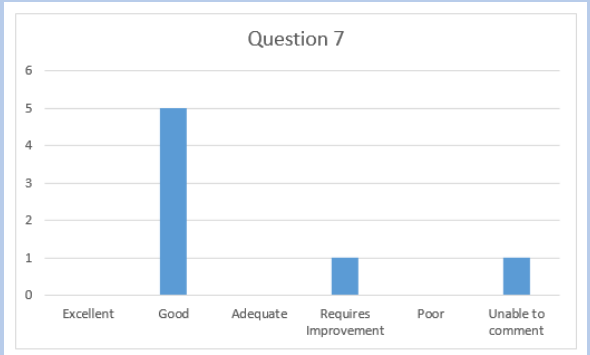
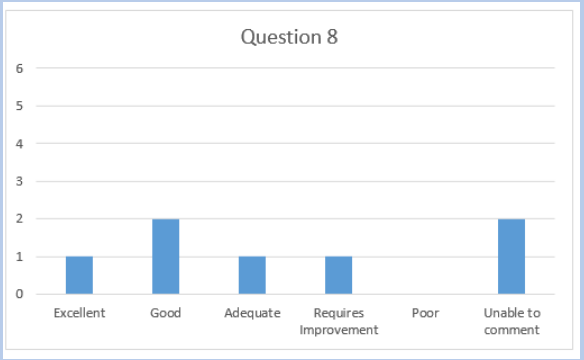
Area	Response Summary
Committee Effectiveness	**Question 5** The relationship between members and the Exec/Senior management team was rated on average as between “adequate to good”, scoring an average of 2.6, with 4 of the 7 responses indicating that this was good (score of 2), 2 as adequate (score of 3) and 1 as requires improvement (score of 4) **Question 6** The relationship between the Committee and the Board was rated on average as between “good to adequate”, scoring an average of 2.4, with 4 of the 5 responses indicating that this was good (score of 2) and one as requires improvement (score of 4)

1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment





Summary of Responses

Area	Response Summary
Committee Effectiveness 1 Excellent 2 Good 3 Adequate 4 Requires Improvement 5 Poor 6 Unable to comment	**Question 7** The extent to which the experience of Committee members is drawn upon was rated on average as between “good to adequate”, scoring an average of 2.3, with 5 of the 6 responses indicating that this was good (score of 2) and one as requires improvement (score of 4)  **Question 8** How well members are updated on relevant major developments between meetings was rated on average as between “good to adequate”, scoring an average of 2.4, with 1 of the 5 responses indicating that this was excellent (score of 1), 2 as good (score of 2) and the remaining 2 as adequate and requires improvement 

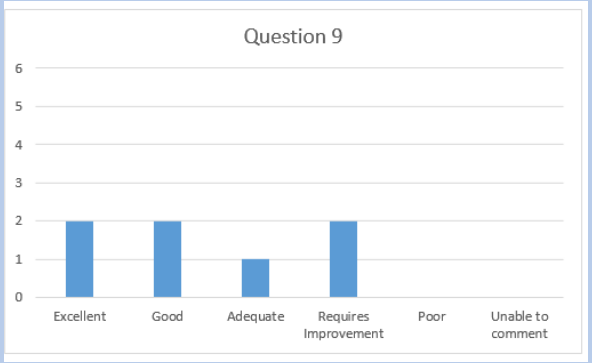
Summary of Responses

Area	Response Summary

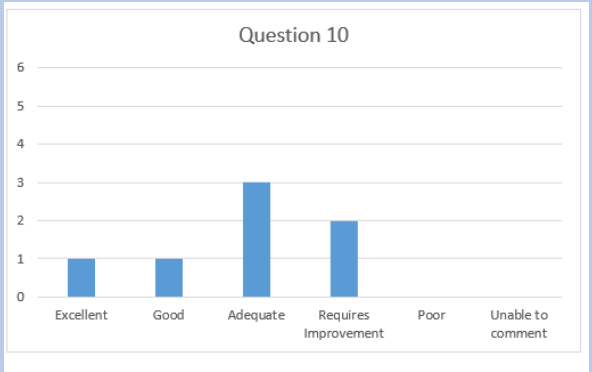
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Committee Effectiveness

Question 9
The review of current risks and control mechanisms was rated on average as between “good to adequate”, scoring an average of 2.4, with 2 of the 7 responses indicating that this was excellent (score of 1), 2 as good (score of 2) and 2 as requires improvement (score of 4)



Question 10
The review of future risks and required control mechanisms was not rated as high as current risks and was rated on average as between “adequate to good”, scoring an average of 2.9, with 3 of the 7 responses indicating that this was adequate (score of 3), 1 as excellent (score of 1), 1 as good (score of 2) and 2 as requires improvement (score of 4)



Summary of Responses

Area	Response Summary
Committee Effectiveness	The focus of what the Committee spends too much or too little time on was commented on by all respondents, with the following extracts being notable: *Comments relating to more time on:* *"Management of risks that score 5 for impact and 1 or 2 for probability"* *"identification of key processes"* *"clinical audit and assurance"* *"internal audit report content and executive accountability"* *"more time needed"* *"Long term scenario scanning"* *Other comments:* *"areas covered by committee are adequate……. At 3 hours it is the longest audit committee that I attend….. but subjects covered are appropriate"* *"proportionally reduce time spent on agenda items to move to a two-hour meeting by Sept 23"*

Summary of Responses

Area	Response Summary
Committee Effectiveness	If there was one practice you could bring to St Andrew's ARC from another Committee on which you serve, what would it be, was commented on by all respondents, with the following extracts being notable: *"Annual assessment of the effectiveness of internal audit function and external auditors"* *"Ensuring robustness of business cases"* *"A more consistent shared view on risk management"* *"More external audit views"* *"More focus on integration between 1st and 2nd lines of assurance"* *"Joint annual meeting with Finance Committee"* *"More discussion time"* *And….. LUNCH ☺*

Summary of Responses

Area	Response Summary
Committee Development	How could candid discussion and critical thinking in the Committee be improved was commented on by all respondents, with the following extracts being notable: *"… a discussion session on a key topic"* *"more meetings in person"* *"actively seeking views and prompting conversation"* *"more discussion time"* *"prepare a members skills matrix and consider training or workshops to address identified gaps"* *"…mandating of all members to ask at least one question (or raise a comment) per topic"* *"….encouragement for members to speak up is helpful"*

Summary of Responses

Area	Response Summary
Committee Development	The majority of respondents provided their top three priorities for the year ahead for improving the Committee's performance, with the following notable points: • *Reduce Committee time to two-hours* • *More time to discuss* • *Reduce size of the agenda* • *More precise papers (use cover sheets to convey 2-3 key points and articulate a clear ask from the Committee, don't repeat intro or summary of your paper)* • *Continuing robust approach to risk, particularly financial risk* • *Risk registers to be more meaningful and embedded* • *Focus on key risks that threaten success* • *Consider including ESG in a VFM assessment* • *Facilitated conversations* • *More Subject Matter Expert input* • *Membership and new member(s) on-boarding* • *In depth discussion on a particular subject* • *Informal get together of the committee, to give members an opportunity for open discussion on any topic*

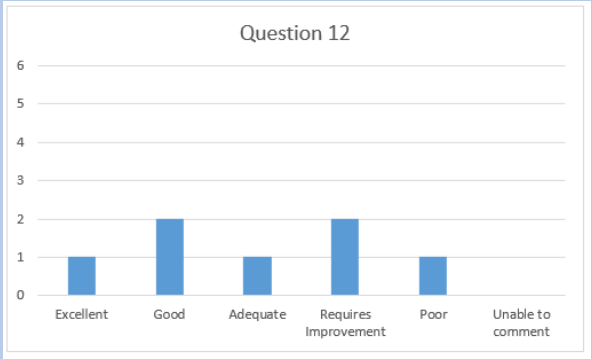
Summary of Responses

Area	Response Summary
Committee Development	All respondents provided suggestions for areas in which they felt ARC members would benefit from additional support or training, including: • *Digital and cyber* • *Integration of assurance functions* • *National changes in audit framework* • *ESG* • *Specifics around Charity responsibilities* • *Understanding clinical operations for non-clinicians* • *Support in understanding structure of responsibilities and tasks*

Summary of Responses

Area	Response Summary
Meeting Administration	**Question 11** The frequency of meetings was rated on average as between “good to excellent”, scoring an average of 1.9, with 3 of the 7 responses indicating that this was excellent (score of 1), 3 as good (score of 2) and 1 as requires improvement (score of 4) **Question 12** The duration of meetings was rated on average as “adequate”, scoring an average of 3, with a fairly even spread across all options, ranging from excellent (score of 1) to poor (score of 5)

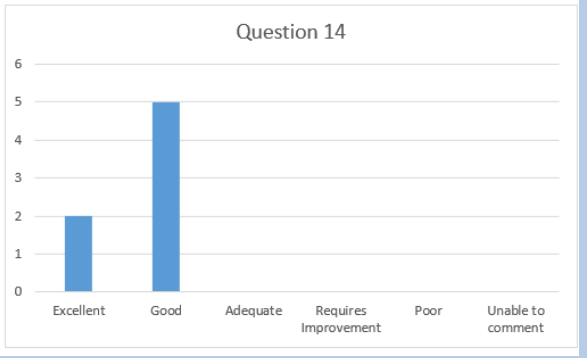
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment



Summary of Responses

Area	Response Summary
Meeting Administration	**Question 13** The management of the annual cycle of work was rated on average as between “good to adequate”, scoring an average of 2.3, with 3 of the 7 responses indicating that this was good (score of 2), 1 as excellent (score of 1) and the remaining as either adequate or requires improvement **Question 14** The management of the Agendas for meetings was rated on average as between “good to excellent”, scoring an average of 1.7, with 2 of the 7 responses indicating that this was excellent (score of 1) and the remaining responses all as good (score of 2)

1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment



Summary of Responses

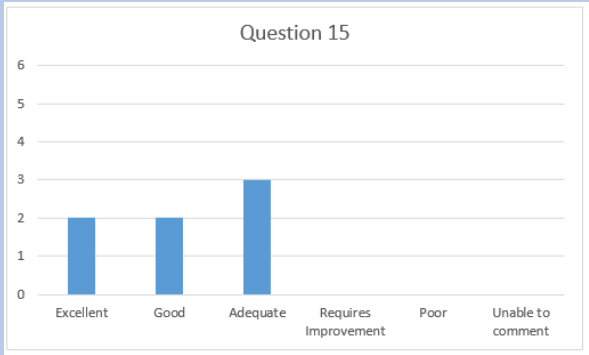
Area	Response Summary

1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Meeting Administration

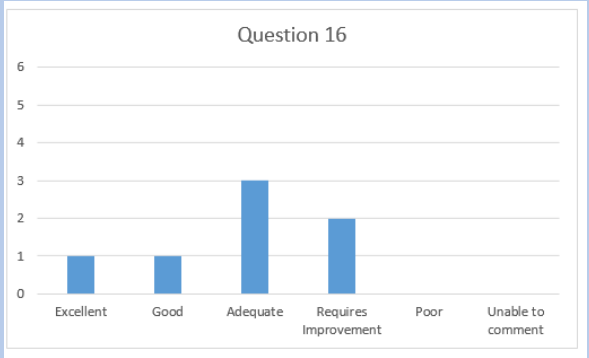
Question 15

The management of the time in meetings management of the annual cycle of work was rated on average as between “good to adequate”, scoring an average of 2.1, with 2 of the 7 responses indicating that this was excellent (score of 1), 2 as good (score of 2) and the remaining as adequate (score of 3)



Question 16

The management of member contribution was rated on average as between “adequate to good”, scoring an average of 2.9, with 3 of the 7 responses indicating that this was adequate (score of 3), 2 as requires improvement (score of 4) and the remaining responses as either excellent or good



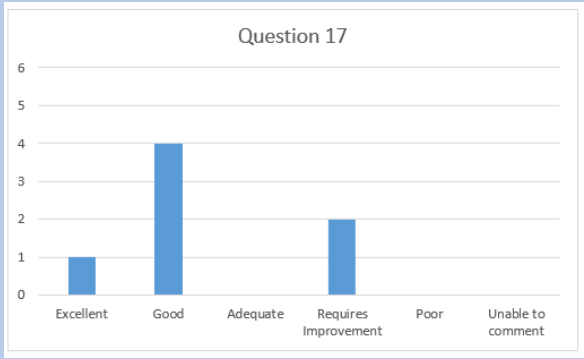
Summary of Responses

Area	Response Summary

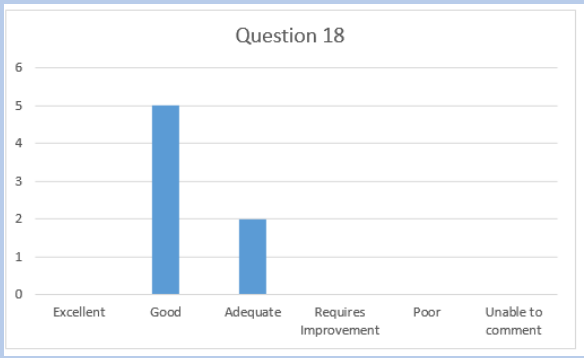
1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Meeting Administration

Question 17
The frequency of presentations to the Committee by management was rated on average as between “good to adequate”, scoring an average of 2.4, with 1 of the 7 responses indicating that this was excellent (score of 1), 4 as good (score of 2) and the remaining as requires improvement (score of 4)



Question 18
The content and quality of the information within the Committee packs was rated on average as between “good to adequate”, scoring an average of 2.3, with 5 of the 7 responses indicating that this was good (score of 2) and the remaining responses all as adequate (score of 3)



Summary of Responses

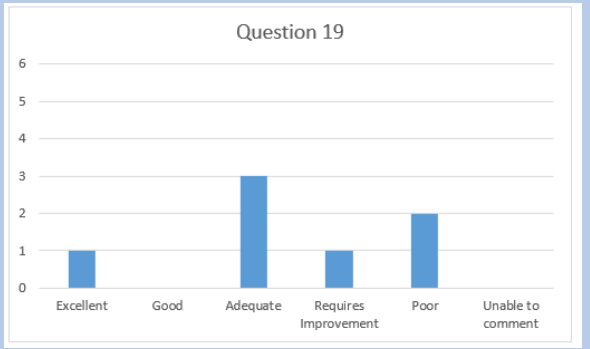
Area	Response Summary

1 Excellent
2 Good
3 Adequate
4 Requires Improvement
5 Poor
6 Unable to comment

Meeting Administration

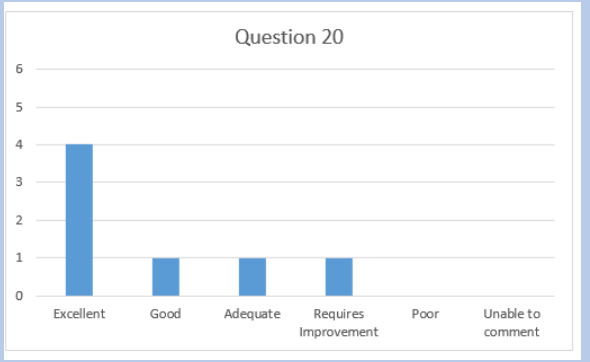
Question 19

The size of the Committee packs was rated on average as between “adequate to requires improvement”, scoring an average of 3.4, with 2 of the 7 responses indicating that this was poor (score of 5), 1 as requires improvement (score of 4), 3 as adequate (score of 3) and 1 as excellent.

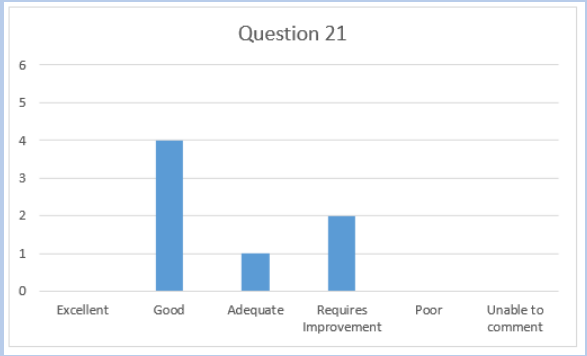


Question 20

The timeliness of the issue of the Committee packs was rated on average as between “good to excellent”, scoring an average of 1.9, with 4 of the 7 responses indicating that this was excellent (score of 1) and the remaining 3 responses as either good, adequate or requires improvement



Summary of Responses

Area	Response Summary
1 Excellent 2 Good 3 Adequate 4 Requires Improvement 5 Poor 6 Unable to comment Meeting Administration	**Question 21** The quality of the information that ARC receives was rated on average as between “adequate to good”, scoring an average of 2.7, with 4 of the 7 responses indicating that this was good (score of 2), 1 as adequate (score of 3) and 2 as requires improvement (score of 4) 

Committee Update Report to the Board of Directors

Name of Committee:

Nomination and Remuneration Committee

Date of Meeting:

7 November 2022

Chair of Meeting:

Stuart Richmond-Watson

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Gender Pay Gap
- Ethnicity Pay Gap

Decisions made by the Committee:

- Gender pay and ethnicity pay gap draft publication agreed to proceed to Board for approval

Implications for the Charity Risk Register or Board Assurance Framework:

- None

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- Approval of the gender and ethnicity pay gap publication to release internally and externally in early 2023.

Ethnicity pay report

At St Andrew's we're committed to inclusion in all its forms. We know that diversity is one of our greatest strengths and we want everyone to feel accepted and included at work. Diversity has a proven effect on our success and, most importantly, improves the care we provide for our patients.

As a charity we work hard to know how well we are doing as an inclusive organisation. As part of this we have examined the relationship between ethnicity and pay at St Andrew's. This report shares a snapshot of our pay gap as of April 2022. It shows the difference in average pay between Black, Asian and Minority Ethnic (BAME) and non-BAME groups across the organisation.

According to the ethnicity pay gap analysis:

Our median ethnicity pay gap is

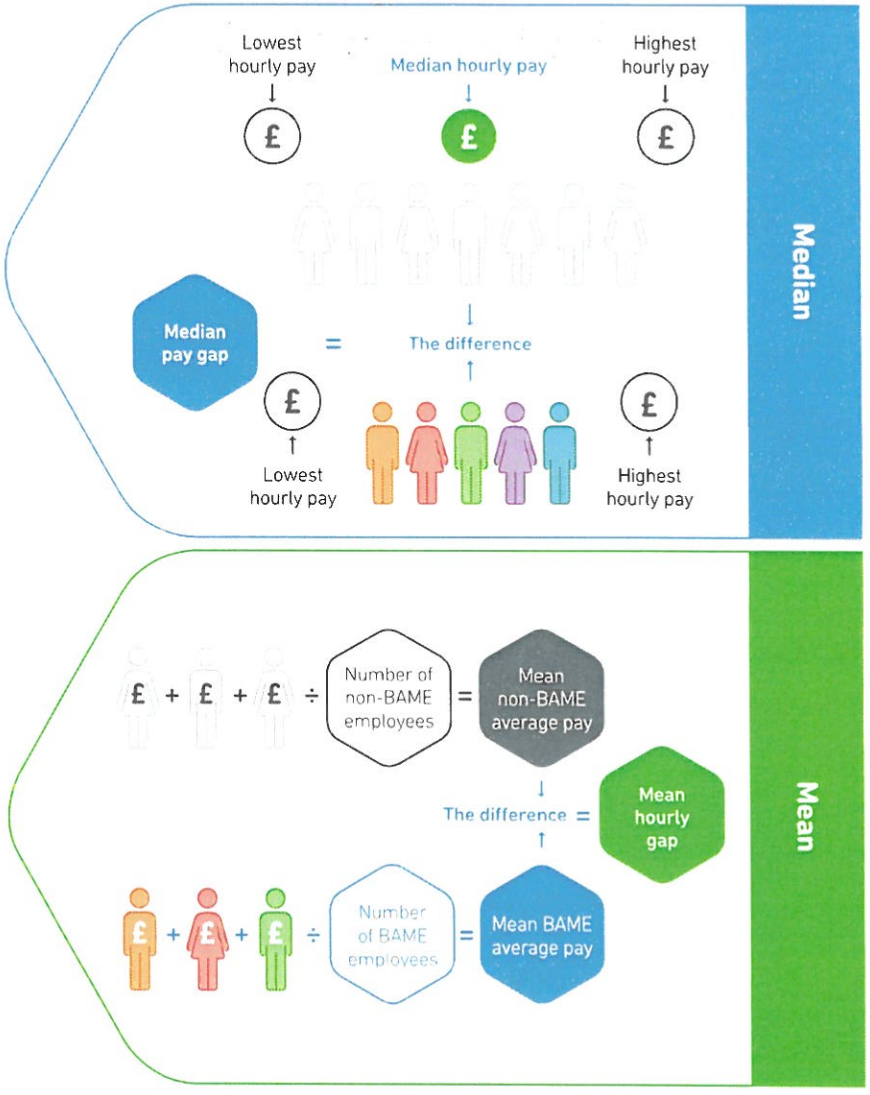
-5.4%

Our mean ethnicity pay gap is

1.5%

The median pay gap is the calculation that organisations focus on. We have a negative median pay gap, which means that BAME employees have a higher overall hourly rate when compared to non-BAME employees.

This is very positive compared with the national average; the 2021 national ethnicity median pay gap is 2.8%, which means that generally across the UK non-BAME employees are paid more than BAME employees.



The calculations are based on an ethnicity disclosure of **59%**.

Pay data

Difference between gross hourly earnings for BAME employees	Median middle		Mean average	
	2022	2021	2022	2021
Asian	-6.4%	-3.6%	-36.7%	-36.7%
Black	-5.5%	-2%	7.4%	10.2%
Mixed	1.8%	1.7%	0.1%	1%
Other Ethnicity	-6.5%	-0.9%	10.3%	9.1%
Overall BAME	**-5.4%**	**-1.9%**	**1.5%**	**3%**

Pay quartiles

	Lower quartile	Lower middle quartile	Upper middle quartile	Upper quartile	Overall
Non-BAME 2022	**70%**	**61%**	**51%**	**62%**	**61%**
Non-BAME 2021	69%	59%	59%	61%	62%
BAME 2022	**30%**	**39%**	**49%**	**38%**	**39%**
BAME 2021	31%	41%	41%	39%	38%

St Andrew's HEALTHCARE

What are we doing?

We are committed to creating a highly inclusive working environment for all, and we have a number of initiatives underway to support this, including:

- **A charity wide 2 year diversity and inclusion plan, which aims to promote fairness and improve ethnic minority representation**
- **Continued monitoring of all recruitment and reward decisions from an ethnicity perspective to ensure that our processes are free from bias**
- **Support for interviews and application processes**
- **Increased coaching and mentoring for Ethnic minority colleagues**
- **Continue support for our Unity Staff Network**

We confirm that the information and data reported is accurate as of the snapshot date of 5 April 2022.

Dr Vivienne McVey, Chief Executive

Martin Kersey, Executive HR Director

Gender pay report

At St Andrew's we're committed to inclusion in all its forms. We know that diversity is one of our greatest strengths, contributing positively to our success and, most importantly, to the care we provide for our patients.

This gender pay report is prepared according to the legislative requirements for organisations with more than 250 employees and shares a snapshot of our pay gap as of April 2022. It shows the difference in average pay between men and women across the whole charity. It does not measure equal pay, which relates to what women and men are paid for the same or similar jobs, or work of equal value.

In the sixth year of publication we have continued to perform ahead of other organisations.

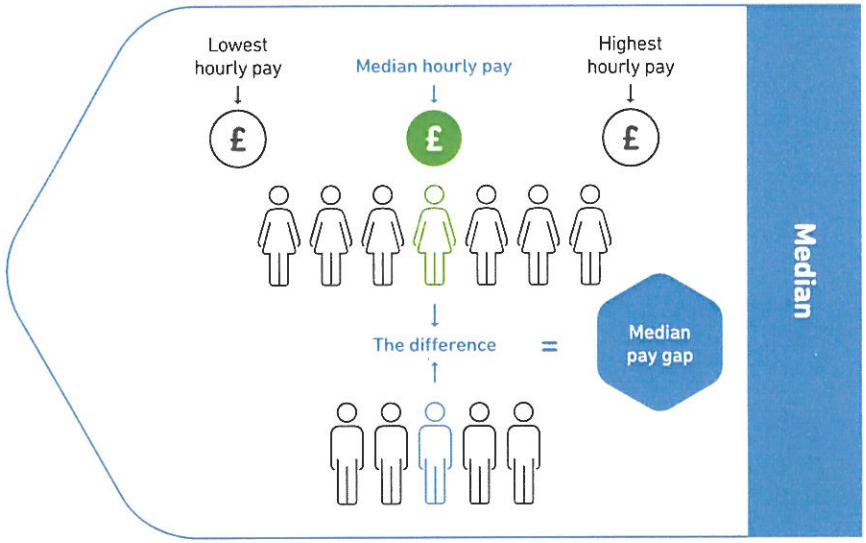
According to the gender pay gap analysis:

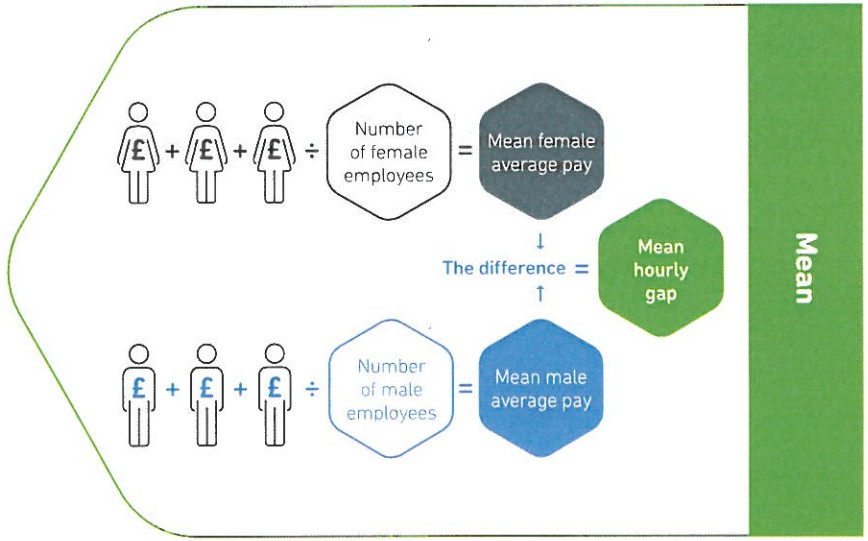
Our **median** gender pay gap is **3%**, this means there is a 3% difference between our median male and female hourly rates, when taking into account total remuneration. This is a small increase on last year and continues to be affected by males completing more unsociable shifts that female staff.

Our **mean** pay gap has also increased to **12%** but based on currently submitted figures is better than the national average.

We are continuing in our efforts to pay fairly and equally and to improve pay for lower earners whilst exercising pay restraint at senior levels.

We're confident in the actions we take to promote and sustain inclusion, in our robust pay governance and our commitment to our reward strategy for all employees.





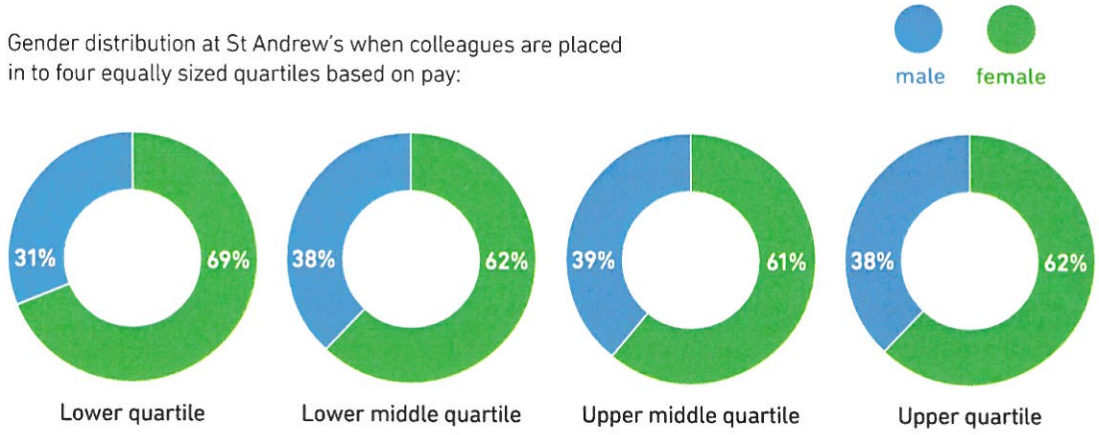
Pay data

Difference between gross hourly earnings for men and women	Median middle			Mean average		
	2022	2021	2020	2022	2021	2020
St Andrew's Healthcare	3%	2%	0%	12%	9%	7%
National	15%[1]	12%	16%	14%[2]	14%	15%

	Lower quartile	Lower middle quartile	Upper middle quartile	Upper quartile	Overall
Male – 2022	31%	38%	39%	38%	36%
Female – 2022	69%	62%	61%	62%	64%

Pay quartiles

Gender distribution at St Andrew's when colleagues are placed in to four equally sized quartiles based on pay:



1. *Average from all reports to Government Portal up to 26th October 2022. Final figure not yet published*
2. *Average from all reports to Government Portal up to 26th October 2022. Final figure not yet published*

St Andrew's HEALTHCARE

We are passionate about supporting colleagues to develop across the Charity. Our approach to values based recruitment and gender analysis of performance and talent management ensure we support and encourage female colleagues to perform at their best.

Our Diversity and Inclusion plan sets out a clear priority to increase female representation in senior roles.

To achieve this we are continuing with a number of actions that include:

- The roll out of unconscious bias training
- An extension of the Director development programme where over 80% of leaders are female
- Continuing support for WISH staff network (Women in St Andrew's Healthcare)
- Mentoring and coaching programmes for senior leaders

We confirm that the information and data reported is accurate as of the snapshot date 5 April 2022.

Dr Vivienne McVey, Chief Executive

Martin Kersey, Executive Director of HR

Paper for Board of Directors	
Topic	CQC Inspection, Report and Actions Update
Date of Meeting	Tuesday, 22 November 2022
Agenda Item	**8**
Author	Jenny Kirkland – Director of Nursing
Responsible Executive	Andy Brogan – Chief Nurse
Discussed at Previous Board Meeting	Progress against CQC actions on the Quality Improvement Plan were discussed at the September Board meeting.
Patient and Carer Involvement	Patients and Carers have not been directly involved in the writing of the report. Their voice has informed actions implemented as a result of the inspections.
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 Charity Executive Committee meetings and Quality Improvement meetings also presented to Quality and Safety Committee

Report Summary and Key Points to Note

The CQC have published their inspection report for the Women's service with an overall rating improving from Inadequate to Requires Improvement. The Men's report has been received and published in the past few days and significant improvement has been noted although the overall rating remains Requires Improvement.

An action plan has been developed at ward, divisional and Charity wide level to address the issues identified for the Women's service and is focused on the response of actions submitted to the CQC in response to this report. An action plan for the Mens report is currently in development and will form the response to the CQC as required for a submission of Response of Actions. The attached Charity wide plan will be updated to reflect these actions once agreed.

As a result the previous QIP has been closed to enable a re-focus on the key requirements from the recent inspections.

The CQC undertook a focused responsive inspection after they received several whistleblowing concerns. They were positive in their feedback to us and reported being assured of a number of our processes and activities. This inspection does not result in a formal report or a change in ratings.

Appendices – CQC report of actions update and New QIP

CQC Report and Actions – Progress Update

ALERT:

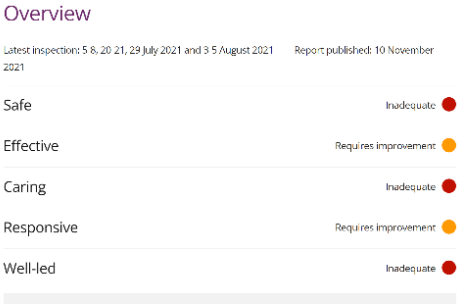
In October the CQC undertook an unannounced responsive inspection of Fairbairn, Allitson and Heygate following whistleblowing concerns being raised about staff sleeping, physical health and management of the deteriorating patient, staffing levels and management of aggression. Whilst this inspection did not result in a formal report or rating we were pleased to receive positive feedback from the visit and that on completion of the inspection they were assured that we were managing the patients and site appropriately. They also acknowledged that whilst staffing remains an issue for the organisation, staff on the wards were able to verbalise the plans implemented to improve the situation. They also appreciated that our oversight and governance processes enabled us to demonstrate appropriate action taken when concerns had been highlighted, specifically the concerns of staff sleeping on duty which we had already identified and HR processes had been implemented.

Following the CQC re-inspected the Women's service in April and the Men's service and the Essex site in June the Women's and Men's service reports have been published.

Women's Service:

The published report for the Women's service notes our overall rating has improved from Inadequate to Requires Improvement. It is also acknowledged that our ratings in the caring domain have improved from Inadequate to Good with improvement also noted in Safe, Responsive, and Well-led domains. The tables below indicates the progress we have made since summer 2021.

July/ August 2021



April/May 2022

In the latest report we received individual rankings for each service as below:

DRAFT SUMMARY April 2022	Safe	Effective	Caring	Responsive	Well Led	Overall
Women's OVERALL	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Acute wards for adults and PICU	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Inadequate	Good	Requires Improvement	Inadequate
Long stay or rehab wards	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
LD or autism wards	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

This in comparison to the previous 2021 ratings:

Jun 2021	Safe	Effective	Caring	Responsive	Well Led	Overall
Women's OVERALL	*Inadequate*	*Requires Improvement*	*Inadequate*	*Requires Improvement*	*Inadequate*	*Inadequate*
Acute wards for adults and PICU	*Requires Improvement*	*Good*	*Good*	*Good*	*Requires Improvement*	*Requires Improvement*
Forensic inpatient or secure wards	*Inadequate*	*Requires Improvement*	*Requires Improvement*	*Good*	*Inadequate*	*Inadequate*
Long stay or rehab wards	*Inadequate*	*Inadequate*	*Inadequate*	*Inadequate*	*Inadequate*	*Inadequate*
LD or autism wards	*Inadequate*	*Requires Improvement*	*Inadequate*	*Requires Improvement*	*Inadequate*	*Inadequate*

A new Quality Improvement Plan has been developed for the Women's service at ward, division and charity level with agreed lines of accountability and assurance. This plan places focus on the response of action submitted to the CQC following the inspection and at Charity level has 19 actions (Appendix 1).

Men's Service

The published report for the Men's service notes significant improvements have been made Caring and Responsive domains moving to Good and the Safe domain improving from inadequate to Requires Improvement with our overall rating Requires Improvement. As part

of their review they have removed the LD and Autism core service line as these wards are currently commissioned under the other core services.

The tables below indicate the progress we have made since summer 2021.

July/ August 2021

June 2022

In the latest report we received individual rankings for each service as below:

June 2022	Safe	Effective	Caring	Responsive	Well Led	Overall
Men's OVERALL	Inadequate	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Acute wards for adults and PICU	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Long stay or rehab wards	Requires Improvement	Good	Good	Good	Good	Good

This in comparison to the previous 2021 ratings:

June 2021	Safe	Effective	Caring	Responsive	Well Led	Overall
Men's OVERALL	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Acute wards for adults and PICU	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Long stay or rehab wards	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
LD or autism wards	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate

The report has been shared with the relevant divisions and functions to agree actions and these will inform the response of actions required by the CQC and any new actions will be added to the Charity QIP (appendix 1).

ADVISE:

Appendix 1 the Charity-wide QIP provides high level detail of the actions being taken with oversight of current progress against them. The detail of the breaches of regulation are noted in the plan for reference. The actions identified from the Men's report will be added to this plan once agreed, as will those for the Essex report once received. The actions will be monitored through the bi-weekly QIP meeting chaired by the Chief Nurse and the monthly Divisional Integrated Quality Performance meetings.

Inspection	Total Number of actions	Action of concern	Action delayed	Not commenced	Action progressing	Action complete	Action embedded
Women's		0	3	1	15	0	0
Men's	Not agreed						
Essex	Report not received						

The East Midlands Health Alliance Quality Improvement Programme, led by our 'buddy trust' Northampton Healthcare Foundation Trust, continues to support the broader improvement work for the Charity that has been identified.

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

ASSURE:

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.

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 have been addressed, we have re-introduced an informal meeting with them to continue to build a positive relationship. This meeting is attended by Jenny Kirkland Director of Nursing. The reports required in these conditions relating to the amount of Section 17 leave taken, incidents occurring on specific wards and enhanced observation compliance with policy continue to be submitted bi-weekly to the CQC. As a result of the inspection reports, discussions have commenced in relation to the removal of the conditions placed on the registration.

Paper for Board of Directors	
Topic	Safer Staffing Report
Date of Meeting	Tuesday, 22 November 2022
Agenda Item	**9**
Author	Chloe Annan – Deputy Director of Nursing for Workforce Safeguards & Patient Experience
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	Yes – September 2022
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	Staff across all divisions are regularly engaged with in order to review Safer Staffing levels on wards and ensure we are having the right clinical conversations. Divisions have helped provide the narrative in the report.
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	

Report Summary and Key Points to Note

This report provides the Board with a Safer Staffing update and provides information on progress with charity wide establishment reviews, CHPPD reporting, and the engagement of the wider MDT in a safer ward environment.

We transferred over to Allocate, from Kronos, mid-September and as such, the last 3 months fill rates have not been provided in this report. Moving forward, the Board will be provided with shift fill rates and will report on Actual Care Hours Per Patient Day (CHPPD) against Planned.

Assurance:

Staff continue to refer to our Safer Staffing Policy and Procedure, which includes a concise staffing escalation plan and action cards should there be challenges. Each division also has a Qualified Contingency Plan, which is regularly reviewed and updated to ensure it accounts for any changes in clinical acuity across the wards. These plans have

helped guide Night Site Co-ordinators in their decision making and helped to mitigate risk associated with insufficient qualified resource. In line with the work in our Operational Staffing Programme Board, our Safer Staffing Policy & Procedure will be fully reviewed in January as scheduled.

A full establishment review across the charity is currently underway. The charity committed to the board that a comprehensive and clinically informed nursing establishment review process would take place yearly. There will also be a mid-year shorter review, and will focus on wards that have had any significant changes in patient group, service type or occupancy. This process involves a triangulated approach, in which the MHOST establishment setting tool is used and triangulated with quality and safety data, and professional judgement. Each ward clinical team is being full engaged in this process and individual ward meetings held. Full reviews have now been completed with Neuropsychiatry and Medium Secure. ASD/LD are currently in progress, and the charity is due to be completed by the end of November.

The Board is asked to:

- Review the current progress on our Safer Staffing approach in line with our policy and procedure.
- Note the work undertaken to date and ongoing work to develop an evidenced approach to decision making, and to ensure compliance with the Developing Workforce Safeguards recommendations.

Appendices -

Safer Staffing Report

The National Quality Boards (NQB) Workforce Safeguards guidance states that providers:

1. Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
2. Must use an approach that reflects current legislation and guidance where it is available.
3. Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively

MHOST (Mental Health Optimum Staffing tool) is just part of our overall Safer Staffing picture, and on its own will not solve our current staffing challenges. The MHOST tool itself provides us with a systematic approach, and one that is evidence based. However, how we deploy staff, our skill mix, and determining our day to day safe working will not be solved with MHOST. We have a significant way to go in terms of changing our culture, behaviours and ways of working to support us in implementing Safer Staffing, and this requires flexibility and openness to new ways of working. Our ability to deploy effectively across our wards, is heavily dependent on our ability to hold the right clinical discussions that are patient centred and based on acuity, and not numbers led.

Establishment Reviews

A baseline nursing establishment review is currently underway as scheduled for the charity. A detailed, comprehensive and clinically informed establishment review process was agreed to and committed to board in January when we launched our new safer staffing approach. This process is in line with the NQB Developing Workforce Safeguards guidance and our own Safer Staffing Policy & Procedure. The MHOST establishment setting tool forms part of this, and is triangulated with quality and safety data for the ward, alongside professional judgement. Wards and their clinical teams are being fully engaged in the process and establishment recommendations made collaboratively.

Reviews for Neuropsychiatry and the Medium Secure division have now been completed, with ASD/LD underway. All divisions across all sites are scheduled to be completed by the end of November. Following which an establishment proposal paper will be submitted.

In the last 2 months, we have rapidly rolled out our MHOST training to our ward senior leaders, in order to be able to facilitate this review and improve the quality of data collected. We now have a number of Clinical Nurse Leaders, Nurse Managers and Heads of Nursing trained in using the tool across all divisions. This training will continue throughout the year to increase our knowledge on this tool.

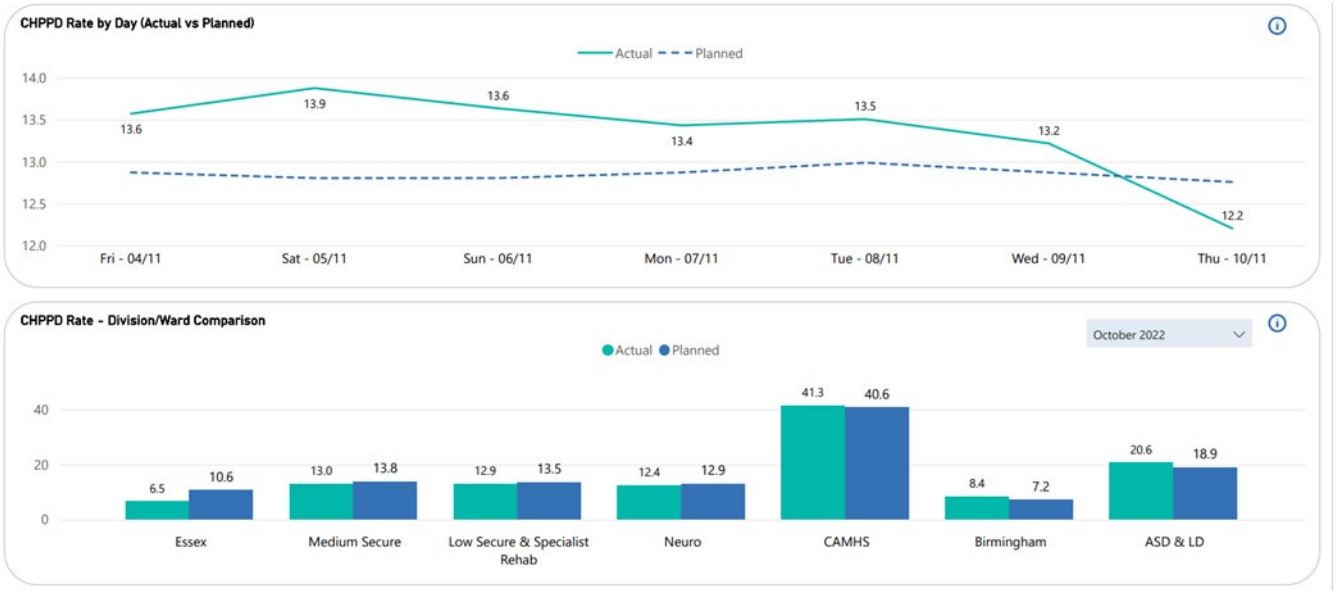
Care Hours Per Patient Day (CHPPD)

The NQB sets a standard for organisations to report in the form of Care Hours Per Patient Day (CHPPD). The care hours per patient day (CHPPD) metric was developed to provide a consistent way of recording and reporting deployment of nursing staff providing care in inpatient ward settings. The metric was designed initially for acute hospitals but has since been tested and adapted for use in mental health and community inpatient wards.

CHPPD data gives nurse managers, nurse leaders and hospital chiefs a picture of how staff are deployed and how productively. They can compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. CHPPD figures can be added together for groups of wards or for an entire hospital to make further comparisons.

The charity has now developed the capability to report on our Actual CHPPD vs Planned. This will allow us to effectively benchmark against other organisations, and provide greater insight into the care hours being achieved at both ward and divisional level. Below are some examples of how this will be presented in future reports. We are also able to provide shift level detail, reporting CHPPD figures of both Q, HCA and totals.

	Fri - 04/11			Sat - 05/11			Sun - 06/11			Mon - 07/11			Tue - 08/11			Wed - 09/11			Thu - 10/11		
	Actual	Planned	Var	Actual	Planned	Var	Actual	Planned	Var	Actual	Planned	Var	Actual	Planned	Var	Actual	Planned	Var	Actual	Planned	Var
Northampton	**13.3**	**12.3**	**1.0**	**13.4**	**12.2**	**1.2**	**13.2**	**12.2**	**1.0**	**13.0**	**12.3**	**0.7**	**13.2**	**12.4**	**0.8**	**12.8**	**12.3**	**0.5**	**11.8**	**12.2**	**-0.4**
Neuro	**13.3**	**12.3**	**1.0**	**13.4**	**12.2**	**1.2**	**13.2**	**12.2**	**1.0**	**13.0**	**12.3**	**0.7**	**13.2**	**12.4**	**0.8**	**12.8**	**12.3**	**0.5**	**11.8**	**12.2**	**-0.4**
NPS Allitsen	**12.2**	**9.2**	**3.0**	**12.4**	**9.2**	**3.2**	**11.9**	**9.2**	**2.7**	**12.5**	**9.2**	**3.3**	**12.4**	**9.2**	**3.2**	**13.1**	**9.2**	**3.9**	**10.8**	**9.2**	**1.6**
Q-RN	0.8	2.3	-1.5	1.6	2.3	-0.7	2.1	2.3	-0.2	2.3	2.3	0.0	2.4	2.3	0.1	2.3	2.3	0.0	1.5	2.3	-0.8
U-RN	11.4	6.9	4.5	10.8	6.9	3.9	9.9	6.9	2.9	10.3	6.9	3.3	10.0	6.9	3.1	10.8	6.9	3.9	9.3	6.9	2.3
NPS Aspen	**17.1**	**19.7**	**-2.6**	**17.9**	**19.7**	**-1.8**	**18.9**	**19.7**	**-0.8**	**17.4**	**19.7**	**-2.3**	**23.9**	**23.7**	**0.3**	**19.4**	**23.7**	**-4.3**	**19.4**	**23.7**	**-4.3**
Q-RN	5.4	5.4	0.0	3.6	5.4	-1.8	5.4	5.4	0.0	5.4	5.4	0.0	4.3	6.5	-2.2	4.3	6.5	-2.2	4.3	6.5	-2.2
U-RN	11.8	14.3	-2.6	14.3	14.3	0.0	13.6	14.3	-0.8	12.0	14.3	-2.3	19.6	17.2	2.4	15.1	17.2	-2.1	15.1	17.2	-2.1
NPS Cherry	**14.2**	**14.6**	**-0.5**	**16.3**	**14.6**	**1.6**	**16.1**	**14.6**	**1.4**	**15.5**	**14.6**	**0.9**	**13.8**	**14.6**	**-0.8**	**13.6**	**14.6**	**-1.1**	**9.0**	**13.0**	**-4.0**
Q-RN	3.9	4.0	-0.2	4.0	4.0	0.0	4.0	4.0	0.0	3.8	4.0	-0.2	5.0	4.0	1.0	4.8	4.0	0.7	2.4	3.6	-1.2
U-RN	10.3	10.6	-0.3	12.3	10.6	1.6	12.0	10.6	1.4	11.8	10.6	1.1	8.8	10.6	-1.8	8.8	10.6	-1.8	6.6	9.4	-2.8
NPS Elgar	**14.1**	**13.4**	**0.7**	**13.4**	**13.4**	**-0.1**	**13.6**	**13.4**	**0.2**	**13.4**	**13.4**	**0.0**	**11.6**	**13.4**	**-1.8**	**13.7**	**13.4**	**0.3**	**12.5**	**13.4**	**-1.0**
Q-RN	2.9	3.0	-0.1	3.2	3.0	0.1	2.7	3.0	-0.3	2.8	3.0	-0.3	3.6	3.0	0.5	2.9	3.0	-0.1	2.7	3.0	-0.4
U-RN	11.2	10.4	0.8	10.2	10.4	-0.2	10.9	10.4	0.5	10.7	10.4	0.3	8.1	10.4	-2.3	10.8	10.4	0.4	9.8	10.4	-0.6
NPS Elm	**13.9**	**12.9**	**0.9**	**13.1**	**12.9**	**0.2**	**12.9**	**12.9**	**0.0**	**11.9**	**12.9**	**-1.0**	**12.6**	**12.9**	**-0.3**	**11.8**	**12.9**	**-1.1**	**11.8**	**12.9**	**-1.1**
Q-RN	3.1	3.7	-0.6	2.8	3.7	-0.9	3.2	3.7	-0.4	3.4	3.7	-0.2	3.4	3.7	-0.3	2.2	3.7	-1.5	2.2	3.7	-1.5
U-RN	10.8	9.2	1.5	10.3	9.2	1.1	9.7	9.2	0.4	8.5	9.2	-0.8	9.2	9.2	0.0	9.7	9.2	0.4	9.7	9.2	0.4
NPS Fenwick	**14.3**	**14.0**	**0.3**	**14.0**	**14.0**	**0.0**	**15.0**	**14.0**	**1.0**	**12.3**	**14.0**	**-1.7**	**12.9**	**14.0**	**-1.1**	**13.9**	**14.0**	**-0.1**	**14.3**	**14.0**	**0.3**
Q-RN	3.2	3.2	0.0	3.2	3.2	0.0	3.2	3.2	0.0	3.2	3.2	0.0	3.2	3.2	0.0	3.2	3.2	0.0	3.2	3.2	0.0
U-RN	11.1	10.8	0.3	10.8	10.8	0.0	11.8	10.8	1.0	9.0	10.8	-1.7	9.6	10.8	-1.1	10.7	10.8	-0.1	11.0	10.8	0.3



Wider Multi-disciplinary team (MDT)

As part of our Operational Staffing Programme Board, and in parallel with our nursing establishment reviews, we are also working with our other disciplines to enhance visibility on our wards. We know that a safely staffed environment is more than simply the number of nursing staff we have on duty. Other disciplines such as Occupational Therapists, Psychologists and Social Workers also contribute to both staff and patients feeling safe.

Divisions are working with their ward teams to establish and embed therapeutic timetables that provide clear sight of what sessions are being provided and when. This will help directly inform how we schedule our nursing staff across a 24 hour period. We are also working with our rostering team to get some of these timetabled sessions and patient facing input visible on Allocate & our Safecare system.

Proposal

- The Deputy Director of Nursing (*for Workforce Safeguards)* will continue to support the established Developing Workforce Safeguards work to provide assurance of safe staffing across the Charity.
- A full establishment review, triangulating the MHOST tool results with quality and safety data, is scheduled to be completed by the end of November 22. This will ensure nursing establishments are set based on current acuity, occupancy, and ES levels.
- A full staffing compliance review – reviewing our current processes, policies & practices, has been completed independently. An action plan will be formulated and presented to the next Board alongside the new nursing establishment proposal paper.
- A full review of our Safer Staffing policy & Procedure will be completed in January 23, in line with the completed work as part of our first establishment review, and Operational Staffing Programme Board.

Paper for Board of Directors

Topic	National Response to Panorama and mental health in patient services
Date of Meeting	Tuesday, 22 November 2022
Agenda Item	**10**
Author	Dr A Roychowdhury
Responsible Executive	Vivienne McVey
Discussed at Previous Board Meeting	Not previously discussed
Patient and Carer Involvement	How the patient and carer voice is supported to be heard is a key aim of our response
Staff Involvement	Discussed with clinical, nursing, ops and at Exec
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	Progress will be reported to QSC

Report Summary and Key Points to Note

The slides set out St Andrew's response to the National MH Director and local Provider Collaboratives who wrote to all providers, in the wake of the Panorama programme showing institutional abuse at the Edenfield Centre, an NHS secure unit, asking for a review of key structures and processes that support the prevention, identification and eradication of similar issues happening here

Appendix A is the full letter of response

The slides then set out our commitment and proposed process to better identify and support wards of concern, whilst also strengthening governance so that fewer wards will need to use this process over time. Members will note that it is proposed that this will be overseen by the Quality and Safety Committee.

Appendices – Appendix A – StAH response

Responding To Panorama Creating a process to support wards of concern

Context and Our Response so Far

- Following a BBC Panorama programme showing abuse of patients at the Edenfield Centre (secure, NHS), Claire Murdoch, the National MH Director, wrote to providers asking for them to review a number of areas that provided assurance that similar events were not occurring elsewhere, as did local PC's
- We have responded in a letter from the CEO (Appendix A) that outlined our current processes and areas for development in the following areas:
- Freedom to Speak Up and Advocacy
- Learning from CETR
- Peer Review
- Restrictive Practices
- We also committed to developing a robust process for identifying and supporting wards of concern, on the premise that it would take constant vigilance to ensure similar events were not and will not take place here.
- We plan a series of workshops from senior leaders to staff on the nature, content and implications of the Panorama programme

St Andrew's HEALTHCARE

Our Approach

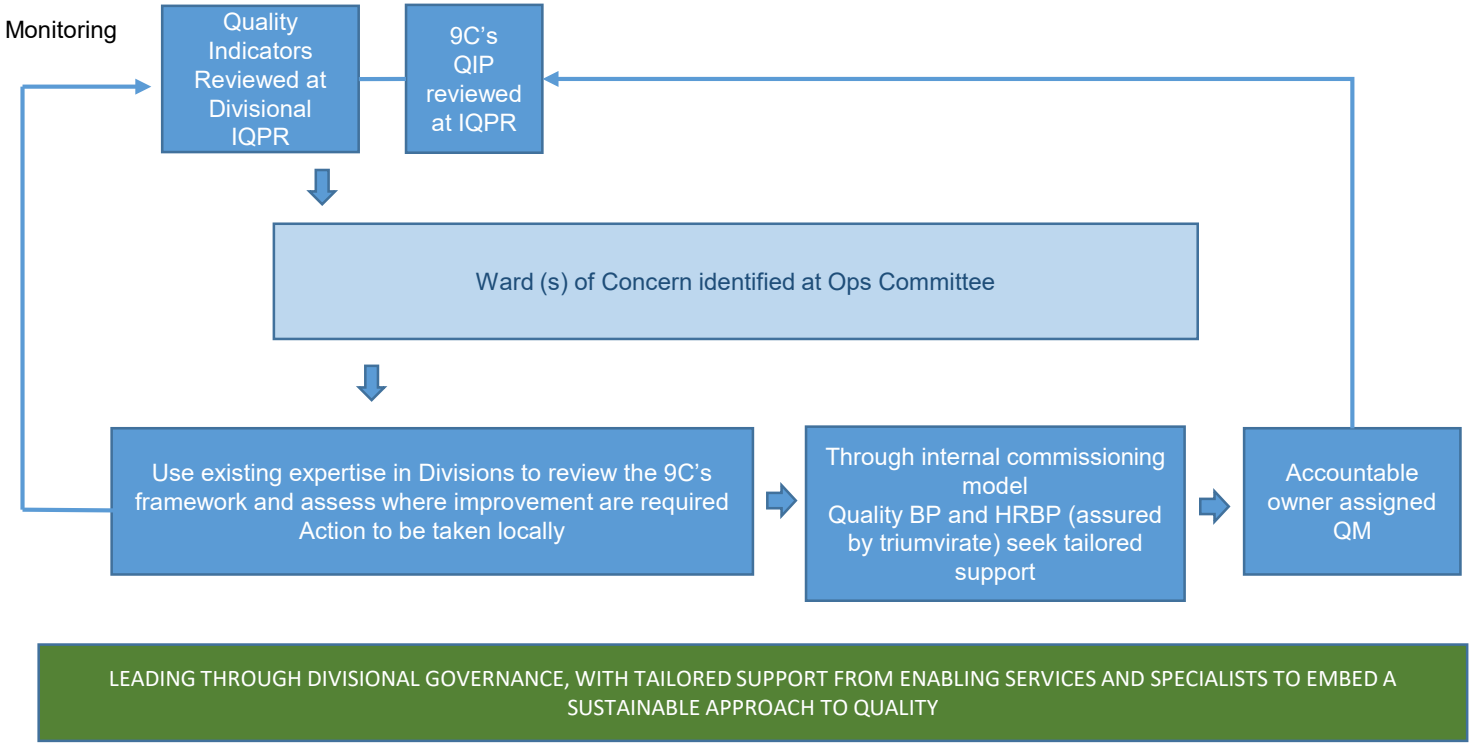
Creating a live ‘hotspot tool’ that will show a heatmap pinpointing wards of concern – can be reviewed daily, weekly and monthly and triangulated at the new Operations Committee

Tool will RAG rate acuity; patient and staff voice (FTSU, complaints, advocacy, safecalls), demand and key leadership vacancies (ward manager, RC)

Adapt the successful 6 C’s programme which underpinned the improvements in Women’s services into the 9 C’s programme: addition of Culture and Care Values, Collaborative Team Working and Continuous Improvement

To use this as a framework for diagnosing the issues in wards of concern and offering a central menu of support interventions in each area, that could be assured through Operations Committee and the Integrated Quality and Performance Meetings with divisions

Ward of Concern Process



Implementing the ‘wards of concern’ process

- Weekly- identified locally via huddles and central review of ‘hotspot tool’
- Monthly: escalated via the Divisional QPR and validated at the Ops Committee.
- The Ops Committee will focus resources on the main wards of concern taking a holistic view of the Charity
- The Quality BP or QM (or other local owner) to review the assessment of need and work with the HRBP to ‘commission internal support required for that ward
- Update intranet site with tools to support and utilise Train the Trainer when applicable
- A structured approach – 9 C’s- allows the accumulation of useful resources as well as the standardisation of approach and learning across the Charity
- *This process will be part of the new quality governance structure ensuring a prospective response is in place.*

CONCLUSIONS

- Existing process to identify and escalate concerns from ward level to be strengthened by a live heat-map tool to be reviewed weekly and monthly by both divisions and central teams
- Tool v1 planned to be ready for Nov Ops Committee meeting
- The 9C's to act as both a diagnostic and improvement framework
- Central support from the quality and L & D team to lead until divisional structures are bolstered, allowing divisional QM's to lead on the action plan co-ordination
- The IQPR to be the vehicle of monitoring action plan progress whilst the Ops Committee prioritises resources taking the Charity perspective into account.
- Update on progress to be given to QSC in January 2023

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2 November 2022

Simon Harris
Director of New Care Models
East Midlands Collaborative for CAMHS & AED
St Mary's Hospital
London Road
Kettering
Northamptonshire NN15 7PW

Dear Simon

Re: St Andrew's Response to the letter from Claire Murdoch, National MH Director, related to the Panorama programme

Thank you for your letter dated October 18th. In the wake of the abuse of patients that occurred in an in-patient service from another provider, the Charity immediately reflected on our governance processes used to prevent, identify and act on any concern of a similar serious nature. This work has been supported by the significant improvement programme currently in progress with support from our partners that has been in place for the past 12 months. A key focus of this improvement programme is that we are working hard to create an open and psychologically safe culture where anyone is able to raise concerns and will be heard. We are pleased that in recent CQC reviews they have acknowledged the improvements we have made, recognising of course, that we need to build upon these as part of our commitment to quality and continuous improvement.

As a result of the Panorama programme and the serious concerns raised providers have been asked to undertake a set of assurance activities premised on the principle that the shocking culture and behaviours seen could be happening elsewhere.

As a result we have undertaken a review and will be reporting this to our Board in November to provide assurance against the specific issues identified and actions implemented to address the areas highlighted to strengthen our approach. Furthermore the concerns identified in Panorama have been discussed at the Executive meeting with a number of key actions identified.

Freedom to Speak Up Arrangements:

Current position

We have a number of routes in addition to the traditional escalation through line managers to enable individuals to raise concerns;

- A network of Freedom to Speak Up Champions across the Charity with a Lead Guardian in post who speaks directly to the CEO and provides a report to the Board via the Quality and Safety Committee.
- SafeCall, which is an external, confidential whistleblowing provider who are available 24 hours a day seven days a week and enable individuals to speak up and report their concerns to the highest levels of management.
- A variety of staff surveys occur with reports feeding into local and organisational governance structures these include Your Voice, and a recent Culture Survey with further surveys in plan.

Development

- Strengthen the feedback processes to those raising concerns and issues directly.
- Review the oversight and inter-relationship with SafeCall and Freedom To Speak Up through the redesigned governance structures
- Increasing frontline operational capacity and competency to ensure greater visibility and support to frontline staff

Advocacy:

Current position

- Independent Advocacy provider within the Charity who immediately escalates concerns to local wards and senior leaders within the Charity.
- Report from Advocacy provider through agreed governance routes including Children and Adults Safeguarding group and Birmingham, Essex and Northampton Experience group (BENS).
- Review opportunity for Peer Support Workers to act as conduit for Advocacy. (Peer Support Worker (PSW) is a staff member, who is specifically hired and trained to use their personal experiences of recovery from mental health distress to support the recovery of others.)

Development

- Review the structure and governance of process and outputs from Advocacy service

Complaints and Listening to Patient and Carer Feedback:

Current position

- Complaints team in place with reporting on key themes and issues through agreed governance routes.
- Family Liaison Officer in post to support engagement and feedback to patients, service users and carers.
- Peer support workers and Advocates visible on wards.

Development

- Explore training provision to support staff in managing concerns and complaints
- Embed new quality governance system to support the triangulation of data and assurance processes
- Strengthen reporting and monitoring of actions identified across whole Charity
- To explore opportunities to strengthen the patient experience feedback systems at ward level with Peer Support Workers and volunteers

CETRs and ICETRs:

Current position

- Ward led with oversight at Divisional level through governance processes.
- Central oversight and direct liaison with CQC in relation to ICETRs occurring within Charity

Development

- Embed new quality governance system to support the oversight and monitoring of actions.

Other feedback:

Current position

- Central oversight of feedback provided by external partners and agencies enabling triangulation and identification of themes and areas of concern
- Expert by experience feedback via ward community meetings and our Charity Patient Experience Meeting
- Governor feedback on complaints and patient experience
- 15 Steps visits by Executives and Non Executives.

Development

- Embed a new quality management system and quality strategy approach to include triangulation of all sources of feedback. This is nearing completion and, subject to Board approval, will be implemented in early 2023.

Peer Review:

Current position

- Peer support workers within Charity supporting patients and wards directly and in provision of training as part of our Recovery College & Every Day Skills (REDS) team.
- Active participants in Quality Networks and a number of Provider Collaboratives and have been engaging partners from these to support and provide a critical friend eye to areas of improvement.

Development

- Review and strengthen the feedback mechanisms for peer support workers
- Create an informal peer review structure with other local providers to facilitate critical friend reviews with a focus on wards of concern.

Restrictive Practices:

Current position

- Policy and processes around seclusion and segregation in place.
- Agreed processes for oversight and assurance with external partners for those in enhanced support and long term segregation.
- Reducing Restrictive Practices Group as a sub group of the Quality and Safety Committee.

Development

- Review current policy and processes around seclusion and LTS
- Review the input of Advocacy in seclusion and LTS
- Strengthen the reporting of real time data currently presented on ward dashboards and monitored through governance processes.
- Strengthen oversight process for actions following independent and external review through new quality governance system
- Audit practice

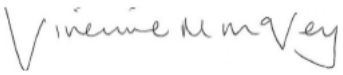
As previously discussed a quality improvement programme for the St Andrews Charity is in progress and there is ongoing work in relation to the monitoring, oversight and improvement of meaningful activity. There is a review of training including the induction program being undertaken at the moment and the outcome of this will inform actions to be

taken forward to ensure that the content and delivery meets the needs of our patients and staff. The review will also consider methods to increase the provision of co-produced and delivered training to ensure that the patient voce remains central to all that we do.

In addition to the actions outlined above we are undertaking a series of steps to identify if any of our services may benefit from an intensive improvement offer. We recognise that all the actions must be underpinned by clear visible, authentic and compassionate leadership. This will include routine service visits by the executive team to our wards so we can listen to our patients and our fellow colleagues and ensure we seek to continuously improve the experience for all.

I hope the contents of this letter assures you that we take the findings of the Panorama programme very seriously. We are absolutely committed to improving the quality of care at St Andrews and this assurance process has given us a further opportunity to maximise the learning from what happened at the Edenfield centre.

Yours sincerely



Dr Vivienne McVey
Chief Executive Officer