CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Thursday 28th September 2023 at 9.30 am

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

		Purpose	LEAD		Page No.	Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*09.30*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*4*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 21 July 2023	Decision	Paul Burstow	✓	*5-12*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*13-17*	*09.35*
Chair's Update						
5.	Chair Update	Information	Paul Burstow		*18*	*09.40*
Executive Update						
6.	CEO Report	Information	Dr Vivienne McVey	✓	*19-38*	*09.45*
Committee Assurance Reports						
7.	**Committee Updates**				*39-45*	*10.05*
	• People Committee (18/07) – formal report	Assurance	Steve Shrubb	✓		
	• Research Committee (02/08)	Assurance	Prof Stan Newman	✓		
	• Quality & Safety Committee (22/08 &12/09), incorporating: ○ Annual Safeguarding Report ○ Responsible Officer & Re-validation Report	Assurance & Decision	Steve Shrubb	✓		
	• Audit & Risk Committee (26/09) – Annual Report update	Assurance	Rupert Perry	Verbal		
Quality						
8.	CQC Inspection, Report and Actions Update	Assurance	Dr Ash Roychowdhury	✓	*46-53*	*10.25*
9.	Safer Staffing Report	Information & Assurance	Dawn Chamberlain	✓	*54-63*	*10.40*
Operations						
10.	Integrated Quality & Performance Report, incorporating: • Quality Scorecard • People Scorecard • Finance Overview	Assurance	Anna Williams, Dawn Chamberlain, Kevin Mulhearn & Sanjith Kamath	✓	*64-79*	*10.50*

	• Occupancy • IT Security Overview					
Break 11.20 am to 11.25 am						
Service and Patient Story						
11.	Social Work update – a patient's perspective (co-produced with Patients and Carers)	Information	Dawn Chamberlain & Ellie Johnston (and patient)	✓	*80*	*11.25*
Any Other Business						
12.	Questions from the Public	Information	Paul Burstow		*81*	*11.55*
13.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*82*	
14.	What would our patients and staff think about our discussions today?	Information	Paul Burstow		*83*	
15.	Date of Next Meeting: Thursday 30th November 2023	Information	Paul Burstow		*84*	
Meeting in Public Closes at 12.00noon						

Annexes - Items for information only	**Lead**		
Annex A – Research Update Appendices: ○ Physical Health Research Stream proposal ○ Clinical Secondments paper ○ Staff Head Injuries paper	Prof Stan Newman	✓ ✓ ✓	*85-94*
Annex B – QSC Update Appendices: ○ Annual Safeguarding Report ○ Responsible Officer & Re-validation Report	Steve Shrubb	✓ ✓	*95-123*

Welcome & Apologies

(Paul Burstow– Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 21 July 2023

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

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

Friday 21st July 2023 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Steve Shrubb (SS)	Non-Executive Director
Rupert Perry (RP)	Non-Executive Director
Dawn Brodrick (DB)	Non-Executive Director
Vivienne McVey (VMc)	Chief Executive Officer
Kevin Mulhearn (KM)	Chief Finance Officer
Dawn Chamberlain (DC)	Chief Operating Officer
In Attendance:	
Anna Williams (AW)	Director of Performance
Alex Trigg (AT)	Director of Estates & Facilities
Simon Callow (SC)	Director of IT
Stacey Carter (StC)	Deputy Director HR Operations
Ash Roychowdhury (AR)	Deputy Medical Director
Duncan Long (DL)	Company Secretary
Leanne Clements (LCl) item 11	Head of Allied Health Professionals
Melanie Duncan (MD) Minutes	Board Secretary
Apologies Received:	
Andrew Lee (AL)	Non-Executive Director
Karen Turner (KT)	Non-Executive Director
Oliver Mackaness (OM)	Lead Governor
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Managing Director, ERT
Lara Conway (LC)	Deputy Director of Workforce Planning

Agenda Item No		Owner	Deadline
1.	**Welcome and Apologies** 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 Andrew Lee, Karen Turner, Sanjith Kamath, Martin Kersey, Lara Conway and Oliver Mackaness were noted.		
ADMINISTRATION			
2.	**Declarations Of Interest** 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 from the Board Of Directors Meeting, Held in Public, on 18 May 2023** The minutes of the meeting held on the 18 May 2023 were **AGREED** as an accurate reflection of the discussion and decisions taken.	**DECISION**	
4.	**Action Log & Matters Arising** It was agreed to **CLOSE** the following actions: • **26.07.22 06** BAF Finance Risk • **22.11.22 02** ARC Update – Functional Resilience • **24.01.23 01** Strategic Risks and Board risk appetite • **24.01.23 02** ARC programme of assurance activity • **31.03.23 02** CEO Report – Call Bells • **31.03.34 03** ARC Update – Health and Safety Reports • **18.05.23 02** DBT Presentation – One day workshop All other actions on the log remained open, either in line with the agreed target dates or to return at a future Board following further review.	**DECISION**	
CHAIR'S UPDATE			
5.	**Chair Update** PB gave a verbal update, highlighting a recent meeting he had attended with the regulator regarding the single assessment process. It was noted from the meeting that in the future, one third of the assessment would focus on co-production and experience. PB noted that consideration would be required as to how the Charity could demonstrate this, as it would signify a challenge for many organisations. PB further added that there was a focus on equality and intersectionality by the regulator which would require consideration, and would impact tertiary suppliers in particular, with an awareness of least restrictive practices to be considered. SS commented on the Government Rapid Review paper and enquiry that had recently been published, noting the correlations with the user environment, and suggested that this be a topic for Board development to gain a clear view of what was required. DL highlighted the areas of the review which were specific to the Board for implementation and noted that all recommendations within the review were to be implemented within 12 months. DL agreed to progress this session for the Board. The Board **NOTED** the update.	**DL**	**28.09.23**
EXECUTIVE UPDATE			
6.	**CEO Report** VMc presented her report, which was taken as read, and noted the input from the Charity and references to St Andrew's Performance Reporting within the Rapid Review paper. VMc thanked the teams involved for their work on this. VMc highlighted the progression of the Lead the Change programme, noting that the final workshop had taken place. There would now be three Champion roles which would cover communications, innovation and culture. As a result, the programme was being embedded and forming part of the Thrive initiative. Thrive was progressing well, with Quality Matrons and General Managers receiving inductions, and the quality of the appointments of particular note. VMc commented that they represented a strong group which would be central to moving the work forward. VMc highlighted that the snapshot survey had received a good response rate of 52% from permanent staff and 48% from bank staff with good scores across the board, given the current changes being implemented. BAME engagement was particularly high with 78% noted. Essex also returned		

	excellent scores, whilst the enabling functions scores mirrored the changes taking place. A full staff survey would be initiated in Autumn. VMc reported a busy second phase of the Thrive programme and noted the recently received CQC report on Essex which indicated good improvements. VMc wished to note the excellent work done by the Essex team. SS offered congratulations on the staff snapshot, noting that the results received were excellent, especially considering the recent changes within the Charity. SS noted that honest communications were helping with the process. SN enquired if there had been an impact within the Charity because of the junior doctor's strike action. VMc replied that there had been no impact on the Charity involving staff locally, however, the impact had been felt where patients had been required to attend hospital. SN also wished to update the Board regarding the collaborative study being undertaken with MeOmics and Cardiff University where partnerships and providing equity may be a consideration and noted that the Board should stay aware of this possibility. KM acknowledged that discussions had taken place on this. PB suggested that the Research Committee should continue to monitor this project to ensure the full value from the partnership and that future ERT updates include updates on all research partnerships, clearly outlining the approach by the Charity to ensure full value is received. SN noted that each partnership would require full scrutiny as different approaches would be followed. RB commented that the inclusive approach to cultural change had helped with the quality of engagement and confidence, evident in the scores observed from the snapshot survey. The Board **NOTED** the update.	**KM**	**28.09.23**
COMMITTEE ASSURANCE REPORTS			
7.	**People Committee** DB presented a written update from the May committee meeting, along with a verbal update from the most recent Committee meeting held on 18 July. DB highlighted that the Committee had looked at the feedback from the snapshot survey and acknowledged the scores attained. The Committee had also considered the long term workforce plan and challenges in light of the Thrive programme, and assured the Board that a vacancy rate had now been implemented and was being reported. Upcoming committee meetings would consider a deep dive into employee relations, targeted areas for pay and internal disproportionality. SN enquired about the level of mandatory training, asking if 89% was indicative of full training, both via eLearning and face-to-face. DC explained that the figure was a combination of both face-to-face and online training, with the face to face rate requiring further improvement, and this would be done with involvement from L&D. The Board were asked to consider for approval: • The Modern Slavery Statement • Terms of Reference for the People Committee. The Board **APPROVED** the Modern Slavery Statement and the revised Terms of Reference for the Committee (subject to the updating of several roles recorded within the membership) and **NOTED** the report and verbal update. **Quality & Safety Committee** SS presented the update from the Committee which was taken as read, and noted that the Committee had conducted a review of Safeguarding and	**DECISION**	

	considered the resultant data. SS recommended that the Board consider holding a seminar on Safeguarding responsibilities from its perspective. SS noted that significant progress had been made on safer staffing which would accelerate with the commencement of the new shift patterns. Night staffing was also considered, with a focus on those wards experiencing difficulties. The Committee had received a presentation on the new HeatMap, which gave the committee assurance over the effectiveness of the approach being taken operationally. The Board were asked to consider for approval the following documents: • Infection Prevention and Control Annual Report • Complaints and Compliments Annual Report • Mortality Surveillance Annual Report (Learning from Deaths) • Terms of Reference for the Committee SN inquired if the Learning from Deaths Report would receive further focus from the QSC. SS confirmed that the QSC had added more detailed reviews of reports from the Mortality Surveillance Group to forthcoming agendas. The Board **APPROVED** the four documents highlighted and **NOTED** the report. **Audit and Risk Committee** RP gave the Committee update and noted the committee's concern regarding resourcing of Internal Audit and Risk, however, the committee was assured that the reduction in resource was acceptable as it was seen as an appropriate level by the external auditors. RP added that the new Integrated Assurance Framework (IAF) would have an impact on the 1st and 2nd lines of assurance and that complying with policies and procedures would help with overall compliance. The Committee agreed that resourcing would be revisited at the end of the current reporting year, considering that less clinical audit work would be undertaken by the function as this was being picked up by the Quality and Clinical Audit teams. RB noted the report from the Medicines Management audit and indicated concern at the findings. VMc agreed with RB, and added that work was ongoing to address the recommendations, however, focus had moved in order to progress the improvements via the quality route. DL added that Medicines Management is one of the first areas being looked at as part of the IAF, RP concurred, adding that associated clinical risks would be considered by QSC. The Board were asked to consider for approval: • The six new Strategic Risks • SIRO and Caldicott Guardian Annual Report • Counter Fraud Functional Standards Return The Board **APPROVED** the new six Strategic Risks, the SIRO and Caldicott Guardian Annual Report and the Counter Fraud Functional Standards Return and **NOTED** the report.	**DECISION** **DECISION**	
QUALITY			
8.	**CQC Inspection, Report and Actions Update** AR presented the update which was taken as read and gave highlights from the report which included an update on the current status of CQC inspection ratings for the Charity's services, along with an update on the actions within the Charity QIP, including those items subject to CQI which could be closed once the findings were implemented, and those actions being progressed by the Divisions.		

	AR gave an update on the internal inspection process, noting that 5 had been completed out of 6 planned. The process involved a wide team including representatives from many functions, with Quality Matrons and General Managers also now involved, with a ratings model being used to focus on improvement. Items from the buddying workstreams continued to be addressed, including fundamentals of care, with a refreshed QIP to be presented to Quality Safety Committee in August. SN offered congratulations on the progress made and suggested that the mock inspection approach would be helpful to the LDA areas prior to any CQC inspections. AR agreed and outlined what had been already planned in this area, including the areas identified for improvement within LDA based upon the division's QIP, adding that a thematic view would be taken. PB noted that in the future, the Charity's quality processes would be even more important with the focus on assurance and that the internally driven quality agenda should improve the Quality Account review and approval process. The Board **NOTED** the report.		
9.	**Safer Staffing Report** DC presented the report which was taken as read, noting that it was a similar paper that had been discussed at QSC during the June meeting, but now included day and night shift comparisons. Good progress was being made, however, there was a challenge regarding quality staffing on both days and nights. Overstaffing was being reduced, and LDA was receiving support on this, including enhanced observations. DC also noted the positive impact of including TIs and Assistant Psychologists into the care hours, along with the additional capacity that Quality Matrons and General Managers have added. RB commented that this was encouraging progress, on appointments, staff cover and how the information was presented and thanked the teams involved. The Board **NOTED** the report		
OPERATIONS			
10.	**Integrated Quality & Performance Report** AW presented the report, which was taken as read, highlighting the tangible improvements being seen and several positive trajectories. Strong patient feedback had been received, with three quarters of patients who responded rating their experience as good or very good. We are also seeing strengthened staff engagement, observed through improved sickness levels. Quality tools are being embedded, however, the Divisions are at differing stages of the process. Positive progress is being seen relating to discharges, with 5 of the 33 delayed discharges now completed. AW summarised by confirming the Charity continued to see an improving picture as the Thrive programme is implemented and that we are taking staff along with us through the changes. <u>Quality</u> The report was taken as read. <u>People</u> The report was taken as read. <u>Finance</u> KM presented the Finance Overview which was taken as read.		

	IT The report was taken as read. SN enquired about discharge rates and asked how many patients could not be discharged due to requiring more care or differing care. AR explained the categorisations and that long stay patients would be looked at separately. SN then asked if the Opex and Capex figures were as expected. KM replied that they were, with Phase 1 of Thrive £200k better than plan. SN asked if the following year's financial pressures would be larger, with KM replying that this was not expected, as costs were not recurrent. In response to the costs of beds, KM replied noting that flexing of staffing costs had an impact. RB asked what the main reasons were for unoccupied beds. KM noted the occupancy figures and what was impacting them, including the proactive decision to reduce occupancy within CAMHS to ensure quality, and the impact of the Essex CQC inspection. VMc added that building and maintaining occupancy was difficult and there were many activities being balanced to manage the levels required. More work was being done by SK to develop model to assist in sustaining the occupancy taking into consideration the multiple balancing factors involved. RB also wanted to know how managers were being encouraged to follow policy on staffing and adhere to the new processes. DC replied that it was a complex picture with commissioning requirements, enhanced observations, and packages of care all being contributory factors, along with addressing the historic issue of wards scheduling unnecessary additional shifts. The new QMs and GMs provide greater capacity to manage these issues and ensure ward staff work within the processes. Work was continuing with the development of the new algorithm that would take into account all these factors and ensure the scheduling was as automated as possible. RB asked about the impact of this within LDA. DC noted that as the largest division, there had been historic capacity issues which were now being addressed. Capability was not an issue and morale had increased with sickness reduced, however challenges had been observed with regard to levels of acuity. AR clarified that a cohort of delayed discharges within the division were being looked at weekly, with support to wards that required it. SN wanted to note that the quality of data provided to the Board was excellent and wanted to thank the teams involved. RP noted that bed and occupancy projections affected budgeting, and wanted further assurance on how this was being addressed, asking if budgets should be lowered in order to address this, noting Essex LDA as an example. DC agreed with the observation on the impact of occupancy, along with the impact of staffing. KM confirmed that Essex had been primarily impacted by reduced occupancy levels, with LDA impacted by a combination of occupancy and staffing, KM added a contingency had been built in to accommodate the fluctuation in occupancy. PB noted the good progress being made regarding the proportion of Non-Patient Facing time, and asked if there was any materiality to the figures if Community Services had not been included. KM replied that Community Services would be reported separately in the future to give greater clarity. The Board **NOTED** the reports.		

SERVICE & PATIENT STORY			
11.	**Occupational Therapy** DC introduced the presentation, along with introducing Leanne Clements and Malcolm, noting the value of Occupational Therapy and the meaningful activity undertaken as a result. LCl and Malcolm then presented, covering OT structure, what OT's do, the top 5 accountabilities for OTs, treatment pathways and meaningful activity. With Malcom highlighting a number of examples of activities undertaken recently. Board members asked questions of both LCl and Malcolm regarding the activities undertaken. Malcolm outlined how he enjoyed bee-keeping, art, music and physical activities as a way of aiding concentration, keeping busy and giving a change of surroundings. Malcolm was asked what could be done to improve meaningful activity. He replied that having more Occupational Therapists on the wards would help a great deal. DC noted that in the future there would be a better balance of professions on the wards. LCl also noted that community based occupational therapy was currently being considered. AR added that the new model of care would give opportunity for more Occupational Therapy input and involvement. Data would also be collated which would indicate the value of the meaningful activity undertaken. PB thanked Malcolm on behalf of the Board and wished him well with his recovery and activities. Malcolm had written a statement for the Board and it was agreed that this would be distributed on his behalf after the meeting.	**DL**	**28.09.23**
ANY OTHER BUSINESS			
12.	**Questions from the Public for the Board** No questions were received for the Board.		
13.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** No items were received for the Board.		
14.	**What would our Patients and Staff think about Our Discussions Today?** PB reflected that discussions had centred on interest in people and quality, with a shift within the Charity to being self-directing regarding quality improvement. With the work being done bringing the dashboards to life, and as a result. the Charity was an organisation which was striving to be a learning organisation.		
15.	**Date of Next Meeting:** Board of Directors, Meeting in Public – Thursday 28th September 2023		

Approved – 28 September 2023

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
24.01.23 **06**	**Mental Health Bill – Therapeutic outcomes** SK agreed to report to QSC on therapeutic outcomes and the percentage of compliance, along with suitable metrics. Note: Next QSC 25 April 2023	SK	18.05.23	Open	**18.05.23 -** The aggregated clinical outcomes and meaningful therapeutic activity dashboards are still being tested in some divisions. An update will be provided when this is complete and fully implemented **28.09.23 –** The meaningful activity module in Rio is now active and all divisions are using this and uptake of usage is increasing. The meaningful activity procedure has been agreed and is being implemented including documented timetabling of activities on all wards. This will move into performance management via the IQPR process in November.
31.03.23 **01**	**Chair Update - CAMHS** DC to provide a paper on Sitwell Ward within CAMHS to Board (via QSC) at a future meeting.	DC	~~28.09.23~~ 30.11.23	Open	**21.07.23 –** Remains open and CAMHS update due at September Board **28.09.23 –** Deferred to November Board
31.03.23 **04**	**People Committee update – Non-Exec Mandatory Training** A review of Trustee related mandatory training to be undertaken, in conjunction with the Nomination and Remuneration Committee, that includes the consideration for a passport approach for using comparable training completed within the NHS.	RB, DL & SC	~~21.07.23~~ 28.09.23	Open	**28.09.23 –** To be done in conjunction with work being completed on the Board skills matrix (via NomRemCo), this is to be concluded by November. Whilst a passport style approach will be

					considered, L&D currently accept comparable training at NHS Trusts and update NED records accordingly. Meeting with L&D scheduled for Sept 21st Action remains open
31.03.23 **07**	**IQPR – Tertiary service providers** DL to liaise with PB and schedule a future Board agenda item on Tertiary Service Providers to better understand any inappropriate placements or what may impact the complexity of discharge.	DL	~~21.07.23~~ 28.09.23	**Closed**	**21.07.23 –** Remains open, with further review on discharge process required and update to be provided at September Board. **28.09.23 –** Covered in part within CEO Part 2 update highlighting the on-going and planned work on reviewing occupancy, bed management longer term streamlining process. Updates on these areas will be brought to Board over time. **Propose action is closed**
31.03.23 **09**	**Oliver McGowan Training – Use of psychotic medications** Medicines Management Group to undertake a review of the use of psychotic medications and report to QSC ahead of Board.	SK	~~21.07.23~~ 28.09.23	Open	**21.07.23 –** Remains open with update due at September Board **28.09.23 -**A review of antipsychotic medication in the LDA division has been undertaken and the findings reviewed and presented to the Quality and Safety Group.
18.05.23 **01**	**ARC Update – AI Fraud risk** DL to liaise with Darren Handley (LCFS) to look into how the Fraud risk relating to the use of AI was being managed from a Counter Fraud perspective and what the LCFS's within the NHS were advising.	DL	~~21.07.23~~ 28.09.23	**Closed**	**21.07.23** – Next NHS LCFS network meeting is on 6th September at which point AI fraud will be raised as a discussion in line with their processes. No information has been shared to date on AI related fraud within the network.

					28.09.23 - This was discussed at the NHS Counter Fraud Managers Group on 6th September. The key points were: 1. Discussed that no information/guidance has been published by the NHSCFA as yet 2. The Group felt that AI doesn't present a new fraud risk, but could be used as an enabler for fraud attempts, e.g. a) Phishing attempts may become more sophisticated b) AI could be used to produce fake references that are more realistic c) 'CEO fraud' emails may be more realistic d) Potential to duplicate human voices for telephone fraud attempts 3. No-one had taken any specific action yet (other than some general research). It is likely that the NHSCFA will publish something in the future, and this will then be incorporated within a future Fraud related comms article. AI will be considered in next year's annual counter fraud plan. **Propose action is closed**
21.07.23 **01**	**Board Seminar – Government Rapid Review Paper** DL to progress a session with the Board covering those areas directly relating to the work of the Board	DL	28.09.23	**Closed**	**28.09.23 –** Initial review update provided to Executive by CQO in September. Updates on actions relating to Board are to be provided at relevant committees and then to Board. **Propose action is closed**
21.07.23 **02**	**CEO Update – Research partnerships**	KM	28.09.23	Open	**28.09.23 –** Propose that action is moved from KM to SK, with action remaining open for update at November Board.

	Future ERT updates to include updates on research partnerships, clearly outlining the approach by the Charity to ensure full value is received.				
21.07.23 **03**	**Service & Patient Story - Occupational Therapy** DL to share Malcolm's statement and the OT presentation with the Board	DL	28.09.23	**Closed**	**28.09.23 –** Presentation and statement from patient shared with Board via email. **Propose action is closed**

Chair Update

(Paul Burstow – Verbal)

Paper for Board of Directors	
Topic	CEO Board Update
Date of Meeting	Thursday, 28 September 2023
Agenda Item	**6**
Author	Dr Vivienne McVey, CEO
Responsible Executive	Dr Vivienne McVey, CEO
Discussed at Previous Board Meeting	Updates have been discussed at the Executive meetings.
Patient and Carer Involvement	A number of these items would have been discussed with patients and carers
Staff Involvement	A number of these items would have been discussed with staff
Report Purpose	Review and comment ☐ Information ☒ Decision or Approval ☐ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Voice ☒ Community ☒ Quality ☒ Service Development ☒ Workforce ☒ Learning and Research ☒ Financial Sustainability ☒
Committee meetings where this item has been considered	Executive Meetings

Report Summary and Key Points to Note

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

Appendices - Hope: Our strategy for the future briefing pack

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.

I would like to introduce Adam Foster, our new Director of Business Development who has had a busy first few weeks with us.

During the first week of September we formally launched our 2023-28 Strategy for Hope across the organisation. We held a series of virtual launch events which were well attended and led to many insightful questions. Our new strategy is a roadmap which outlines the steps we will take to ensure that our Charity achieves its potential, supporting those we serve. It has been developed closely with those who we care for and those who work with us or for us. The full briefing deck is attached to this report, as is the fun film the Communications Team made to bring our strategy to life (a link is here). We have identified seven ambitions and three enabling programmes through which we will deliver our mission of being a leader in the care of those with complex mental health needs.

We are now rolling the strategy out to our staff, and ensuring everyone understands our purpose, mission and values, and the steps we will take to achieve our ambitions. Following a series of Teams sessions where staff had the opportunity to ask questions, we are now distributing a selection of strategy materials – posters, leaflets and lanyard cards – which will remind our staff of who we are, what we stand for, and the part they play in Team St Andrew's.

I was thrilled to be part of my first FestiVol this year on 2nd September. It was a really joyous event with great attendance from volunteers, staff, patients and the public, and is a great example of Ambition 2 of our strategy where we are reaching out into our community to make social impact. There is a fuller description of the fun at the end of this report.

1. People and Culture

- **Pay review**
  We are really pleased that we have been able to communicate this year's pay review, which will be paid in September and includes a base pay increase of 5% to all career level A-D roles (subject to the relevant eligibility). This brings our minimum pay rate to £11.03 per hour, 13p above the Real Living Wage (RLW). The pay rate for our Health Care Assistant roles will increase to £11.45 per hour, which is 55p above the RLW.

- **Nursing workforce plan**
  We continue to respond to the challenges presented by the national shortage of Registered Nurses that are contributing to our vacancy levels and have agreed a three year Nursing Workforce Plan focused on the recruitment, development and retention of nurses. In Year 1 (2023-24) we are extending our routes to nursing to include recruiting 10 Trainee Nurse Associates, testing the UK market for Adult Nurses, offering an internally delivered mental health CPD module and recruiting a Return to Practice cohort to enable individuals to regain their Nursing and Midwifery Council (NMC) registration following a break from nursing. To support our workforce plan we have established a new Creative Recruitment and Retention group and we will be participating in a number of external forums to share best practice.

2. Clinical services operations

The Operations Committee has been working on a number of different areas to improve the management grip and control in key domains and has made good progress since the last Board meeting. These include implementing a process to ensure a timely review of all overdue operational policies and procedures, ensuring line management structures for ward staff are formally articulated and input into SAP and fully embedding the role of the Duty Manager. Our NHSE EPRR annual submission was completed in August with significant improvements on last year's submission. Progress on performance continues to be driven through the operational management structure with a significant reduction in non-patient facing shifts, improvement in retention and full overall compliance of mandatory and statutory training at over 90% in all divisions in line with the target set for July. The implementation plan for patient call bells is underway with full compliance against this CQC action due to be completed by the end of November. Progress on a Clinically Informed Staffing Dashboard is underway as well as our approach to the development of an enhanced multidisciplinary ward staffing model that incorporates best practice.

3. Introduction to Business Development

I am pleased to note that our new Business Development Director, Adam Foster has now joined the team and has used his first few weeks to take a fresh deep dive look into the commercial elements of business at St Andrew's. There are a number of key themes that have been identified that are being addressed in the short term to get the Charity back into a stronger commercial position. These include strong leadership and a clearer commercial direction for the Strategic Partnerships function to drive occupancy, the acceleration of new service development with a particular focus on step down community services and the re-provision of existing inpatient services where demand is diminishing, more robust governance of commercial processes across the Charity, building in capacity and capability to focus on income generating activities as well as a focus on increasing the pace of activity in growing community partnerships and developing our fundraising ambitions.

To address these areas, the management team will, by the end of September, have clear plans to bring occupancy back to budget driven by a coordinated, cross functional team. New roles will be created to drive new service development and leadership for bids and tenders. There will be a clearer and accountable partnerships management structure aligned with the clinical triumvirate to support growth. The first draft 5 year commercial strategy will also be written.

4. Estates and Facilities

Following the Government's announcement instructing the closure of some school buildings constructed from RAAC (Reinforced Autoclaved Aerated Concrete), we have taken swift action to assess and understand our risk. RAAC is a lightweight form of reinforced concrete used from the mid-1960s to the mid-1990s and is mainly found in roofs, and occasionally walls and floors. We have identified the buildings constructed within this time frame, have created a due diligence pack, and have instructed a structural engineer to undertake surveys and inspections on 19 and 20 September. Our preliminary findings have identified parts of Wantage/Kemsley House, Spencer House, Isham House, The Braye Centre and parts of Essex as the areas of particular focus, although we deem the risk to be low. We will update the Board and Governors accordingly.

In early August, we invited three sets of consultants to prepare proposals to support us in the formulation of a brief to assist in shaping the future use of the Main Building. Each consultant team brought different perspectives as dictated by their respective disciplines – purely architectural, asset consultancy, and occupier consultancy. We have invited them to submit formal proposals by the third week of September, at which point we will evaluate and chose a team to lead the briefing and feasibility process. We have been, and continue to be, supported by Governor, David Laing. A further verbal update will be provided at Board.

5. Communications

- **Government's Suicide Strategy**
  Our Executive Medical Director, Dr Sanjith Kamath, has shared a statement regarding the Government's ambitious new National Suicide Prevention Strategy, which aims to reduce the number of tragic suicides in England within 2.5 years. Sanjith explained: "We need to ensure there is sufficient funding and improved partnership working between physical healthcare, mental healthcare and social care. Suicide is complex but entirely preventable and we must see the ambition put behind this Government strategy for it to be successful." The Statement can be accessed via: St Andrew's responds to Suicide Prevention Strategy » St Andrew's Healthcare (stah.org)

- **Innovation sprint**
  A key focus to achieving our ambition of a thriving workforce is improving our staff retention rates. In 2022, 31% of newly hired staff left within the first 12 months of joining. Of those, 48% were HCAs. To get to the root cause of this issue and focus on retaining our talent we recently held our first innovation sprint - a rapid innovation method designed to quickly develop and evaluate new ideas.

  A group of colleagues from across the Charity spent the time brainstorming, and working with key stakeholders such as new HCAs in order to understand the causes of the problem and to formulate ideas to address it. These ideas were evaluated, challenged and refined until a workable solution began to form. The plans were then presented to key stakeholders for their additional input, and are now being refined ready to get the project ready for pilot stage. Watch our short film about the innovation sprint here.

- **Raising concerns**
  October is Freedom to Speak Up month, and we will be focusing our energies on ensuring everyone, in any role across our Charity, is confident in raising concerns about patient care. This is especially timely in light of the recent Lucy Letby trial.

- **Media coverage**
  One of our veteran service users, who has been receiving treatment for her complex PTSD, has been sharing her story in the national media. Martha Prinsloo, who is set to complete in the Invictus Games this month, survived an explosion in Afghanistan. Her recovery journey has now been reported in the MailOnline, Yahoo News, multiple local publications and on Regional BBC radio and TV.

- **Business awards finalists**
  We are thrilled to announce that St Andrew's have made the finals of the NNBN Awards which are Northamptonshire based Business Awards. We have been shortlisted in the Charity of the Year category for the work we do with our patients. Sanjith will be attending the ceremony in October, when hopefully he will be walking away with an award!

- **FestiVol**
  We recently held our third annual festival dedicated to the benefits of volunteering. FestiVol, held at Workbridge, attracted crowds of almost 2,000,

visitors had the opportunity to find out about volunteering with St Andrew's and also with our Charity friends.

Attendees enjoyed live music, meditation sessions, drumming and bagpipes and had an opportunity to cuddle Pets as Therapy dogs before enjoying goodies from local artisans and delicious food.

Guests included Deputy Lieutenant Neelam Aggarwal-Singh MBE JP, WNDC Chairman Cllr John Shephard, Mayor Cllr Stephen Hibbert and Mayoress Liz Cox, Lord and Lady Northampton, and John Leivers from NLive Radio who shared soundbites on his show. The event was a real team effort, with support from our Voluntary Services team and amazing volunteers, the Workbridge team, Estates, Grounds, Communications, Horticulture, Creative Studios, Arts and Innovation, and of course several of our four-legged friends.

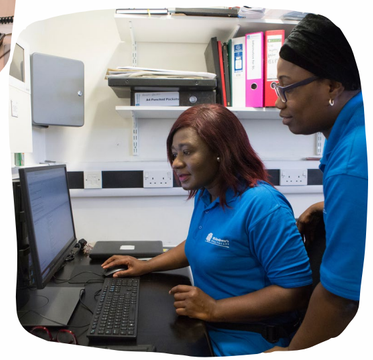
A few photos from the event are below**.**

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

Dr Vivienne McVey
Chief Executive Officer

Hope: Our strategy for the future

2023-2028



St Andrew's HEALTHCARE

#WeAreSTAH

St Andrew's HEALTHCARE

Who we are

We are St Andrew's – a thriving charity with a proud history of helping those with a mental health need find hope

Our purpose is hope

As part of becoming a contemporary charity, we will diversify our charitable activities and organise them into a group structure

Estates and Commercial

+

Clinical Services

+

Education, Research & Training

Corporate Services (enabling functions)






St Andrew's HEALTHCARE

Vision

Imagine a society in which everyone living with mental health need is heard, valued and has hope for their future. That's our vision.

Mission

By 2028 we will be a leader in helping people with complex mental health needs transform their lives.

That's our mission.





St Andrew's HEALTHCARE

Our ambitions

Our strategy outlines 7 co-produced ambitions for the next 5 years, which will help us achieve our mission of becoming a leader in transforming the lives of those with complex mental health needs.

St Andrew's HEALTHCARE

Our 7 ambitions

1: Voice

Ensure everyone has an equal voice to drive change and reshape society's response to mental health

2. Social Impact

Be part of our community – a trusted partner

3: Quality

Lead the way – through high quality care every day

4: Service Development

Develop ground-breaking services meeting the needs of those we serve

5. Workforce

Be a thriving workforce – doing the right thing

6. Learning & Research

Transform lives through learning and research

7. Financial Sustainability

Invest responsibly, be confident in our future

St Andrew's HEALTHCARE

The detail

Each ambition has a plan attached to it which explains "how" we will achieve it

1: Voice

- Voice strategy

2. Social Impact

- Social Impact strategy
- Sustainability

3: Quality

- Quality strategy

4: Service Development

- Clinical Services
- Business Development

5. Workforce

- People plan
- Diversity & Inclusion

6. Learning & Research

- Education, training & research

7. Financial Sustainability

- Estates & Commercial
- Fundraising
- Financial plan

St Andrew's HEALTHCARE

Our 7 ambitions are supported by 3 enabling programmes...

THE THRIVE Programme
FULFILLING OUR POTENTIAL

Thrive

Tranforming Data and Digital

Refreshing our Culture & Brand

Our milestones for 2023-2024

1: Voice	There is zero tolerance of stigmatised language
2: Social Impact	We have defined our social impact objectives for engaging with our communities, volunteers and partners
3: Quality	We are using our Quality Management System
4: Service Development	We have launched our long-term clinically and commercially aligned growth plan for our inpatient, outpatient and community services
5. Workforce	We are consistently supporting recruitment, retention & employee satisfaction
6. Learning & Research	We have designed our approach to research, education & training
7. Financial Sustainability	We have exceeded our financial targets, ending the year with 20% more money in the bank than forecast

Our milestones for 2024-2025

1: Voice	All staff are trained and educated in working with people who have complex mental health needs
2: Social Impact	We are part of a network of aligned community and voluntary organisations
3: Quality	Every service has specialist training taken from their clinical model
4: Service Development	We are implementing our first step-down community pathways and expanding our outpatient service offering
5. Workforce	We have built stable teams (leadership and critical roles) and achieved a 20% improvement in the retention of these roles
6. Learning & Research	Education, training and research activity is financially sustainable
7. Financial Sustainability	Our Estates & Commercial unit is financially sustainable

Finding out more

We have also developed milestones for each year until 2028

You can read what these are on the strategy area of the Hub

To deliver our strategy we will be guided by our CARE values

Compassion

Be supportive and understanding to everyone around you

Accountability

Be proactive, take ownership and responsibility - do what you say you will

Respect

Act with integrity,
be open, be honest

Excellence

Innovate, learn, improve, deliver
whatever you do, do it well

St Andrew's HEALTHCARE

What other content is availab

- Printable PDF with milestones
- Fun film showcasing our ambitions
- Pocket-sized pull-outs
- Card for lanyards with vision, mission & values

#WeAreSA

Questions?

Please share!





St Andrew's HEALTHCARE

Committee Updates

People Committee
(Steve Shrubb)

Research Committee
(Prof Stan Newman)

Quality & Safety Committee
Incorporating:
Annual Safeguarding Report
Responsible Officer & Re-validation Report
(Steve Shrubb)

Audit & Risk Committee
Annual Report Update - Verbal
(Rupert Perry)

Committee Escalation Report to the Board of Directors

Name of Committee: People Committee

Date of Meeting: 18 July 2023

Chair of Meeting: Dawn Brodrick

Significant Risks/Issues for Escalation (based on May data):

- The Nurse fill rate remains a core risk. A Nursing workforce plan was presented to provide assurance on the recruitment, development and retention initiatives taking place or planned.
- Mandatory training was at 89% (for perm and bank - adverse to target) with the recovery plan supporting improvements. All divisions were above 90% for permanent staff (with the exception of Essex & Medium Secure at 89%).

Key issues/matters discussed:

- Deputy Director HR & Workforce Planning Update provided the snapshot engagement survey results showing positive improvements in from 51% (2021) to 64% 2023.

- **Thrive Programme Operating Model update including 'Champions' development -** The Committee received an update on the Thrive Programme and upcoming phases; phase 1 – reset, phase 2 – reshape, phase 3 – refine confirming that phase 1 is complete.

  New Champion roles (communiction, culture and innovation champions) are being set up within the Charity to further embed the staff voice and allow greater alignment to the Charity's key priorities following Lead the Change. Each Champion role links to a central group or initiative to ensure alignment and progress. Where relevant they continue to link into the Thrive workstreams.

- **Nursing workforce plan**
  Assurance was provided to the Committee on the nursing workforce plan previously approved by the Executive Team. This focuses on a 3-year plan to meet current vacancy challenges although it will be revisited following the multi-disciplinary review.

  In year 1 (2023-24) the Charity are extending our channels/routes to nursing to include recruiting 10 Trainee Nurse Associates, testing the UK market for Adult Nurses offering an internally delivered mental health CPD module and recruiting a Return to Practice cohort for individuals to regain their NMC PIN after taking a break from nursing.

- **People KPIs**
  The Committee received a report on People KPIs relating to May 2023 data. Sickness was within target at 5.8% and voluntary turnover aligned to target at 13.3%, both showing an improving trend.

- **Pay Review**
  The Committee received an overview of the pay review proposal. This was approved and proceeded to a verbal update at the July Board. The pay review is being processed for the September payroll.

Decisions made by the Committee:

- Modern Slavery statement – approved at the July Board.
- Finalised Terms of Reference - approved at the July Board.
- Pay review proposal – verbal update at the July Board.

Implications for the Charity Risk Register or Board Assurance Framework:

- Based on May's data mandatory training was 89% overall. Courses behind target were predominately BLS (perm 86%) and SIT (perm 78%).

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Appendices: None (covered at July Board)

Committee Escalation Report to the Board of Directors

Name of Committee: Research Committee

Date of Meeting: 2nd August 2023

Chair of Meeting: Stanton Newman

Significant Risks/Issues for Escalation:

- Stan Newman, RC Chair, is stepping down as NED.
- Martin Kersey stepping down as head of ERT.

Key issues/matters discussed:

- **1 Continue with agenda initiatives, or delay until new MD of ERT appointed**

- **2 Creation of Physical Activity research stream**

Discussion of new research stream along with funding for:

- 2 x PhD students (co-funded by Loughborough University)
- Appointment of part-time "Research Director" in charge of this stream
- Research Associate

Paper attached.

- **3 Clinical Secondments**

Discussed whether R&I should advertise for new Clinical Secondments after the current two finish in December 2023. Paper attached.

- **4 Staff Head Injuries**

Martin Kersey advised that our Insurance Company have provided STAH with £30,000 to conduct research on the incidence and prevention of staff head injuries. This money will assist with scoping the research. Paper attached.

- **5 Huntington's disease research programme**

Initial presentation by Inga Stewart on HD. Scoping review currently taking place with the plan to initiate a programme on HD subject to funding approval by the Fundraising and Donations Group later in the year.

Decisions made by the Committee:

- **1 Continue with initiatives, or delay until Managing Director of ERT appointed**

The Committee agreed to evaluate each initiative and proceed on those where agreements had been reached with external bodies. They recognised that many activities will take some time to reach finalisation, by which time it is hoped that a Managing Director of ERT had been appointed and can review all these initiatives.

- **2 Creation of Physical Activity research stream**

Agreement to support and provide funding for 2 x PhD students, jointly funded by Loughborough University, due to commence in January 2024. Committee approved in principle appointing a part-time "Research Director" in charge of this research stream along

with a Research Associate. Kieran Breen to work on writing draft job descriptions for two potential posts. Funding to be sought from Fundraising and Donations Group.

- **2 Clinical Secondments**

Approved in principle, subject to review of contribution of current secondments. Funding to be sought from Fundraising and Donations Group.

- **3 Staff Head Injuries**

Committee approved with job description and reporting lines to be agreed by ERT.

Implications for the Charity Risk Register or Board Assurance Framework:

None

Issues/Items for referral to other Committees:

None

Appendices (see Annex A):

- Physical Health research stream proposal
- Clinical Secondments paper
- Staff Head Injuries paper

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meetings: 22 August 2023 (Committee), and
12 September 2023 (Extra-Ordinary)

Chair of Meeting: Steve Shrubb

Significant Risks/Issues for Escalation:

- CAMHS – covered by a separate report issued for Part 2 of the Board

Key issues/matters discussed:

- **Quality Improvement Plan (QIP)**
  The update to the QIP was discussed with the Committee discussing the ongoing and open actions.
  The use of restraints and a move toward the reduction and prevention of use was discussed with it being agreed that it would be beneficial to hold a further in depth discussion on the usage of restraint, the differing types, and the instances where they were used.
  The completion and review dates on the actions within the QIP were discussed with it being agreed that the updates would concentrate on the previous 2 months, and that those actions with longer lead times to completion would have review Committee review dates allocated to them.

- **Quality Risk Management**
  Those risks relating to quality were discussed with the Committee extending thanks for the clarity of information contained within the report.
  The risk relating to training was highlighted with it being confirmed that there was excellent progress on both mandatory and statutory training. A cleanse of Bank staff had also been undertaken, with those individuals whose training was not up to date either being asked to undertake urgently or they would be informed that their services would no longer be required.
  The process for scoring and management of risk was clarified for the Committee.

- **Visits – themes and emerging issues**
  A paper covering the themes and emerging issues from the internal key lines of enquiry inspection process and Governor visits was presented by AR, with it being noted that this view would give the opportunity for consideration of differing practices and outcomes within the divisions. The reporting of obvious and immediate risks was discussed, along with how these could then be managed. It was hoped that over time a more robust system would develop.

- **Safer Staffing**
  The Safer Staffing Report presented now contained snapshots of both day and night shifts. The current challenges within night shifts were noted, with DC outlining the innovative ways of ensuring cover for challenged shifts. The work being undertaken on recruitment and retention were also noted with early signs of improvement being seen

via reduced turnover and sickness and retention rising. The Committee thanked DC for the approaches being taken to staffing and the anticipated positive effect this would have on staff overall. It was pleasing to note that the work had the support of the local RCN, with regular updates being given to the Unions.
Further grip and control was noted on disciplinary processes particularly with regard to those members of staff noted as being AWOL or sleeping on shift. This work was acknowledged as being an important part of the culture change and that approaches should be observed as being executed in a fair and just manner.

- **Mechanical Restraint**

  AR presented a report on Mechanical Restraint. The Committee discussed the usage in the previous 2 months where there had been 11 instances of handcuff usage and 7 instances of soft restraints. It was explained that handcuff usage was mainly as a result of Police involvement or by the direction of the Ministry of Justice. The relationship between the Charity and the Police was noted, with positive outcomes.

  The Committee agreed that a Board seminar on the use, rules, reduction and prevention of use of restraints would be beneficial.

- **Safeguarding**

  A report on Safeguarding was presented, with it being noted that level 3 training and above required focus. It was hoped that the onboarding of T-Block would ensure the requisite time for attendance on training courses. Navigator training to up-skill ward staff had already begun. The Committee acknowledged the usefulness of the report and requested that further analysis on the incidents would be helpful.

Decisions made by the Committee:

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

- Annual Safeguarding Report (at 12th September meeting)
- Responsible Officer Re-validation Report (at 12th September meeting)

Implications for the Charity Risk Register or Board Assurance Framework:

- CAMHS Culture

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- CAMHS Leadership structure (to be covered in separate report for Part 2)

Appendices (See Annex B):

- Appendix A – Annual Safeguarding Report
- Appendix B – Responsible Officer Re-validation Report

Paper for Board of Directors

Topic	CQC Report and Action – Progress Update
Date of Meeting	Thursday, 28 September 2023
Agenda Item	**8**
Author	Dr Ash Roychowdhury, Chief Quality Officer
Responsible Executive	Dr Ash Roychowdhury, Chief Quality Officer
Discussed at Previous Board Meeting	Previously discussed in July 2023
Patient and Carer Involvement	Co-production activity across all divisions has attributed to the closure of a number of actions within this reporting period.
Staff Involvement	Staff engagement and collaboration has been instrumental in the initiation and embedding of Quality Improvements across divisions.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Voice ☐ Community ☐ Quality ☒ Service Development ☐ Workforce ☐ Learning and Research ☐ Financial Sustainability ☐
Committee meetings where this item has been considered	Updates have been discussed at the Executive Team meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

A comprehensive Care Quality Commission (CQC) Inspection was carried out in Essex in March 2023, the final report was published in July with a rating of Requires Improvement. A Report of Actions has been returned to CQC outlining improvements to be made against Regulation 9: Person Centred Care, Regulation 12: Safe Care & Treatment and Regulation 15: Premises and Equipment.

A Quality Improvement Plan has been developed and is monitored through Governance and learnings from this inspection are provided as intelligence through the surveillance system.

As previously reported, an application for removal of conditions applied to the charity's CQC registrations for Men's and Women's services was submitted to the CQC. The CQC commenced their focussed inspection on the Northampton site on the 4th of July 2023 with specific focus on the conditions and wards identified in the conditions for the Men's and Women's services. No new warning notices were issued following this inspection.

At this stage, we await receipt of the draft report from this inspection although the CQC have confirmed their assurance against previous concerns identified and have subsequently removed all conditions applied to our registration. Revised registration certificates have been received and displayed throughout the charity.
The Divisions Quality Improvement Plans (QIP) continue to be monitored through the monthly divisional Integrated Quality and Performance reviews continue, this will include progress against any CQC actions that remain open and actions progressing from the internal KLOE inspections.

As previously reported, actions on the Charity level QIP have been refreshed 1 action associated to the previous CQC inspection in Essex continues to progress and is in relation to the provision of patient call bells in areas needed across the charity. Actions to reduce Enhanced Support across the charity, development of the Quality Impact Assessment process and improvements to handover quality and processes are also progressing along with a further 3 actions linked to the charity's quality priorities as outlined in the Quality account.

Internal inspections based on the CQC Key Lines of Enquiry continue through the baseline Y1 programme. 6 areas have been completed to date and a further five are yet to be completed. 3 of these are currently rated with the CQC as requires improvement and will be prioritised.

An update is also given on the Rapid Data review and the Quality Strategy

CQC Report and Actions – Progress Update

Overall Current CQC inspection ratings:

The table below identifies the overall ratings in the Key Lines of Enquiry (KLOE) approach used by the CQC.

The application to the CQC for the Northampton site to be registered as a single location with all divisions identified as core services has now been processed by the CQC, as previously reported, and revised registration certificates are now received and displayed throughout the charity. The application for removal of the conditions applied to the Men's and Women's Service has now been processed with those conditions successfully removed. This was following a focused inspection carried out by the CQC in July 2023.

Ratings applied to our services are in the table below;

Service Date published	**Safe**	**Effective**	**Caring**	**Responsive**	**Well Led**	**Overall**
STAH Well Led 07/01/2020	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Birmingham 28/08/2018	Requires Improvement	Good	Good	Outstanding	Good	Good
Broom Cottage 02/03/2023	Good	Good	Good	Good	Good	Good
Community Partnerships 28/02/2023	Requires Improvement	Good	Good	Good	Good	Good
17 The Avenue Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Essex 17/03/23	Good	Good	Good	Requires Improvement	Good	Requires Improvement
Northampton 06/03/23	Requires Improvement	Insufficient evidence to rate	Good	Good	Requires Improvement	Requires Improvement
Winslow 19/10/2021	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

The situation for Neuro is that they are rated overall RI based on an inspection of Allitsen ward in March 23. In 2017, Neuro had a full inspection and was rated good across all domains.

Charity QIP

7 open actions, all progressing and in date, most actions to March 24

These are:

- Installation of Call Bells in all wards
- Improving handover practice – including being supported by technology
- Charity wide CQI on reducing ES
- QIA processes
- QA priority 1: Improving Patient and Carer experience
- QA priority 2: Supporting staff
- QA priority 3: Safety Culture- PSIRF planning and implementation

Divisional Quality Improvement Plan (QIP) – CQC Actions

For our Essex division, the actions taken from the Report of Actions returned to the CQC from the inspections carried out in March 2023 are now being monitored through the QIP. There are currently 3 actions open and progressing. These are in relation to involvement of family and carers, training and learning and development needs for staff and finally, patients in the the rehabilitation ward having access to education and work opportunities.

There are no outstanding CQC actions for Medium Secure and Low Secure & CAMHS

From the Men's 2022 CQC Inspection there remains 3 Should Do actions for completion in the LDA division, with dates to Nov 23 for completion. These are for individualised and person-centred care plans, specialist training and communication to patients with specific communication needs.

Charity Surveillance Programme

Our first year of the base line internal inspection surveillance continues for all Divisions with Essex, Neuropsychiatry, Women's Medium Secure, Learning Disability and Autism and Birmingham completed to date. This will enable our position on the surveillance model methodology to be established moving forward.

Divisions take the findings, develop improvement actions on their Quality Improvement Plans (QIP) and report on progress through the Integrated Quality Performance Reviews.

Themes taken from the Internal KLOE inspections are reviewed by the Lessons Learned Group, which is attended by representatives from all divisions. Themes are summarised, impact across the charity is reviewed and decisions to develop improvement actions on the Charity QIP will be agreed by this group.

The IQPR process continues to review the incorporation of KLOE inspection actions into divisional QIP's.

The table below demonstrates the full and current schedule

Year 1 – Baseline KLOE Inspections	Current CQC Rating	Status/Provisional Timeframe
Essex Division	Requires Improvement	Completed in March 2023
Neuro Division	Good	Completed in March 2023
Birmingham Division	Good	Completed in April 2023
CAMHS Division	Requires Improvement	Completed in May 2023
Women's Medium Secure Wards	Inadequate	Completed - May/June 2023
Learning Disability & Autism Division	Requires Improvement	Completed - June/July 2023

Medium Secure Division (remaining male wards)	**Requires Improvement**	In progress - August/September 2023
Winslow (LDA Division)	**Requires Improvement**	In progress - Sept 2023
Low Secure Specialist Rehab Division	**Requires Improvement**	Planned for September/October 2023
Community Partnerships	**Good**	Planned for October 2023
Broom (LDA Division)	**Good**	Planned for November 2023

Reports are created to detail the high-level themes of good practice and areas for improvement from these inspections are presented to the Quality & Safety Committee.

A surveillance dashboard, which collates all the assurance activity linked to a ward is being collated and this will allow a more holistic view of ward performance from a quality assurance perspective:

	STAH Internal Surveillance	CQC (Care Quality Commission)	MHAr (CQC)		Quality Network		NHS Wales	IMPACT	CYPMHS East Midlands (CAMHS)	East of England Adult Secure Provider Collab (Essex)	REACH OUT	Mental Welfare Commission for Scotland	WNC	Doc links
Rating type	Rating	Rating	Actions (No)	Pt Actions (No)	Met %	Not met %	Q Status	Rating	Rating	Rating	Rating			
Wards														

Future Directions

Quality Improvement Plans

The primary purpose and function of the Charity Level Quality Improvement Plan (QIP) is to support and oversee the delivery of strategic quality improvement initiatives. The QIP is currently going through a process of redesign incorporating improvements to its functionality and reporting capability. The intent is to always have a minimum of a 12 month forward view.

The new system is in development and will have the ability to track transactional items, able to be done in 4 weeks, that do not necessarily require a deeper understanding of causal factors and typically come from individual sources; whereas the QIP is more thematic, with consideration from multiple sources, consideration of causal factors and structured actions that will take longer and are often subject to iteration and testing.

As previously shared, the QIP process and structure that would enable more intuitive categorisation of issues into Themes, and actions into 9 C Categories, enabling easier internal and external assurance. The system in development will provide greater functionality that will enable a better experience for the end user, reduce all risks associated with the current format and with improved accessibility to inform and enhance governance.

The Charity QIP will be in the new structure and format by the end of September and this will include a revision of content that will be presented to Exec and Board. Early verbal feedback from IMPACT is positive and are working with us to align their sinepction feedback with our QIP structure for more seamless integration.

Single Assessment Framework Data Directory

The CQC Single Assessment Framework (SAF) is due to go live later this year. In preparing for the SAF and understanding that CQC assessments will be based (more than before) on evidence they request from providers, work to focus on our preparedness to ensure we can quickly respond to data requests is underway.

A new system is under development which will enable us to pre-qualify data and information which will align to the CQC new approach to inspections. Our system will better align with the improved ways of working that have come about from the THRIVE programme.

Strategic Assurance Framework

Failure to deliver high quality services is a key strategic risk related to Strategy ambition 3. I have worked with Darren Handley to develop a summary of the key controls, assurance and improvement actions to close gaps in assurance.

Rapid data review in Mental Health June 23

A summary review has been discussed at Exec and will need further work through the Board sub-committees as there are recommendations that may impact such as having a patient Board representative and that half of the NED’s be trained as hospital managers.

Development of the Quality Management system- Year 1 of the Quality Strategy

This can be considered in 2 parts: the actual quality objectives, covered in the QIP, and the development of the quality system that supports and enables those objectives. Both are summarised below:

Implementation – Year 1- 23/24

Infrastructure

- New Ward to Board Governance Architecture – in place Charity wide
- Use of Risk Registers and QIPs to integrate quality activity ward to Board – part of IQPR
- Operating Model implementation: new Quality Matrons and General Managers; increased qualified nursing skill mix and broader MDT skillmix delivering care hours on wards- QM/GM's in post

Culture and Leadership

- Comprehensive training on St Andrew's approach to quality, with clear roles and responsibilities -being developed
- Engagement plan for leadership forums as established groups (SMT, Leadership forum) – new forums in place e.g senior quality huddle

Quality Planning

- Every ward to have a clinical model, evidence based, aligned to national standards and co-produced to meet the needs of patients and reviewed annually – in place and quality assured by Therapies Group
- Staffing- nursing and MDT establishments with the right capacity and skills to deliver to the clinical models- THRIVE
- Annual engagement exercise with staff, patients, carers and external stakeholders to help define and set quality priorities – done for recent QA

Quality Control

- Every ward to have access to a Ward Quality Control and Assurance Dashboard that drives frontline review and problem solving- in place
- New 9C's wards of concern process, supported by Ward HeatMap- in place

Quality Assurance

- Start an internal CQC KLOE inspection process- combination of self review and quality team review using a developed tool applicable to our services – in place
- Develop IAF- in development
- Develop CQC single assessment framework dataset – in progress

Quality Improvement

- QIP structure and process improvements – in progress
- PSIRF implementation – in progress
- Robust lessons learned processes- in place
- Design and implementation of a Co-Production and Carers Strategy- draft stratgeies being finalised
- CQI training delivery – regular training aligned to role types being delivered by central CQI team, working with system partners such as NHFT

Dr A Roychowdhury
Chief Quality Officer

Paper for Board of Directors	
Topic	Safer Staffing
Date of Meeting	Thursday, 28 September 2023
Agenda Item	**9**
Author	Dawn Chamberlain & Chloe Annan
Responsible Executive	Dawn Chamberlain
Discussed at Previous Board Meeting	Safer Staffing is regularly discussed at Board.
Patient and Carer Involvement	Patients are involved in discussions around Safer Staffing levels in Community Meetings, where appropriate.
Staff Involvement	All wards and divisions are regularly engaged with to regularly review safer staffing levels and take action where required. Directors of division and GM/QM's maintain close oversight of this.
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 an overview of Safer Staffing and summarises a number of areas of improvement and success within the last few months.

There have been concerns that there is less than adequate management cover at night and out of hours and as such a number of improvements have been progressed. The new GMs and QMs have now completed a full weeks training in their role as Night and OOH Duty Manager/Operational Bronze Command. As of the beginning of August, our new Strategic/Gold, Tactical/Silver, Operational/Bronze Command structure has been fully operational, and we now have 7 day on site duty manager cover across days and nights.

In response to National guidance acknowledging that inpatient care is delivered by multidisciplinary staff with no single staff group solely being responsible for patient outcomes, we have progressed work to embed our Occupational Therapy Technical Instructors (TIs) into ward care hours. We have already seen early signs of

improvement with the embedding of our TI's onto our wards including; improving levels of therapeutic activity against the 25 hour requirement, improved attendance of patients at meetings including BENN's and some improving levels of patient Section 17 leave usage.

The recruitment of qualified Nurses remains our core focus area with a nursing workforce plan agreed at Exec and People Committee in July. This identifies strategies related to recruitment, development and nurse retention to meet our vacancy challenge. Voluntary turnover rates show a continued positive trajectory towards target, with special cause improvement at 13.3% in June (compared to 14.5% in June 22).

All Divisional Director roles have now been appointed to, as well as Appointments of a Patient Safety and Least Restrictive Practice Lead, Clinical Safer Staffing Lead and Associate Director of Patient and Carer Experience.

These metrics are shared through the Exec Committee before traveling to both the People Committee and Quality & Safety Committee and on to the full Board.

Appendices –

Appendix 1 – Nursing Workforce Standards Benchmarking 2023

Safer Staffing Update –
Staffing Dashboards
Optimal Skill Mix for Patient Recovery – Embedding our Multidisciplinary team
Nursing Workforce Plan Update
Thrive Programme Updates

There are now a number of Operational Staffing Dashboards available to help inform the right staffing adjustments to the baseline based on both occupancy and levels of enhanced observations, escorting needs or extra-care packages (these are summarily known as Enhanced Support).
A few examples are set out below to demonstrate the granular information available on a daily basis, as well as being able to look ahead for planning purposes and look back for assurance and learning purposes.
It is important to note that the General Managers and Quality Matrons who will be accountable and responsible in that order for their Group's staffing have now received their full week of training, which took place on the 10th July.

Operational Staffing Dashboard

Day shift snapshot:

	Occupancy				Enhanced Support				Q-Registered (Q-RN and Q-RP)								U-Unregistered (U-RN)							Totals					
e-Division-Group-Ward	Baseline	Actual	Var to Baseline	Var to Prev Day	Baseline ES	Actual ES	Var to Baseline	Var to Prev Day	Planned	Adjusted	Planned + Adjusted	Q-RN Actual	Q-RP Actual	Q Actual	Variance	Variance %	Q Unfilled	Planned	Adjusted	Planned + Adjusted	U Actual	Variance	Variance %	U Unfilled	Planned	Adjusted	Planned + Adjusted	Actual	Variance	Variance %
Northampton	434	431	-3	-3	109.0	139.8	30.7	0.1	99.7	-0.5	99.2	75.7		75.7	-23.5	76 %	18.5	251.5	46.0	297.5	293.1	-4.4	99 %	20.3	351.2	45.5	396.7	368.8	-27.9	93 %
Low Secure & Specialist Rehab	82	80	-2	-2	8.5	8.4	0.0	2.6	22.0	-2.0	20.0	16.3		16.3	-3.7	81 %	2.2	37.3	4.4	41.7	39.9	-1.8	96 %	2.7	59.3	2.4	61.7	56.1	-5.6	91 %
CAMHS	20	14	-6	0	10.2	11.1	0.9	-1.3	6.0	1.0	7.0	4.8		4.8	-2.2	68 %	1.6	17.2	-0.9	16.3	19.3	3.0	119 %	2.0	23.2	0.1	23.3	24.1	0.8	103 %
LDA	103	104	1	-1	45.2	61.4	16.2	-0.2	24.7	0.0	24.7	14.8		14.8	-9.9	60 %	10.0	81.2	17.1	98.3	98.0	-0.3	100 %	9.3	105.9	17.1	123.0	112.8	-10.2	92 %
Medium Secure	115	123	8	0	19.7	22.5	2.8	-0.2	23.5	0.5	24.0	21.4		21.4	-2.6	89 %	3.7	56.1	7.5	63.6	60.9	-2.7	96 %	2.3	79.6	8.0	87.6	82.3	-5.3	94 %
Neuro	114	110	-4	0	25.5	36.3	10.9	-0.8	23.5	0.0	23.5	18.5		18.5	-5.0	79 %	1.0	59.7	17.9	77.6	75.0	-2.6	97 %	4.0	83.2	17.9	101.1	93.4	-7.7	92 %
Birmingham	123	119	-4	-2	9.3	7.0	-2.3	-0.9	19.5	0.0	19.5	16.2		16.2	-3.3	83 %	1.6	37.0	3.0	40.0	41.4	1.4	103 %	3.1	56.5	3.0	59.5	57.6	-1.9	97 %
Essex	66	58	-8	1	4.7	8.0	3.3	-0.5	12.5	0.0	12.5	9.2		9.2	-3.3	73 %	7.0	23.2	3.5	26.7	24.0	-2.7	90 %	4.5	35.7	3.5	39.2	33.1	-6.1	85 %
Nottingham		10	10	0		10.0	10.0	0.0	1.0	0.0	1.0	1.0		1.0	0.0	102 %	1.0	14.0	0.0	14.0	13.6	-0.4	97 %	3.1	15.0	0.0	15.0	14.6	-0.4	97 %
Total	623	618	-5	-4	123.0	164.8	41.8	-1.3	132.7	-0.5	132.2	102.1		102.1	-30.1	77 %	28.1	325.7	52.5	378.2	372.0	-6.2	98 %	30.9	458.4	52.0	510.4	474.1	-36.3	93 %

This is the daily staffing dashboard that shows the full breakdown of both Qualified and Unregistered staff as well as totals by ward, group, Division, or Site.

This is a snapshot of a weekday shift late August (during the summer holidays) that shows staffing levels, against current levels of Occupancy and Enhanced Observations. As we have been embedding members of our Multi-Disciplinary Team (including TI's) into ward care hours, we have steadily seen our staffing position improve across the weekday day shifts. The Qualified position across all divisions has been challenging throughout the month of August. This is a combination of annual leave, sickness and our current establishment gap. Some divisions have been able to partially mitigate this gap by uplifting the number of unregistered staff (shown in purple) which has kept their total planned staffing above 90% and in green. Day qualified provision is also supported by the presence of Ward Managers and Quality Matrons, most of whom are qualified nurses, and have been able to support with break cover and controlled drug checks. Despite some of our continued challenges with qualified staffing, all divisions (with the exception of Essex) were able to keep their total planned staffing above 91% and in the green.

Night shift snapshot

	Occupancy				Enhanced Support				Q-Registered (Q-RN and Q-RP)								U-Unregistered (U-RN)							Totals					
e-Division-Group-Ward	Baseline	Actual	Var to Baseline	Var to Prev Day	Baseline ES	Actual ES	Var to Baseline	Var to Prev Day	Planned	Adjusted	Planned + Adjusted	Q-RN Actual	Q-RP Actual	Q Actual	Variance	Variance %	Q Unfilled	Planned	Adjusted	Planned + Adjusted	U Actual	Variance	Variance %	U Unfilled	Planned	Adjusted	Planned + Adjusted	Actual	Variance	Variance %
Northampton	434	434	0	-1	98.5	128.0	29.5	2.2	57.7	0.0	57.7	41.3		41.3	-16.4	72 %	15.1	226.9	43.5	270.4	279.9	9.5	104 %	19.4	284.6	43.5	328.1	321.1	-7.0	98 %
⊞ Low Secure & Specialist Rehab	82	82	0	-1	8.6	9.0	0.5	3.0	13.5	0.0	13.5	9.1		9.1	-4.4	67 %	5.0	31.3	4.0	35.3	32.5	-2.8	92 %	4.0	44.8	4.0	48.8	41.5	-7.3	85 %
⊞ CAMHS	20	15	-5	0	11.3	14.1	2.8	-0.8	5.0	0.4	5.4	3.1		3.1	-2.3	58 %	2.6	17.2	3.6	20.8	22.3	1.5	107 %	2.3	22.2	4.0	26.2	25.4	-0.8	97 %
⊞ LDA	103	105	2	0	40.3	54.6	14.3	0.0	14.4	0.0	14.4	11.2		11.2	-3.2	78 %	3.0	73.6	15.7	89.3	94.1	4.8	105 %	6.0	88.0	15.7	103.7	105.3	1.6	102 %
⊞ Medium Secure	115	122	7	0	17.8	22.0	4.2	0.0	11.8	0.0	11.8	8.2		8.2	-3.6	70 %	1.6	54.8	5.4	60.2	65.3	5.1	108 %	6.0	66.6	5.4	72.0	73.5	1.5	102 %
⊞ Neuro	114	110	-4	0	20.5	28.3	7.8	0.0	13.0	-0.4	12.6	9.7		9.7	-2.9	77 %	3.0	50.0	14.8	64.8	65.7	0.9	101 %	1.1	63.0	14.4	77.4	75.4	-2.0	97 %
Birmingham	123	122	-1	0	9.3	6.0	-3.3	-1.0	12.0	0.0	12.0	9.0		9.0	-3.0	75 %	2.0	22.0	5.0	27.0	30.0	3.0	111 %	0.0	34.0	5.0	39.0	39.0	0.0	100 %
Essex	66	58	-8	0	6.3	6.0	-0.3	0.0	8.0	0.0	8.0	9.0		9.0	1.0	113 %	0.0	16.0	3.0	19.0	18.0	-1.0	95 %	0.0	24.0	3.0	27.0	27.0	0.0	100 %
Nottingham		10	10	0		9.2	9.2	0.0	1.0	0.0	1.0	1.0		1.0	0.0	102 %	0.0	12.0	0.0	12.0	12.3	0.3	102 %	0.0	13.0	0.0	13.0	13.3	0.3	102 %
Total	623	624	1	-1	114.0	149.2	35.1	1.2	78.7	0.0	78.7	60.3		60.3	-18.4	77 %	17.1	276.9	51.5	328.4	340.1	11.7	104 %	19.4	355.6	51.5	407.1	400.4	-6.7	98 %

The night shift snapshot shows a similar picture to days with the total staffing across all 3 sites being 98% during the week (and during the summer holidays). However, the qualified position has been more challenged with all divisions, except Essex and Nottingham, flagging as red. Similarly, to the day, most divisions have been able to mitigate some of this gap by uplifting their unregistered staffing and keeping their total staffing position above 90% and in the green. The presence of night site coordinators at night, all of which are qualified nurses will also have partially mitigated this skill gap. We do continue to experience some consistent challenges across the site with our night qualified staffing, and the summer holidays have seen this increase. We are working closely with divisions to prioritise the rostering of permanent qualified staff to fill our night gaps, as well as rolling out new roster training to all Ward Managers, to support with effective and safe rostering. All divisions have updated their night contingency plans and these are regularly communicated, along with the implementation of action cards as and when required.

This dashboard should be used for daily shift adjustments in daily ward and divisional huddles, based on changes to clinical need – this is still not being utilised appropriately everywhere and is particularly challenging in both LDA where enhanced support is extremely high but where there is less access to contractual income than in Neuro where it is equally high but contractually most/all of it is paid for by commissioners.

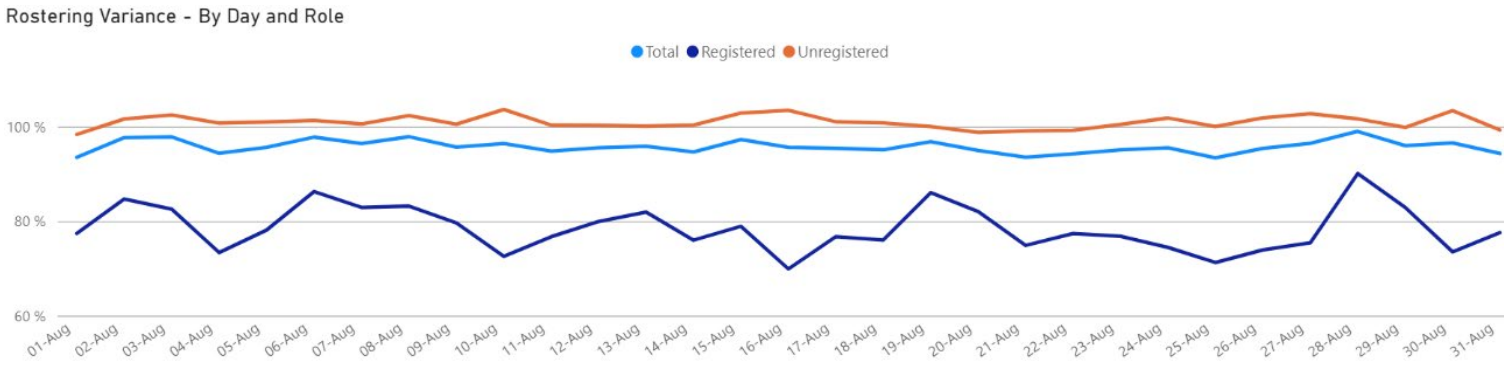
In addition to the overall Operational Staffing Dashboard there is a forward look known as the Daily Staffing Assurance Dashboard which allows Exec Directors to check the position on a daily basis and look ahead in terms of what has been planned ahead.

In terms of trends and assurance data there are multiple lenses to look through and the following tools are highlighted below

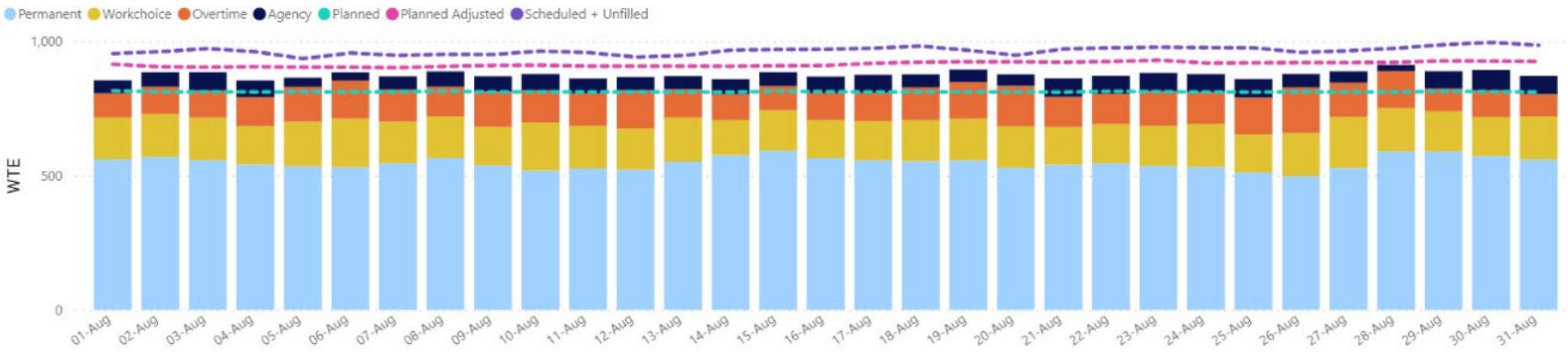
Daily Staffing Assurance

Date	14/08/2023				15/08/2023				16/08/2023				17/08/2023				18/08/2023			
Shift	Day		Night		Day		Night		Day		Night		Day		Night		Day		Night	
Site-Division-Group-Ward	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %	Var	Var %
Northampton	-35.4	91 %	-7.0	98 %	-20.0	95 %	-2.4	99 %	-12.7	97 %	-21.2	94 %	-16.0	96 %	-9.5	97 %	-32.3	92 %	-2.1	99 %
⊞ Low Secure & Specialist Rehab	-4.0	93 %	-7.3	85 %	-4.1	94 %	-2.9	94 %	-1.7	97 %	-6.7	87 %	0.7	101 %	-5.6	88 %	-10.1	83 %	-2.5	95 %
⊞ CAMHS	-5.3	78 %	-0.8	97 %	-0.1	100 %	1.0	104 %	3.4	115 %	-0.9	96 %	3.4	115 %	-1.7	93 %	1.8	108 %	0.5	102 %
⊞ LDA	-11.4	90 %	1.6	102 %	-7.1	94 %	-1.3	99 %	-10.9	91 %	-5.0	95 %	-13.5	89 %	-0.8	99 %	-12.2	90 %	1.6	102 %
⊞ Medium Secure	-7.6	91 %	1.5	102 %	-6.8	92 %	1.5	102 %	-2.8	97 %	-2.1	97 %	-5.6	94 %	-2.1	97 %	-6.8	92 %	-2.7	96 %
⊞ Neuro	-7.0	93 %	-2.0	97 %	-2.0	98 %	-0.8	99 %	-0.6	99 %	-6.5	92 %	-1.0	99 %	0.7	101 %	-5.0	95 %	1.1	101 %
Birmingham	-3.1	95 %	0.0	100 %	1.7	103 %	1.0	103 %	2.7	105 %	-1.0	97 %	-1.0	98 %	-2.0	95 %	0.0	100 %	-2.0	95 %
Essex	-1.2	97 %	0.0	100 %	-2.9	92 %	0.7	103 %	-4.9	87 %	-2.0	93 %	-8.3	79 %	-6.0	80 %	-4.7	88 %	-5.0	83 %
⊞ Essex	-1.2	97 %	0.0	100 %	-2.9	92 %	0.7	103 %	-4.9	87 %	-2.0	93 %	-8.3	79 %	-6.0	80 %	-4.7	88 %	-5.0	83 %
Nottingham	-2.0	87 %	0.3	102 %	-1.0	93 %	-1.7	87 %	-1.0	93 %	0.4	103 %	0.4	103 %	0.5	104 %	-0.1	99 %	1.2	109 %
Total	-41.8	92 %	-6.7	98 %	-22.2	96 %	-2.4	99 %	-15.9	97 %	-23.8	94 %	-24.9	95 %	-17.0	96 %	-37.1	93 %	-7.9	98 %

Rostering Trends



Staffing Composition



Night Cover

There have been concerns that there is less than adequate management cover at night and out of hours and as such a number of improvements have been progressed. The new GMs and QMs have now completed a full weeks training in their role as Night and OOH Duty Manager/Operational Bronze Command. As of the beginning of August, our new Strategic/Gold, Tactical/Silver, Operational/Bronze Command structure has been fully operational.

Additional night cover arrangements are also being considered as part of Thrive Phase 2, including the potential rotation of our Deputy Ward Managers across nights to enhance experience and leadership at the front line.

Optimal Skill Mix for Patient Recovery – Embedding our Multidisciplinary team

St Andrew's Healthcare have also responded to the NHS England guidance on Care Hours per Patient Day (CHPPD) and the acknowledgement that inpatient care is delivered by multidisciplinary staff and no single staff group is solely responsible for patient outcomes. As such, we have progressed work to embed our Occupational Therapy Technical Instructors (TIs) within the ward care hours which will strengthen the non-nursing MDT presence on the ward to improve the skill mix and ultimately to provide a better experience through increased access to meaningful activity and therapeutic interventions leading to better outcomes for our patients.

We have already seen early signs of improvement with the embedding of our TI's onto our wards including; improving levels of therapeutic activity against the 25 hour requirement, improved attendance of patients at meetings including BENN's and some improving levels of patient Section 17 leave usage.

Increasing our skill mix on wards, combined with improved activity and leave, is also key to us tackling one of our most persistent challenges across the Charity around high levels of Enhanced Observations.

Nursing Workforce Plan Update

The recruitment of qualified Nurses remains our core focus area with a nursing workforce plan agreed at Exec and People Committee in July. This identifies strategies related to recruitment, development and nurse retention to meet our vacancy challenge. During year 1 (2023/24) this includes accessing new channels such as a trainee Nurse Associate cohort (10), a return to practice cohort (5), direct recruitment of Nurse Associates (2) and a UK based adult nurse recruitment campaign (5).

Voluntary turnover rates show a continued positive trajectory towards target, with special cause improvement at 13.3% in June (compared to 14.5% in June 22). The Charity Retention Framework and associated actions continue to focus on sustaining and improving this further.

The Lead the Change programme is now moving into phase 2 with Champion roles across the Charity. One of these is Innovation Champions where we undertook an 'Innovation Sprint' pilot during August. This involved 5 Champions from across the Charity who were given protected time for 5 consecutive days to solve a key challenge highlighted within our turnover data: improving new starter retention during the first 12 months (which has a significant cost for the Charity). During September the ideas the group have come up with will be piloted.

Thrive Programme Staffing Changes

We launched the Thrive Programme in May 2023 and the following staffing reviews have been concluded across Clinical Services:

- Service Directors and Associate Directors of Nursing appointed to form the Triumvirate with the Clinical Directors in every Clinical Division including Community Partnerships (who have an Associate Director of Psychology in place of an ADN). All of which have now been filled.
- 13 General Managers and 12 Quality Matrons established for Clinical Services – nearly all of these have now been appointed.
- Appointments of a Patient Safety and Least Restrictive Practice Lead, Clinical Safer Staffing Lead and Associate Director of Patient and Carer Experience are now complete.
- Doctors review resulting in an increase in WTE
- All Allied Health Professionals staffing groups have been reviewed including Occupational Therapy, Physiotherapy, Speech & Language Therapy, and Dietetics. This has resulted in a small number of reductions in line with bench-marking and best practice but a significant increase in budgeted TIs to one per ward in the care hours in line with the CHPPD guidance.
- Psychology has also been reviewed resulting in an increase in APs in the care hours and a small increase in qualified psychologists.
- with advice from partners within the Association of Mental Health Providers, a new Director of Social Care advert is now live.

Measures of Success

All aspects of staffing data including recruitment, retention, training, performance and absence management are reported through to the Divisional Quality & Performance Reviews where the Triumvirates are held to account for improvement against under-performing metrics and share their solutions and learning where there have been successes.

These metrics are shared through the Exec Committee before traveling to both the People Committee and Quality & Safety Committee and on to the full Board.

Appendix one details the Charity's progress and current position against the Nursing Workforce Standards.

Appendix One: Nursing Workforce Standards Benchmarking 2023

Nursing Workforce Standard (NWS)		RAG	Evidence
NWS 1	Senior nurses set nurse staffing and report to Executive Boards.		Annual establishment reviews take place in line with Safer Staffing Policy & Procedure (currently being updated).
	Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision.		Establishment review template updated & will be used consistently across all wards, all sites.
			Annual MHOST acuity & dependency data collection currently being collected in line with license (Sep 23)
			Division establishment proposals planned for review by exec group Nov 23.
NWS 2	Nurse establishments based on service demand and user need		Annual MHOST data collection enables on-going review of acuity and dependency
	Registered nurse and nursing support workers establishments should be set based on service demand and the needs of people using services. This should be reviewed and reported regularly and at least annually. This requires corporate board level accountability		Safecare acuity pilot continues in Essex (daily acuity & dependency collection)
			Quality, Safety & Workforce metrics regularly reviewed in monthly divisional IQPR's, to support safe staffing decision making.
			Allocate enables robust advanced shift planning
			Daily Ward & Divisional Huddles to oversee safe staffing against clinical demand
NWS 3	Business continuity plans enable staffing for safe effective care		Staffing Escalation flowchart & action card procedure sets out the Charity's standard approach to managing challenging staffing levels from day to day, to critical levels.
	Up-to-date business continuity plans must be in place to enable staffing for safe and effective care during critical incidents or events.		All divisions have Qualified contingency plans in place (updated Sep 23).
			Regular divisional & Charity review of Datix incidents for use of action cards (no Q on shift).
NWS 4	Nursing workforce is recognised and valued		Nursing pay structure is aligned with national guidance and Agenda for Change pay Structure. 5% increase communicated to workforce Sep 23.
	The nursing workforce should be recognised and valued through fair pay, terms and conditions		Charity HR policies and procedures are in place, & recently been reviewed to fairly manage staff within the organisation
			Nursing career development and progression plans are in place, & recently reviewed, to meet new roles such as Nurse Associate.
			6 Nursing Update calls held throughout August, reaching out to over 75 of our Q Nurses across the charity.
			Regular Ward Manager, Quality Matron and ADN huddles in place.
NWS 5	Each nursing embedded service has a Registered		The Charity has a robust divisional nursing

	Nurse Lead		leadership structure, with the recent investment into Associate Director of Nursing & Quality Matron positions in all divisions.
	Each clinical team or service that provides nursing care will have a registered nurse lead.		All Nursing teams have a dedicated Quality Matron, Ward Manager & Deputy Ward Manager.
			A clear Ward to Board structure is set out in the governance Structure.
NWS 6	Nurse leaders receive dedicated workforce planning time		All wards have an identified Ward Manager with 100% supervisory time allotted. This time remains fully protected to support;
	A registered nurse lead must receive sufficient dedicated time and resources to undertake activities to ensure the delivery of safe and effective care.		• Leadership and team management • Improvement and monitoring of care quality service delivery • Workforce monitoring and planning • General ward management • Staff wellbeing support
			MHOST training held throughout August for all Deputy Managers & above, to support annual review process.
			Roster training sessions being held throughout September to support WM's with effective rostering.
NWS 7	Practice development time considered when defining workforce		The Charity has a dedicated Head of Practice Education, Practice Educators & a Preceptorship Lead who support post registration nurses during preceptorship and internationally educated nurses to complete the OSCE process and achieve NMC registration at ward level.
	The time needed for all elements of practice development must be taken into consideration when defining the nursing workforce and calculating the nursing requirements and skill mix within the team.		Nursing Protected time pilot starting this September in Essex.
NWS 8	Apply sufficient uplift when calculating nursing workforce		The Charity uses the MHOST staffing tool for nursing workforce establishment calculations. The tool overlays acuity and dependency data against workforce parameters such as annual leave, sickness and study leave.
	When calculating the nursing workforce Whole-Time Equivalent (WTE) uplift will be applied that allows for the management of planned and unplanned leave and absence.		Total Establishment uplift of 25% applied
NWS 9	Substantive nursing workforce below 80% is exceptional		Monthly review of vacancies at divisional level as part of IQPR.
	If the substantive nursing workforce falls below 80% for a department / team this should be an exception and should be escalated and reported to the board / senior management.		Recruitment files now in place for all wards, with every role having a post reference number – owned by GM's and SD.
			Regular recruitment panel to review requests against vacancies prior to advert.
NWS	Nursing workforce is prepared and works within		All nursing staff working as substantive or

10	scope of practice		bank members of staff undergo a robust induction period and undertake mandatory training as required. Each member of staffs training records are accessible to the individual, & their line manager through SAP.
			Individual training skills (e.g. SIT, ILS, Dysphagia) currently being uploaded into Allocate to support with appropriate skill mix deployment & visibility.
	Registered nurses and nursing support workers must be appropriately prepared and work within their scope of practice for the people who use services, their families and the population they are working with.		Mental Health Competency Framework has been developed to support all our Adult/Child/International Nurses. Currently been piloted in CAMHS prior to charity wide rollout.
NWS 11	Nursing workforce rostering accounts for safe shift working		Electronic rostering (Allocate) is fully established in all clinical nursing teams across the Charity.
	Rostering patterns for the nursing workforce will take into account best practice on safe shift working. Rostering patterns should be agreed in consultation with staff and their representatives		E rostering policy has recently been reviewed, updated & due to be published.
			Allocate audits & KPI reporting available.
			Roster Performance group established & regular divisional roster performance meetings being set up to monitor rostering practice, & measure compliance with policy.
			Individual skills & training profiles being uploaded to Allocate (Sep) to improve skill mix visibility & deployment of staff when required.
NWS 12	Nursing workforce is treated with dignity and respect		Staff expect to be treated in accordance with the Charity Values.
	The nursing workforce should be treated with dignity, respect, and enabled to raise concerns without fear or detriment, and to have these concerns responded to.		Freedom to speak up guardians, provide one of the many mechanisms for staff to speak up. Currently recruiting for a Lead Freedom to Speak up Guardian (0.6).
			Regular ward staff meetings being promoted, with staff encouraged to attend. Teams options available.
			Nursing protected time pilot in Essex starting September.

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

St Andrew's Healthcare Integrated Quality Performance Report

September reviewing the period ending July 2023

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

Concerns Improvements In Control

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

Concerns Improvements

Performance headlines

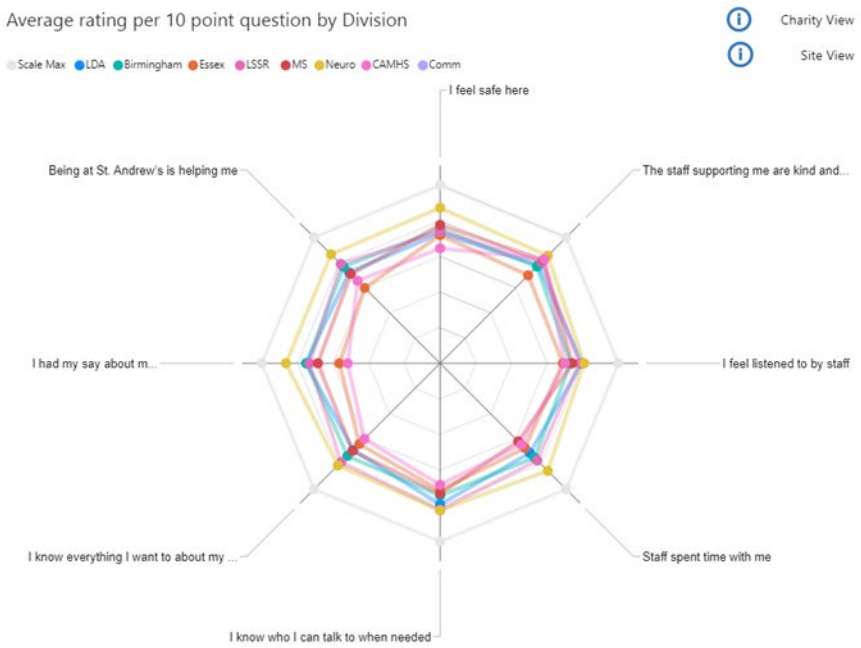
What has gone well

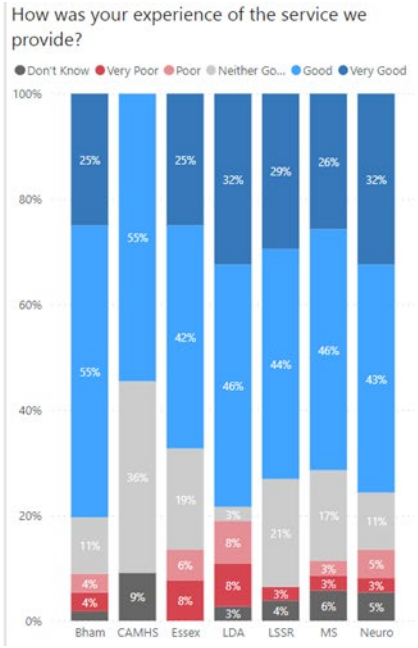
- **My Voice result** continues to perform well, with 73% of respondents rating their experience as good or very good
- **My Voice response rate** remains strong (with response rate expectations per service being set)
- **Discharge destination** – 68% of June & July discharges were to a lower level of security – of those remaining at the same level 78% moved closer to home
- **Patient leave** continues to shows a special cause improvement at Charity level
- **Neuro** are demonstrating special cause improvements across level 1 incidents, restraint, seclusion and patient leave
- **LSSR** are demonstrating special cause improvements across incidents, level 1 incidents, restraints and patient leave
- **CAMHS** are demonstrating special cause improvements across incidents of violence, level 2 incidents and patient leave
- **Enhanced Observation recording** – maintained performance, 98% of observations recorded, with 86% recorded within the designated time window
- **Mandatory training** – in line with the agreed trajectory and showing special cause improvement. All business units above 90% target – with the exception of Estates & Commercial (89.2%), within Clinical Services all divisions were above 90% at the end of July
- **Sickness** – favourable to target and showing special cause improvement & **Voluntary turnover** – continued special cause improvement
- **Non-patient facing shifts** – notable improvement, performing consistently within revised budget position

What is being focused on

- **Delayed discharges** – 26 patients are clinically ready for discharge – with their next placement pending, LDA most notably impacted, escalations in place
- **LTS & Enhanced Support special cause concern** – CQI initiated for Enhanced Support, see clinical narrative for further details
- **LDA** – whilst clinical challenge remains, incident levels have begun to return towards the mean, ES & LTS levels remain high due to the discharge delays
- **Meaningful activity** – recording process embedding until end of November 23
- **Registered Nursing** – recruitment challenge remains, Workforce plan approved and Yr 1 actions in roll out, strengthened multi-disciplinary review planned
- **Supervision** – management supervision being redesigned. Clinical Supervision rates require improvement in two divisions
- **Clinical Training** – ILS (perm 72%), BLS (perm 88%) and SIT (perm 83%) continue to require focus. Bank at 85% - focus plan due to complete in August
- **Finance** – continued focused to ensure financial budgets are achieved – see Financial Performance for further detail

Quality – My Voice & Discharges



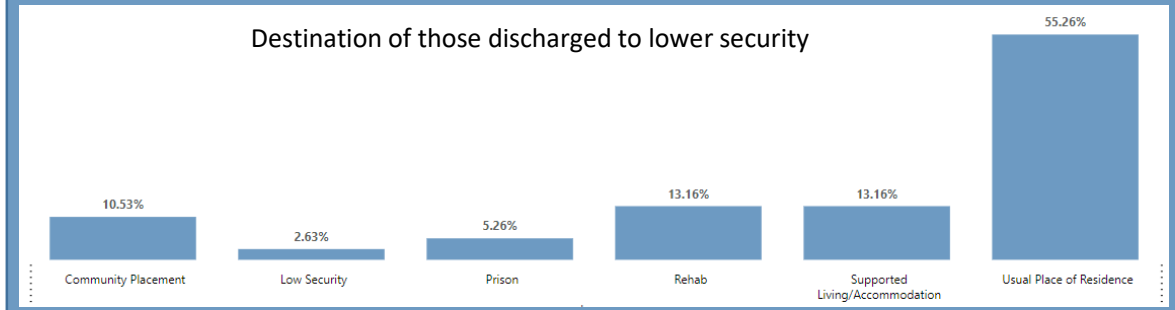


*My Voice responses data for period May 23 - Jul 23

My Voice - between May and Jul 73% of responding inpatients rated their experience of the care provided by St Andrew's as good or very good (75% - 18mths)

- Response levels have remained strong following dedicated ownership (Divisions are determining target response frequency – tailored for their patient group)
- Verbatim comments suggest varied experience, with positive themes highlighting caring and supporting staff and from July we are seeing an increase in positive comments regarding the range and helpfulness of the activities/sessions. The areas of focus are: staffing levels & food.
- Divisions utilise their community meetings to share how they are acting on feedback (e.g. chefs attend to discuss food requests) & have 'You said We did' boards
- Charity wide themes are considered and resolved via OpCom or QSG
- Community Partnerships have a tailored My Voice, which has been relaunched – July result 82%
- We are working collaboratively with Microsoft to apply AI to verbatim feedback in order to draw out additional insights, helping us to ensure patient voices are heard

Discharges during June & July (excluding PICUs) 56 people moved on from St Andrew's. Of those, 68% transitioned to a lower level of security, this includes 55% to their usual residence. For the remaining 32% moving to an identical or higher security level, 78% have moved closer to their usual place of residence address.



PICUs transitioned a further 23 people.

In line with new national guidance for the reporting of patients whose discharge has been delayed - as at 1st September 26 patients are clinically ready for discharge (CRFD).

Quality – safety and outcome indicators

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	Seclusion Hours	LTS	LTS Days	Safegrd	Rapid Tranq	ES Episodes	ES WTE	Ptn Leave
St Andrew's										A	B				C	

-	Incident	Violence	Incident L1	Incident L2	Incident L3	SI	Restraint	Seclusion	Seclusion Hours	LTS	LTS Days	Safegrd	Rapid Tranq	ES Episodes	ES WTE	Ptn Leave
Birmingham	1			2												
CAMHS								3								
Community Services				4												
Essex															5	6
LDA	7		8	9										10	11	
Low Secure & Specialist Rehab															12	
Medium Secure			13							14						
Neuro															15	

How to use the above table:

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

Statistical improvement

Improvements

At a Charity level, patient leave continues to increase and is demonstrating a special cause improvement – with the same apparent for Birmingham, CAMHS, LSSR and Neuro. There are further clusters of improvement apparent divisionally for LSSR and Neuro.

Clinical Exceptions - Charity

A. Charity – Long Term Segregation Episodes

There was a rise in use of LTS across Essex and Northampton PICUs and 1 case on Fairbairn ward. Appropriate management plans and discharge plans are in place but this may take 1-2 months to drop back to common cause variation.

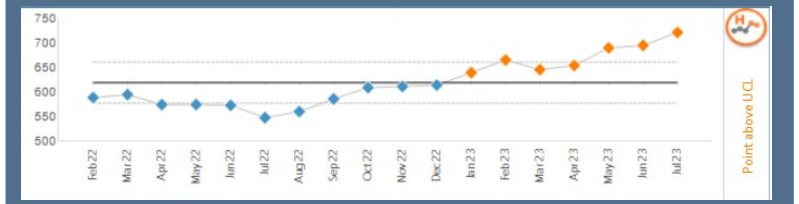
B. Charity – Days in Long Term Segregation

Point above upper control limit

Reflects issues with a cohort of delayed discharges in LDA, for which there is a weekly commissioner meeting and engagement with senior interveners from NHSE to plan discharge. There are also long term single placements treated like LTS. Some additional 'acute' LTS has added for July.

C. Charity – Enhanced Support WTE

Point above upper control limit

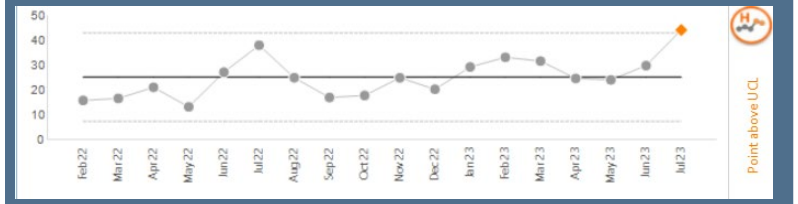


Remains a concern, across multiple divisions. First PDSA cycles of an ES reduction CQI start in Sep 23 involving wards across all divisions. This is a particular issue in LDA on the LD wards and the leadership team have been asked to provide specific plans as to how the clinical model and approach needs to change.

Clinical Exceptions - Divisions

1. BHAM - Incidents

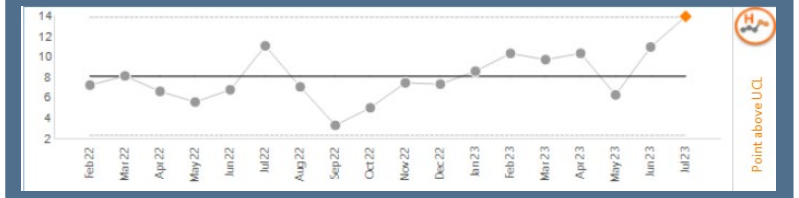
Point above upper control limit



Short term rise on Hawkesley ward, within the scope of normal clinical management to resolve

2. BHAM – Incidents L2

Point above upper control limit



As per Hawkesley explanation.

3. CAMHS – Seclusion Events

Point above upper control limit

Use of short, successive seclusion episodes continues to be the least restrictive intervention to safely manage one patient. Care plan in place to support this.
Plans to ensure seclusion episodes are being initiated by qualified members of staff. Has an exit plan to a bespoke placement. Rise down to better recording

Clinical Exceptions - Divisions

4. Community Services – Incidents L2

Ascending run >=7

Incidents specific to one patient about internet access- now resolved.

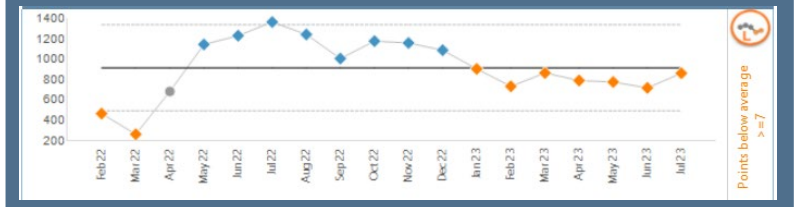
5. ESSEX – Enhanced Support WTE

2 of 3 points close to upper control limit

Increased acuity across the wards.
Relapse of two patients on recovery ward.
May take 2-3 months to reduce.

6. ESSEX – Patient Leave

Point below average >=7



Requested to re-baseline due to ward profile changes
Remains stable over the past several months. Comparative data includes secure services which are now closed. Due to the increased proportion of acute services – a lower level of patient leave was expected.

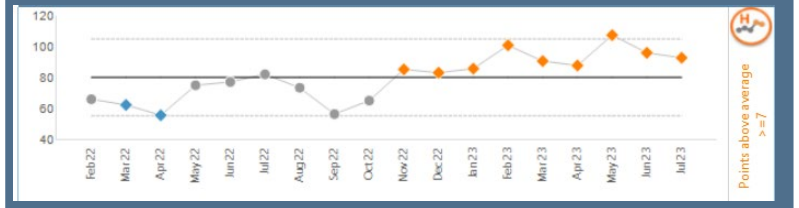
7. LDA – Incidents

Points above average >=7

Acuity in Church, Sunley, Hawkins and Oak accounts for this. Church is in the 9Cs process and there has been an improvement in leading indicators such as supervision and staffing rates so we expect incidents to be back in control over the next 2-3 months.

8. LDA – Incidents Level 1

Points above average >=7



Sunley is not formally in the 9Cs process but is receiving support from the new QM/GMs due to medium term gaps in ward and deputy ward manager input. One patient on Church accounts for half of all incidents - they are now managed in LTS which should bring overall ward acuity down.

9. LDA – Incidents Level 2

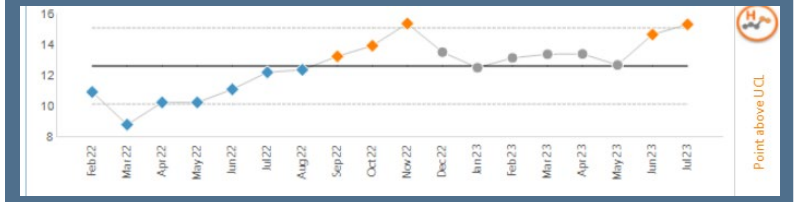
Points above average >=7

The LDA wards are presenting with a period of increased acuity that needs robust input and oversight. There are early signs of incidents moving back to the mean.

Clinical Exceptions - Divisions

10. LDA – Enhanced Support Episodes

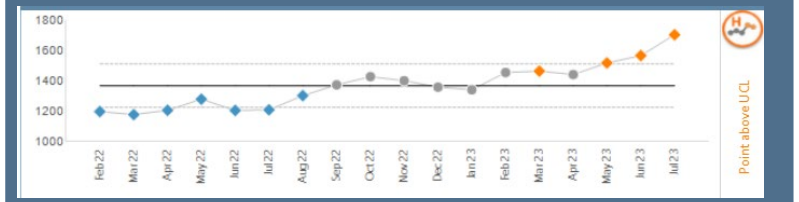
Point above upper control limit



This is an issue spread across Sunley and Marsh, the latter seeing a rise in some incidents requiring short term ES management.

11. LDA – Enhanced Support WTE

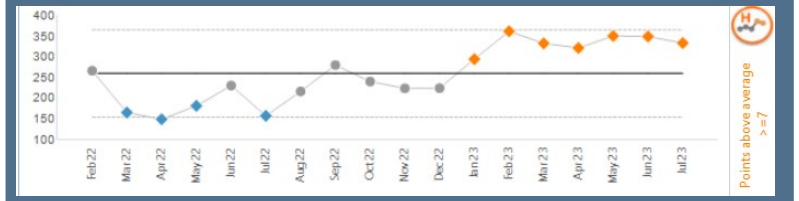
Point above upper control limit



As for ES episodes – this includes staff required for LTS. High on Sunley, Church, Hawkins and Meadow. Needs significant input re delayed discharges, bespoke placements and CQI initiatives to address key drivers. Improvements noted in Oak ward.

12. LSSR – Enhanced Support WTE

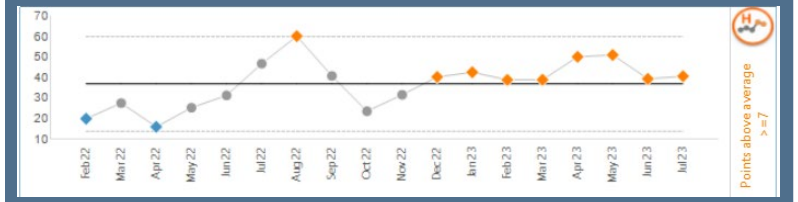
Points above average >=7



Lower Harlestone continue to use enhanced support for inappropriately placed patient and used for a patient at risk of suicide overnight who had stopped sleeping well. A short term rise on Heygate, now lower in August.

13. MSU – Incidents L1

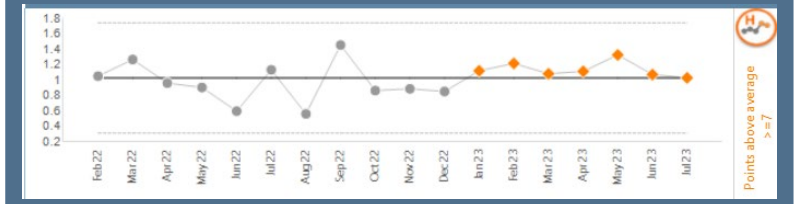
Points above average >=7



Short term rises in acuity on Bracken (mainly), Willow and Rose. Three patients account for over half of all incidents. Reduced below the mean for August.

14. MSU – Long Term Segregation Episodes

Points above average >=7



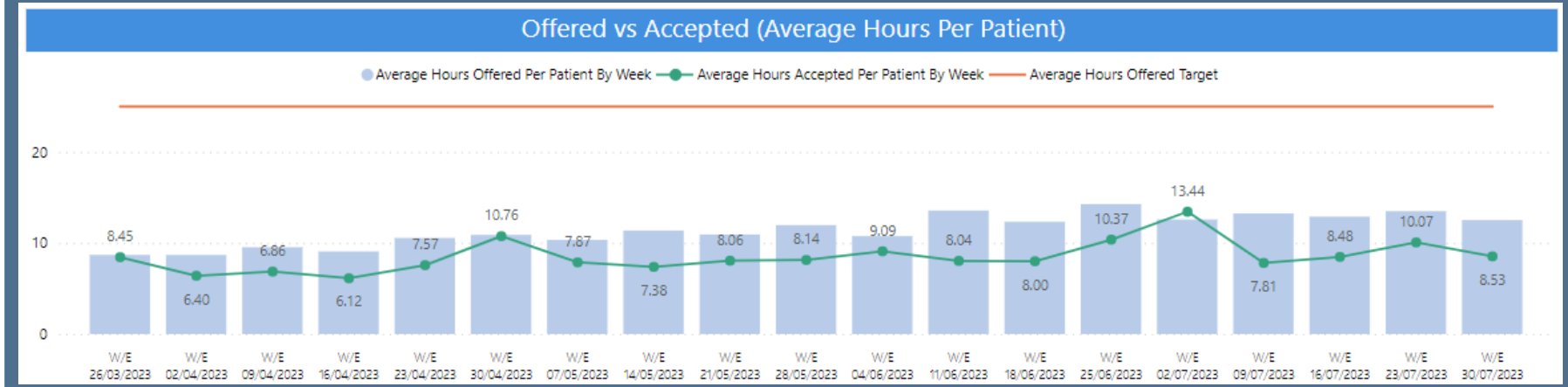
A number of patients in LTS due to a mix of existing patients becoming destabilised, and using LTS as a planned admission pathway to get patients improved (particularly Rose and Cranford) .

11. NPS – Enhanced Support WTE

Point above upper control limit

Across multiple Neuro wards (five wards) with active participation in the ES CQI . Fenwick ward in the 9Cs ward of concern process.

Quality Drivers – Meaningful activity & Observations compliance



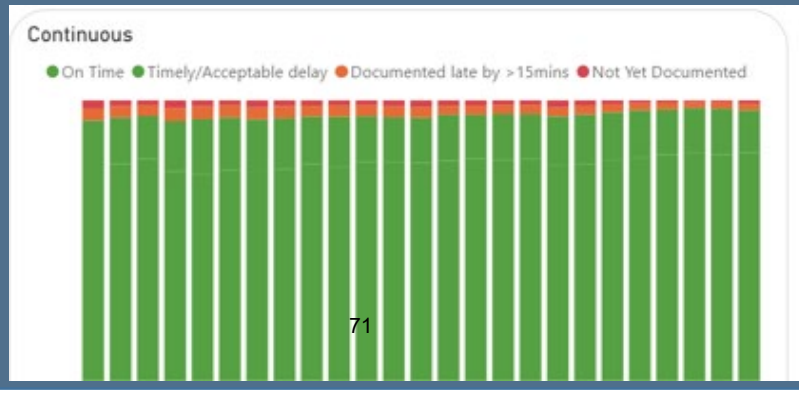
Actions to support the Meaningful Activity (MA) target being reached:

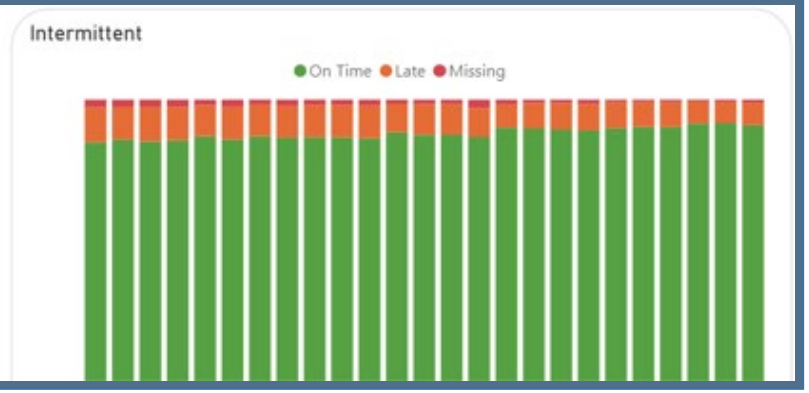
- MA procedure and socialisation of that by the Head of AHP and through the Therapies Advisor Group
- Each ward has Technical Instructor input rostered (where possible)
- Ad hoc recording is available through RiO and tablet devices
- Looking at how we enable Workbridge and Adult education staff to add to the MA system (as they don't necessarily have RiO access)
- Links to the MA dashboard directly from RiO to encourage oversight in ward governance.

Meaningful activity - The expected target is 25 hours per week. The divisions each have this target on their QIP to achieve by the end of November 23. With this in mind, we remain in the embedding/ improvement phase as it pertains to accurate recording and so we believe the current outturn represents an under-recording of offered and accepted activity.
LSC and Birmingham have made the most progress so far. The MA procedure sets out how timetables should be planned. The MA dashboard continues to be developed to allow easier visualisation of reasons for Cancelled sessions, what types of therapies are being offered and whether they match the intent of the clinical model and/or are associated with better outcomes. A common gap is ad hoc nursing sessions with patients and ensuring they are recorded, especially activity within secure buildings that may not be recorded as S17 leave (which would automatically add to the system). The 'dip' in accepted sessions is due to a higher percentage of un-outcomed sessions in July.

Observations - Weekly view – last 24 weeks

- Steady rise in compliance with exceptional performance in LSC and Medium Secure. Continued focus to get all divisions above 90% on time.
- New ES dashboard was launched in September - giving greater detail on missed or late observations and times of day – this insight will drive further improvement activity.
- The majority of self harm whilst on enhanced observations is head banging or wound interference which cannot be prevented by ES, only the harm mitigated. Improvements to the safety dashboards are planned to include harm levels for all incident types.





People

Measure	Target	St Andrews			Clinical Services			Corporate Services			Estates			ERT		
		Jul-23	6 month trend	SPC	Jul-23	6 month trend	SPC	Jul-23	6 month trend	SPC	Jul-23	6 month trend	SPC	Jul-23	6 month trend	SPC
Voluntary Turnover In Year	13%	13.1%		Improvement	13.9%		Improvement	17.5%		In control	10.0%		Improvement	6.8%		In control
Voluntary Turnover In Month	1.1%	1.1%		In control	1.0%		In control	1.5%		In control	1.9%		In control	0.5%		In control
Vacancy Rate*		15.1%														
Mandatory Training**	90%	90.8%		Improvement	90.5%		In control	94.0%			89.2%			96.4%		
Mandatory Training (Perm)*		92.1%			92.0%			94.4%			89.9%			96.4%		
Sickness % In Month	7.7%	6.0%		Improvement	6.4%		Improvement	0.8%		In control	6.6%		In control	1.8%		In control

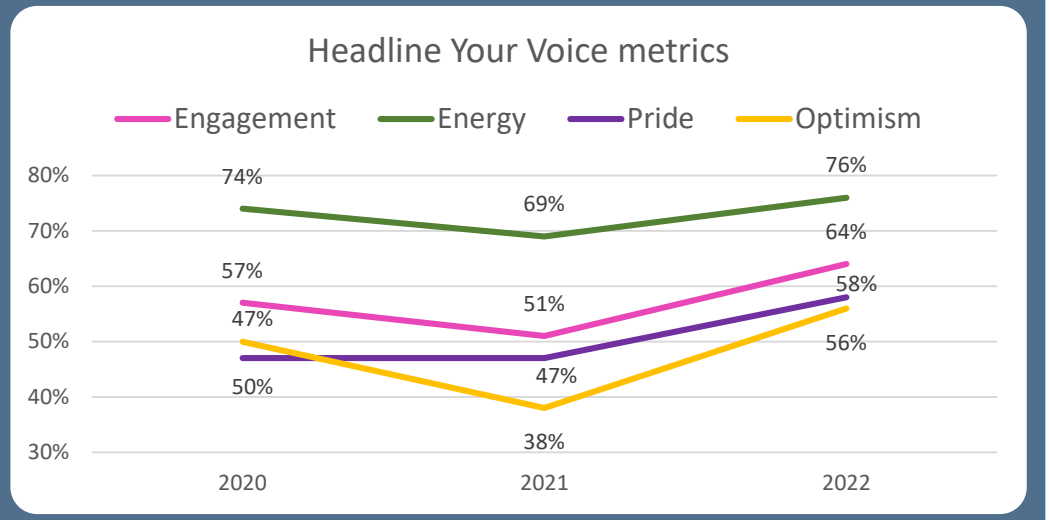
*Historic data not aligned to new structure
**Historic data includes changes made to course requirements July 23

How to use above table chart:

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

Positive People Performance:

- Notably both **sickness and** recent **voluntary turnover** performance are remain **favourable to target** (sickness is in focus due to recent adverse trends, notable for August)
- Additionally July saw **mandatory training return above target –** this reflects the combined efforts of Clinical Service and L&D. The metric returned to target in line with the planned trajectory
- The non-patient facing metric continues to show strong performance, remaining **favourable to budget**
- The above correlates with the **very positive improvements in staff Engagement scores** from 51% (2021) to 64% 2023 (with a response rate above the NHS average)



Focus areas:

- Management Supervision is being redesigned. Clinical Supervision is below target at Charity level, this is chiefly driven by LDA and Birmingham with associated actions on their Quality Improvement Plans.
- The following slide provides explanations for adverse to target metrics, alongside providing additional specifics for metrics the Board have asked to have visibility of

Multi-disciplinary establishment review:

The annual nursing establishment review has been strengthened and expanded becoming a full multi-disciplinary establishment review, determining the mix and quantum of professionals working collaboratively together, with patients to enable positive outcomes. The review is live, due to complete late 2023 - reporting professional level establishment will follow.

People

Voluntary Turnover

Special Cause Improvement (with a trajectory towards target)

The positive trajectory towards target continues – with the performance showing special cause improvement. The Charity Retention Framework and associated action plan provides a continued focus. Continued strong performance through the early stages of organisational change - aligning with the improved Engagement scores. August is marginally higher, in line with seasonal norms.

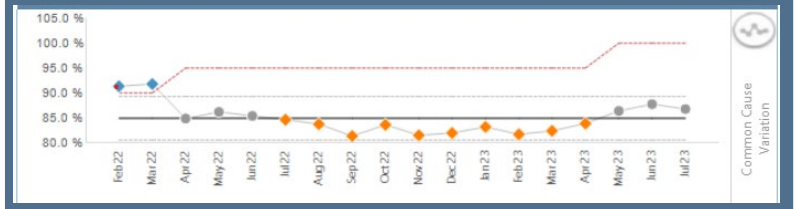
Mandatory Training

Special Cause Improvement

The Charity is now favourable to target. At course level, Oliver McGowan training favourable, BLS and SIT levels are progressing towards target. The ILS refresh period reduced to one year (extended previously due to COVID) impacting the result and requires focus. Refreshed scheduling approach will support. Bank compliance has improved – with targeted activity due to close in August.

RN Establishment

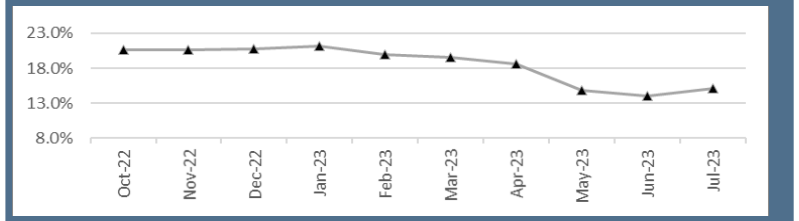
Challenge continues



Challenging local and national recruitment picture continues. In the Autumn we will see the addition of our ASPIRE nurses. The Nursing Workforce plan has been approved at Exec and People Committee – this sets out the longer term plan for securing the required nursing workforce. This plan will be revisited following the results of the live multi-disciplinary establishment review.

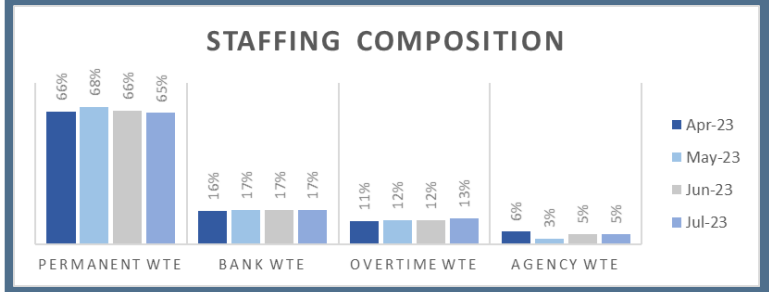
Vacancy rate

Consistent performance



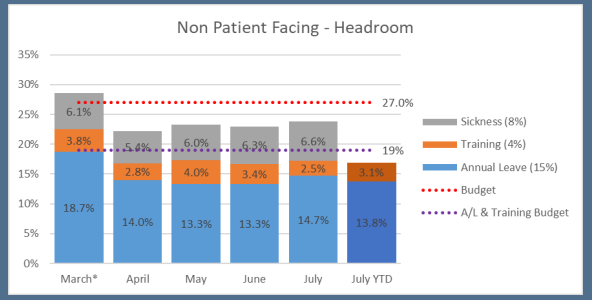
The vacancy rate remains in line with expectation – a target is to be added in the October KPI review. To complement the vacancy rate a Stability Index is additionally being monitored, with the July return at 85.3% - meaning that less than 15% of employees have been with the organisation less than one year.

Rostered ward staffing composition



Shifts completed by permanent staff (including overtime) represented 78% of the July patient facing shifts (80% in May). Agency usage is negligible in percentage terms. Focus remains on utilising agency when strictly necessary – typically for registered shifts.

Non-patient facing shifts



July saw sickness for rostered staff running positively below budget. Annual leave was well planned being in line with budget, a strong performance in a historically high leave month. Training was lower than target, this did not hinder the achievement of the training KPI, yet remains in focus to ensure training spaces are optimised and compliance levels remain high.

Divisional integrated performance summary

	Measure	Community Services	LDA	LSSR	CAMHS	Medium Secure	Neuro	Birmingham	Essex	Community Partnerships
Safety	Ward level SPC Concerns	0%	10%	2%	4%	3%	5%	2%	1%	N/A
	Ward level SPC Improvements	3%	6%	4%	8%	1%	4%	2%	0%	N/A
	Positive My Voice (May23 – Jul23)	Under development	78%	73%	55%	72%	75%	80%	67%	Being relaunched
Workforce	Voluntary Turnover In Year (13%)	11.1% Improvement	11.3% Improvement	15.4%	25.6%	12.2% Improvement	12.1% Improvement	8.0% Improvement	19.8%	11.3%*
	Voluntary Turnover in Month (1.1%)	0.0%	0.7% Improvement	1.1%	1.7%	1.3%	0.5%	0.4%	1.3%	0.0%*
	RN Establishment (100%)	111.1%	99.7% Improvement	83.1% Improvement	78.2%	74.2%	90.7% Improvement	92.6% Concern	81.3% Improvement	N/A
	Training (90%)	90.0% Improvement	89.0% Improvement	93.2% Improvement	92.4% Improvement	90.8% Improvement	91.0% Improvement	87.5% Improvement	89.6% Improvement	95.0% Improvement
	Sickness % In Month (7.7%)	10.7%	9.5%	5.5% Improvement	8.6% Improvement	5.4% Improvement	5.7% Improvement	5.4%	5.5%	1.2%
	Non Patient Facing Headroom (27%)	N/A	24.6%	24.4%	Included in LSSR	23.8%	23.2%	22.5%	23.2%	N/A
Safer Staffing	Shifts <80%	4%	14%	12%	6%	6%	9%	11%	24%	N/A
Finance	Shifts >100%	80%	33%	20%	40%	42%	39%	17%	17%	N/A
	Mth Net contribution vs budget % (100%)	28.3%	78.3%	85.3%	Included in LSSR	103.4%	88.1%	108.2%	94.9%	33.1%
	YTD Net contribution vs budget % (100%)	6.6%	81.1%	94.9%	Included in LSSR	98.7%	104.0%	97.9%	81.7%	90.9%
	Occupancy vs Budget %	100.0%	90.9%	93.6%	Included in LSSR	99.2%	95.7%	101.3%	87.4%	N/A
Focus wards	9C review wards		Church	Seacole & Stowe		Willow	Fenwick			N/A

LDA - 10% of safety related metrics at ward level returning SPC concerns. My Voice is strong and there has been improvement in the workforce metrics, noting the requirement to focus on sickness. The COO has instigated a review of the financial outturn of LDA (including Community Services) and Neuro to refine the improvement planning. CAMHS, now under the leadership of Low Secure, are making progress – plans are in place to improve their combined finances. Community Partnerships growth plans are supported by new BD Director. Birmingham and Medium Secure are performing well across the majority of the above metrics.

Financial Performance August 2023 YTD

Net deficit £3.46m, which is **£0.17m better than budget**

- August 2023 closing occupancy of 626 **was 97% of budget** (lower income than budget)
- Operational costs **exceeded budget (£1.6m)** partially due to higher patient acuity offset by income (higher income than budget) but also costs have exceeded budget (both staffing and non pay).
- Corporate Services costs £0.47m below budget due to HR savings and then smaller savings across most areas.

Net impact of these factors - Operating Deficit **£0.8m worse** than budget. Executive Team have taken immediate action to mitigate ongoing impact to operational financial performance.

- Operating deficit offset by non operating costs **£1m lower than budget** with lower exceptional costs and Opex project costs incurred
- At August 2023 **cash held was £9.3m** (£5m above budget) mainly due to slower CAPEX expenditure than budgeted and payment of backdated staff pay increase (paid September 2023).
- No material movement in investment portfolio and no covenant risk existed.

Financial Year 2023/24 Outlook

- Next update of 2023/24 forecast v budget to be shared with Private Board in November 2023

Financial Performance August 2023

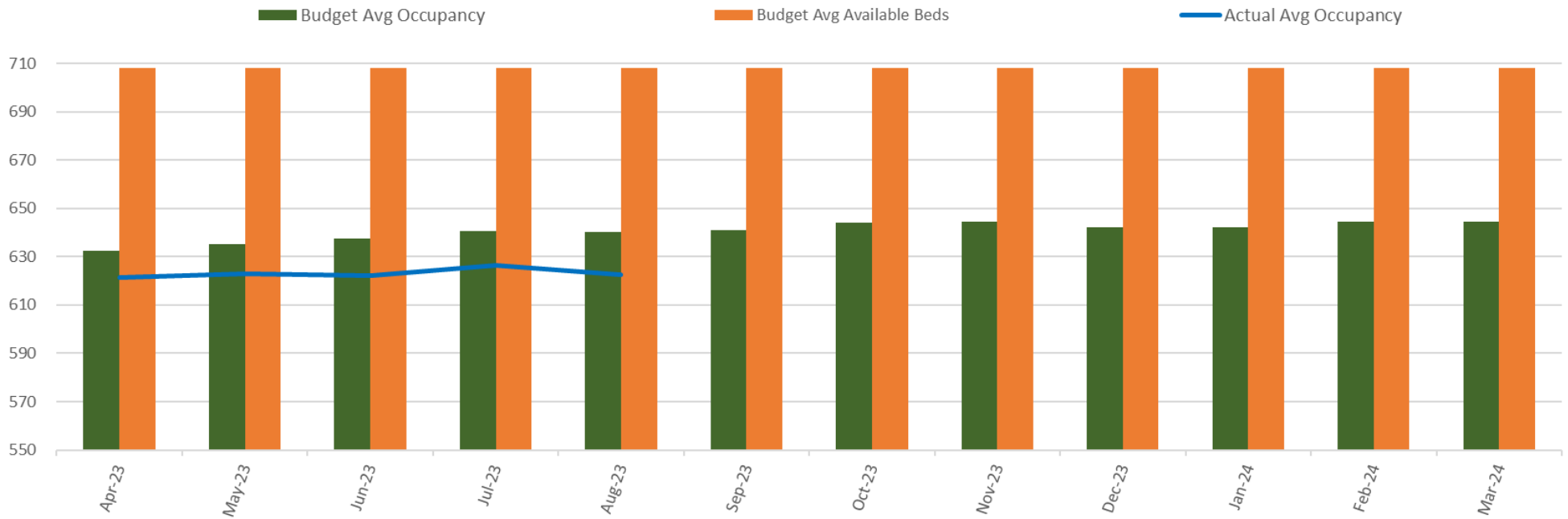
	August 2023 YTD			Full Year
Financial Performance - £m	**Actual**	**Budget**	**Variance**	**Budget**
Income	78.71	78.37	0.34	189.79
Operational Costs	(68.29)	(66.72)	(1.57)	(159.84)
Net Contribution	**10.42**	**11.64**	**(1.23)**	**29.94**
Corporate Services	(7.38)	(7.86)	0.47	(18.48)
Depreciation	(4.21)	(4.20)	(0.02)	(9.89)
Operating Surplus/(Deficit)	**(1.18)**	**(0.41)**	**(0.77)**	**1.57**
Non Operating Costs	(2.28)	(3.23)	0.95	(6.16)
Net Surplus/(Deficit)	**(3.46)**	**(3.64)**	**0.17**	**(4.59)**
KPI's				
Available Beds	710	708	2	708
Avg Occupied Beds	623	637	(14)	641
Closing Month Occupancy	626	638	(12)	645
Avg Occupancy %	88%	90%	(2%)	91%
Net Contribution % Income	13%	15%	(2%)	16%
Investment/One Off Costs £m				
CAPEX Costs	(0.2)	(3.6)	3.4	(6.1)
OPEX Project Costs	(1.3)	(2.1)	0.7	(4.9)
Exceptional Costs	(1.0)	(1.1)	0.1	(2.1)
Total	**(2.6)**	**(6.8)**	**4.2**	**(13.1)**

Cashflow & Balance Sheet August 2023

	YTD			Full Year
Cashflow £m	**Actual**	**Budget**	**Variance**	**Budget**
Net Inflow / (Outflow) from Operations	1.3	(0.3)	1.6	3.7
Other Net Cash Inflow / (Outflows)	(0.2)	(3.6)	3.4	(5.9)
Total Cashflow Movement	**1.0**	**(3.9)**	**5.0**	**(2.3)**
Cash Held	**9.3**	**4.4**	**5.0**	**6.1**
Bank Loan Balance	(20.0)	(20.0)	0.0	(19.0)
RCF Headroom	**7.0**	**7.0**	**0.0**	**7.0**
Investment Portfolio	11.4	11.4	0.1	11.4
Covenant Risk	N	N	-	N

Balance Sheet Summary £m	**Sept 22**	**Dec 22**	**Mar 23 Unaudited**	**June 23**	**Jul-23**	**Aug-23**
Fixed assets	192.7	190.8	189.1	186.5	185.8	185.0
Investments	17.4	16.5	16.5	17.1	17.1	17.2
Net Current Assets/(Liabilities)	0.1	(0.1)	0.5	(0.0)	0.5	1.0
Bank Loan Balance	(20.0)	(20.0)	(20.0)	(20.0)	(20.0)	(20.0)
Pension	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)
Total Assets Employed	**189.6**	**186.6**	**185.5**	**183.0**	**182.8**	**182.6**

Occupancy



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Budget Avg Available Beds	708	708	708	708	708	708	708	708	708	708	708	708
Budget Avg Occupancy	633	635	638	641	640	641	644	645	642	642	645	645
Actual Avg Occupancy	621	623	622	626	623							
Actual Closing Occupancy	625	620	631	624	626							
Actual % Achievement of Budget	98%	98%	98%	98%	97%	0%	0%	0%	0%	0%	0%	0%
Avg Occupancy of Available	88%	88%	88%	88%	88%	0%	0%	0%	0%	0%	0%	0%

IT Security Metrics (JUN – AUG 2023)

Legend	No Change	Trending Down	Trending Up

	JUN	JUL	AUG	RAG Rating	AUGUST *Causal*	AUGUST Remediation
Vulnerabilities not fixed within SLA Highlights the amount of vulnerabilities that haven't been fixed within the agreed timescales with no dispensation.	0	0	0		**Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix.	**Remedial Actions:** There are currently no active non-conformances.
Overdue Penetration Test Remediation The last Pen test for the Charity was in September 2022. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: We are due an external Pen test for 2023, early discussions have begun to identify a target and to agree the scope of engagement with a third party. This is expected in September.	**Remedial Actions:** There are currently no outstanding actions from previous Pen Tests.
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 2 P3 3	P1 0 P2 2 P3 6	P1 0 P2 0 P3 2		**Causal Analysis**: There were two phishing incidents in August the incidents were contained. IT Security continue to proactively monitor for phishing threats.	**Remedial Actions:** A full phishing exercise was conducted in May, it is evident that some staff are not reporting phishing emails even if they are interacting with it. Another test is due next month to test improvements.
Blocked Network Attacks These are blocked network attacks directed at our external network edge	28484	18919	30359		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. High risk IPs are automatically dropped and blocked at the firewall. This trend is seen globally and follows NCSC and NSA trend analysis due to present conflicts.	**Remedial Actions:** A new network threat detection tool is fully operational and is monitored 24/7 by a third party Security Operations Centre. (SOC)
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	1	1	0		**Causal Analysis**: We have received our ISO27001 surveillance report from SGS, the report contains two minor non conformances and three opportunities for improvement. Several ISMS controls are due for internal auditing.	**Remedial Actions:** One finding is overdue and relates to the asset tagging of historical information baring assets. Secure destruction of all legacy tapes, hard disks and IT equipment is planned for early august to address this.
% of Fully Patched Systems % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 90.32% Client = 91.77%	Servers = 90.52% Client = 92.22%	Servers = 94.21% Client = 95.60%		**Causal Analysis**: An Overall percentage - an average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc).	**Remedial Actions:** The team are working through the non-patched to ensure they are fixed and up to date as they come online.
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	98%	98%	99%		**Causal Analysis**: Older versions will be updated as computers come back online, the update process is fully automated. Percentages are within tolerable levels.	**Remedial Actions:** IT Security will continue to monitor and chase Advanced for any stragglers.
Network Security Events Critical/High cases detected by 'SenseOn' which monitors for unusual or suspect network/user activity.	18	11	7		**Causal Analysis**: There have been 7 high cases in August, 6 were benign and 1 needed investigating. SenseOn is beginning to learn what is normal and has resulted in a drop in false positive alerts.	**Remedial Actions:** All network activity is monitored by a 24/7 SOC. 99% of the estate is monitored. Ransomware detection and isolation is active across the estate.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	92%	91%	90%		**Causal Analysis:** The data has not yet been released for July, but is expected for cyber awareness training to be at similar tolerable levels for the estate.	**Remedial Actions:** All staff who are out of date with any of these areas prioritise completion of this e-learning. Managers to check via SAP to ascertain who in their times has outstanding e-learning and enable them to complete.

Service and Patient Story

Social Work Update
A Patient's perspective

Questions from the Public

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Meeting Reflections

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

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public -

Thursday 30 November 2023 9.30am

(Paul Burstow - Verbal)

Annex A

Research Update
Appendices

Physical Health Research Stream
Proposal
Clinical Secondments Paper
Staff Head Injuries Paper

Annex B

QSC Update Appendices

Annual Safeguarding Report
Responsible Officer &
Re-validation Report

Annex A

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Research theme - Physical healthcare and physical activity

The Charity's Research Strategy, approved by the Board in 2022, has five primary strands:

- Physical healthcare and physical activity
- Trauma-focussed care
- Community mental health
- Technology-assisted therapies
- Precision medicine

More recently, due to the generosity of a legacy from the Garlick family, a sixth strand focussing on Huntington's disease has now been included and a detailed research programme will be brought before the Board at the end of 2023 to start in early 2024. The Trauma-focussed care strand has already been initiated with the established of the Centre for Developmental and Complex Trauma under the leadership of Dr Deborah Morris. The next strand to be initiated will be "Physical healthcare and physical activity". This is already an active research area at St Andrew's Healthcare with a number of joint PhD studentships having been co-funded by the University of Loughborough. Now is an opportune time for this to be established as a "stand-alone" research strand with a dedicated research staff member to lead the stream. This will allow the Head of Research and Innovation, who has previously co-supervised the PhD students, to focus on the development and implementation of the research strategy as well as externally funded contracts such as the NHSE CAMHS evaluation and Innovate UK MeOmics collaboration.

It is acknowledged that we can achieve sustained improvements in our patients' health outcomes through the development of a parity between physical and mental health outcomes. To this end, we will carry out research into new ways to improve our patients' physical health; for example, though research into physical health treatments, sleep, exercise, screening programs and innovative physical health therapies targeted for patients with severe mental illness. We can develop novel treatment pathways which will optimise the therapeutic journey that our patients receive while they are within our care and will ensure that their time with us is minimised.

The stream will be led by a consultant clinical psychologist who will spend two days per week focussed on research. The candidate will report to the Managing Director of ERT and they will be expected to become an independent researcher with responsibility for this research strand, reporting regularly to the ERT Board Committee.

The cost of the post will be determined by the level of the appointment of the candidate. However, based upon our existing clinical fellowships, the annual salary cost for 0.4FTE will be approximately £36k (at 2023 salary rates).

Research associate – fixed term post

As the physical health theme expands, there will also be a requirement for a senior researcher at post-doctoral level (research associate) to take responsibility for the day-to-day running of the research strand, considering that there are a number of projects either already ongoing or already in the pipeline (see PhD studentships below). This person will also be responsible for the collaboration with the Physical Health and AHP teams and the clinical staff as well as stimulating a research ethos within this staff group. It is anticipated that the Research Associate will be appointed to an initial fixed-term (3-year). The post holder will also be expected to facilitate other research projects within the theme, such as those that support MSc-student placements, as part of our collaborations with

the University of Buckingham and University of Northampton. In addition, the role will include assisting the Head of Research & Innovation in the generation of new research grant applications to increase our research revenue streams.

Year	Grade 7 Research associate	Pension and NI (14%)	Total
2024	£34,308	£4,803	£39,111
2025	£35,333	£4,946	£40,279
2026	£36,386	£5,094	£41,480
Total	**£106,027**	**£14,843**	**£120,870**

Additional posts – funded postgraduate students

Primary collaborator - Loughborough University (PhD studentship co-funding agreed by the University)

STRAND: SLEEP

Project – The benefit of physical activity for sleep problems associated with mental ill-health
Supervisors: Dr Iuliana Hartescu

Staff focus groups and inpatient interviews reported that irregular sleep schedules are common, sleep is often disturbed by noise and disruption from staff and inpatients, and physical activity in the daytime can enhance sleep quality.

An initial feasibility study was conducted at St Andrew's, in order to design a personalised physical activity intervention to improve inpatient sleep quality. The 10-week intervention involved 21 adult inpatients engaging in physical activity for 3x10 min intervals (self-selected intensity) across the day for five days per week. Although there was a level of inter-patient variation, there was an overall decrease in insomnia symptoms, a significant advance in sleep phase, and an increase in moderate-to-vigorous physical activity levels over a 24-hour period over the time of the intervention. Staff and inpatients completed structured qualitative evaluations which indicated that the intervention (and research team) were acceptable, feasible, and effective in improving inpatient sleep quality.

The next stage in this trial is to roll this out on a wider scale, learning from the lessons obtained from the feasibility study. This will include the development and implementation of educational programmes which encourage good sleep hygiene practices, including use of daytime physical activity, but which are flexible to enable them to be tailored for the needs of individual patients. The patient-to-patient variance in health outcomes provides evidence for the need to focus on person-centred care and future research and clinical practice should place emphasis on co-production.

Projected timelines: Jan 2024 – Dec 2026
Costs: PhD student

Year	Total	St Andrew's	Loughborough
2024	£28,334	£14,167	£14,167
2025	£29,592	£14,796	£14,796
2026	£30,924	£15,462	£15,462
Total	**£88,850**	**£44,425**	**£44,425**

STRAND: PHYSICAL ACTIVITY AND NUTRITION

Project - The impact of nutrition and physical exercise on mental recovery

Co-supervisors: Dr Flo Kinnafick & Dr James King

While physical exercise and activity are essential components of good physical health, ultimately contributing towards mental health recovery, other elements including diet also play a key role with nutrition having a particular impact on energy balance and weight. The first part of the study will be to profile the weight trajectories of patients to identify who are most likely to gain weight over time and what the key risk factors are. This data will then set the broad initial guidelines for the co-production of a combined intervention package that will include elements of exercise and activity in combination with a healthy lifestyle and will involve combined members of the multidisciplinary team. The overall aim will be to design a united tailored care package for the patient and to assess its effectiveness using a combined physical and mental healthcare outcome package based upon the data collected routine in the clinic. The ultimate aim will be to make this toolkit available on a wider basis throughout the community.

Projected timelines: Jan 2024 – Dec 2026

Costs: PhD student

Year	Total	St Andrew's	Loughborough
2024	£28,334	£14,167	£14,167
2025	£29,592	£14,796	£14,796
2026	£30,924	£15,462	£15,462
Total	**£88,850**	**£44,425**	**£44,425**

STRAND: PHYSICAL ACTIVITY

Project – Physical activity – the "Move More" toolkit

Co-supervisors: Dr Flo Kinnafick & Dr James King

Current treatment for symptoms of severe mental illness (SMI) largely includes expensive medication and/or psycho-therapy interventions such as talking therapies or cognitive behavioural therapy (CBT). Whilst both approaches are effective treatments for SMI symptoms, they do not address the growing physical health burden in this population. Those with SMI have a reduced life expectancy of up to 20 years compared to the general population, and are more likely to be obese and have a range of physical co-morbidities (e.g., cardiovascular disease, diabetes). The effect of physical inactivity is magnified in the restricted environment of a secure setting. Sustained physical activity (PA) can reduce susceptibility to a range of physical co-morbidities, whilst improving mental health symptoms.

There are two versions of the 'Move More' toolkit, one for staff and one for patients; both were co-produced by patients at St Andrew's, following funding from Loughborough University, and will support staff (multi-disciplinary team, including physiotherapist, occupational health, nurses and healthcare assistants) to facilitate exercise as part of individual care plans for patients on secure mental health wards. Introduction of the 'Move More' staff *and* patient toolkits will be supported by 2 training sessions tailored to specific staff members (primarily HCA and nursing staff) and used on the wards with patients. A 12-week person-centred intervention to increase movement will be implemented with each patient with ultimate benefits to the patients' mental and physical health. An application is currently being prepared for the Research for Public Benefit (RfPB) stream of the National Institute for Health and Care Research (NIHR) to fund the development of this "Move More" intervention. This will be piloted at St Andrew's and an NHS site, with recruitment,

adherence, retention and response being the primary outcome measures. The results will be used as the basis for a subsequent larger trial that will explore this physical health intervention from a health economics perspective.

Projected timelines:

Nov 2023	Project submission (value £150k)
May 2024	Project decision
July 2024	Project start (tbc)
Dec 2026	Completion with preparation of follow-on study

Other collaborators - University of Birmingham

The University of Birmingham has established a Centre for Doctoral Training Plus in Sport, Exercise and Rehabilitation Science that is due to open in October 2023. The focus of the Centre is on understanding behaviour and the goal is to develop behavioural researchers for the future who are equally prepared to work in academia or in government, health or industry. A key component of the Centre involved the identification of partners who will co-fund PhD studentships, with St Andrew's Healthcare being one such collaborator. The role of partners includes contribution to the training, design and delivery, proposing topics for challenge days, and taking students on placement to do research that is of interest to the organisation. The academics in the Centre will work with partners to co-design PhD studentships that meet the interests of the partner and also meet the requirements of a doctoral degree. Topic-led opportunities will then be advertised as fully-funded PhDs, which means we can get applicants genuinely interested in the topics to do this important research. The Centre also includes a scheme for a 1-year post-PhD fellowship, where the student continues to be paid by the Centre's funds (no cost to partners) to translate their research into practice (e.g., training, toolkits, etc.) or work on developing a communication strategy for the relevant practitioner community or the public. These are just examples but essentially the point is to ensure the research has a positive impact in the world outside academia. Partners can also access training we provide as CPD for their staff.

Potential timelines: PhD studentship start date Oct 2024 (tbc)

Total 3-year physical health programme financial investment:

	2024	2025	2026	Total
Consultant	36,000	37,800	39,690	113,490
Research associate	39,111	40,279	41,480	120,870
PhD student 1	14,167	14,796	15,462	44,425
PhD student 2	14,167	14,796	15,462	44,425
TOTAL	103,445	107,671	112,094	323,210

Dr Kieran Breen
Head of Research & Innovation
20 July 2023

Clinical Fellowships: Development of our Research Potential

Introduction

There is a substantial appetite for clinicians to be involved in clinical research and the NHS routinely ring fences 0.1 FTE (1 clinical session per week) for research and/or audit. However, the primary reason for poor involvement within the charity has traditionally been lack of time due to clinical and administrative commitments. Previous internal discussions, including a stakeholder review in 2020 and an external benchmarking exercise (against a similar sized NHS Trust), in addition to an informal evaluation of the first two Clinical Fellowships, have indicated that 2 days per week of ring-fenced time for each clinician would be sufficient to develop and implement an appropriate research programme.

One of the drivers behind the Fellowship Programme was the perception that certain clinical staff members, who may have had an interest and expertise in research, were being frustrated by not being able to pursue this area and that this may have been one of the reasons behind talented staff leaving the charity prematurely. Furthermore, the lack of research opportunities may also have acted as a barrier for talented clinicians applying for positions at St Andrew's Healthcare.

In 2020, the Clinical Fellowship Programme was launched to facilitate ring-fenced research time for clinicians and Dr Inga Stewart and Dr Charlie Staniforth were awarded two-year 0.4 FTE Fellowships to allow them to carry out specific research projects (subsequently extended to 2.5 years). They have been supervised by the Head of Research and Innovation while being assigned an external academic mentor to assist them in their research studies. They were also assigned a part-time research assistant for the final year of their project to assist in the data collection and analysis.

Candidates

In 2020, the Clinical Fellowships were restricted to internal candidates and from five applicants, two successful candidates were chosen. However, informal enquiries suggest that there would be currently few potential internal candidates interested in applying if Fellowships were to be advertised in autumn 2023 (to start in 2024). This would be an ideal opportunity to open this up to external candidates who are joining St Andrew's Healthcare either as consultant psychologists or psychiatrists. This would allow them to have joint clinical/research posts for the first two years of their position at St Andrew's Healthcare, which could prove to be an attractive proposition and therefore would be likely to entice strong candidates who already have a research background and potentially a history of research funding and publication as well as collaborative research.

Each Clinician's role would be to lead a programme (strand) of research that will deliver a *'step change'* in the research and innovation activity in their agreed area (refreshed strategy). The following is a non-exhaustive list of examples of such step change as a part of developing a new programme of research:

- Delivery of a new tool, treatment or therapy
- Use of existing data to identify, develop and test innovations
- Increase in meaningful engagement between Divisions and Research & Innovation
- Collaborations with academic organisations

While the role holder must have the necessary skills to conduct and lead independent research; however, the Research & Innovation team will provide support around project governance, ethical approval, grant applications, statistical analysis and access to charity-wide clinical data. The posts will be line managed by the Head of Research and Innovation or another senior researcher within St Andrew's Healthcare and they will also be assigned to an external academic mentor appropriate to their field of study for additional support.

Next steps

If approved in principle by the Research Committee in August, the next stage is to identify the potential clinical roles that are likely to become available over the next six months following a discussion with the EMD and Director of Psychological Therapies which will conclude how these to be advertised. The potential for internal candidates to apply for Fellowships should still be considered. It is planned that there will be a maximum of two posts (0.4 FTE) starting in January 2024 for 24 months. The cost will depend on their salary.

This will be separate from any posts that may be agreed as part of other research strands such as the Huntington's Research Programme.

Dr Kieran Breen
Head of Research & Innovation
20 July 2023

Staff Head Injuries

There has been an increasing awareness of the incidence of patient-initiated staff head injuries resulting in short-term sick-leave, long-term illness or even premature termination of employment due to physical or mental health reasons. This has been specifically highlighted by Dr Annette Greenwood of the Trauma Response team.

Therefore, there is an urgent need to develop an empirical evidence base to determine the extent of the problem at St Andrew's and also how this may compare with similar institutions of a similar nature (low/medium secure hospitals treating patients with mental health issues). Our insurance company has agreed to, at least in part, underwrite a scoping study to understand the extent of the problem and to plot the next stages of potential research and policy implementation in the area.

Study plan

The scoping exercise will be carried out by a research assistant over a three month period. The data collected would include:

- Datix incidents of staff injuries over five years (July 2018 – June 2023) according to ward/division throughout the charity
- Staff time off due to injury (anonymised HR records according to ward/division)
- Co-variants (e.g. COVID, staff absences, ward incidents etc.)
- Patient acuity levels
- Literature search on staff head injuries reported in other similar institutions in the UK and abroad

The study would also include a number of individual case study interviews with staff members (with their permission) to understand the background to the serious incidents which resulted in staff head injury and the impact that it has had on them. This will help to contextualise the issue.

Conclusions and next steps

On completion of the review, we will have a better understanding of the number of incidents of severe staff head injuries within St Andrew's and whether this is increasing and therefore is a problem that needs to be addressed as a matter of urgency. By looking at historical incidents over a five year period, this will overcome any changes that may have been associated with staffing due to organisational re-structure or external factors such as COVID. It will also address our fluctuating patient population within divisions by monitoring

patient acuity. By scoping publications in the area, we will also understand what other research has been carried out into head injuries suffered by staff working in secure mental health institutions and the factors that may have been responsible for these. Ultimately, this will provide the base for making an informed decision on how to proceed on the development of a trauma-based therapeutic rehabilitation programme for staff who have suffered head injuries at work while employed at St Andrew's. Furthermore, we need to be proactive to reduce the risks that the staff are exposed to. The aim is to change policy and procedure around how staff injuries are dealt with including educating staff and assigning appropriate responsibility to managers.

21st July 2023

Annex B

QSC Update Appendices

Annual Safeguarding Report
Responsible Officer &
Re-validation Report

Part 2 – Safeguarding Annual Report

Review of priorities for 22/23 set in prior report

- Develop the recruitment of Safeguarding Navigators on each ward to improve immediate and safe responses to patient safeguarding incidents. They will have extra training in the processes related to safeguarding and will support other colleagues on the wards to understand their responsibilities when a safeguarding incident occurs.
    - *Progress made and this initiative is ongoing in 23/24. SG navigator training has been delivered across multiple wards*
- Safeguarding supervision slots will be offered to all staff to book (virtually and F2F)
    - *Offered and is available*
- Bi-weekly Action Learning Sets in each area to support team planning and responses to evolving themes on wards or in divisions.
    - *Not implemented as intended reflective of divisional capacity*
- Safeguarding Practitioners allocated to divisional areas to ensure immediate response to wards where incidents have occurred to provide reactive advice and guidance to support staff to develop in their own confidence when dealing with safeguarding incidents.
    - *Complete*
- Charity wide audit of safeguarding processes and responses to ensure we are compliant with statutory guidelines and good practice expectations.
    - *Internal Audit completed Oct 22 and related action plans formed.*

Review of 22/23 Safeguarding Incidents

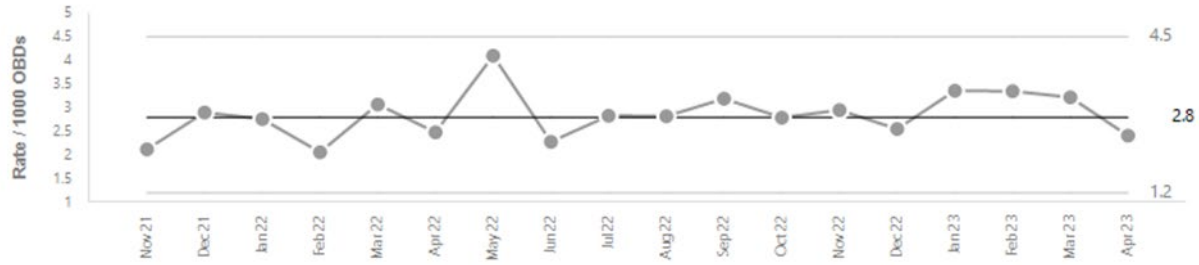
The total number of safeguarding incidents referred out to the relevant local authorities between 1st April 2022 and 31st March 2023 was 656, this identifies an almost stable rate of referrals when compared with the number of referrals for the same period in 2021 when the charity referred out a total of 668 concerns (-2%).

Approximately 59% of all referrals sent out were returned as needing NFA, This is an increase on the same period in 21/22 when the number of incidents assessed as NFA was 52%. An increase in the number of incidents assessed as NFA by the relevant Local Authorities evidences the quality of the action and safety plans put in place immediately by the teams looking after the patient(s) involved.

Within Northampton the majority of the referrals requesting a Section 42 investigation were requested to be completed by the Charity with the remaining being completed by the external safeguarding adult's team (41 in total). All

investigations within Essex and Birmingham are completed by the local area teams and CAMHS complete all of their investigations for submission to the Northants Designated Officer.

Total number of Safeguarding incidents per OBD referred out to the Local Authority across all Charity sites



The above graph shows a fairly steady rate of referrals over the last twelve months without any special cause variation.

There has been an increased level of support offered to the LDA divisions due to a high level of reoccurring incidents with poor evidence of actions taken and learning within this area. All divisions have had 'hot spots' throughout this year and the safeguarding team has offered targeted support to a number of wards. There were no specific themes across LDA, with each ward having different issues driving their safeguarding incidents.

The key themes for Safeguarding within Adult services during this review period have been:

- Staff sleeping on duty – no common causal theme identified
- Increased concerns being raised on night shifts – THRIVE programme changes to strengthen the senior nursing presence at night
- Concerns re closed cultures on some wards – SG team have done closed culture work with teams and culture work is a key part of the 9C wards of concern process

Northampton

Approximately 59% of all referrals sent out to WNC were returned as needing NFA, evidencing the quality of the action and safety plans put in place immediately by the teams looking after the patient(s) involved. As has occurred in previous years the majority of the referrals requesting a Section 42 investigation were completed by the Charity with a small number being completed by the WNC safeguarding adult's team.

Submission of completed reports within Northampton have a required timescale of 28 working days, whilst the majority of these are met by the charity a number have had to have extension timelines requested and it should be noted that the number of extension requests has increased during this year, which has been highlighted by WNC and also discussed with NHSE Safeguarding during regular review meetings;

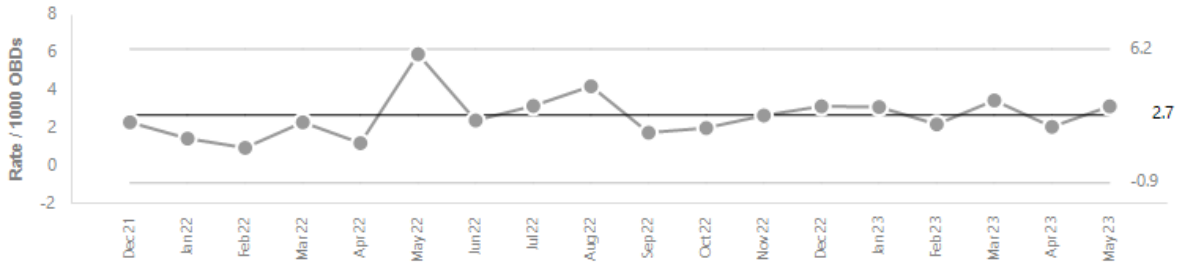
Assurance has been provided that the charity has an assurance system in place to monitor and review report timelines. A revised extension request template has been devised and agreed with WNC which will place the onus on divisional managers to ensure the criteria for an extension request is met.

The quality of completed reports have significantly improved as the assurance system reviews all reports and gives feedback for improvements before submission to Northants (satellite sites do not complete sec 42 investigations). The charity has received positive partner feedback in regards to the improvements made in report quality.

During this year concerns have continued to be raised by West Northants Council in relation to a small number of wards across a number of divisions in relation to increased incidents and/or a concern regarding themes of safeguarding incidents not being addressed appropriately resulting in continued incidents occurring. WNC have conducted unannounced visits alongside the ICB resulting in a number of action areas that have been agreed with divisional managers and ward staff.

Regular monthly meetings continue with both WNC and Northants ICB to review and discuss any concerns within the charity and any themes arising. These meetings are positive and productive and have encouraged increased partnership working with our external safeguarding partners.

LDA



There were 121 referrals in total completed by the LDA division. Of these referrals 67 (56%) were returned as needing NFA, 41 (32%) Section 42 enquiry reports were completed by the charity and the remaining 13 (12%) were completed by the Local Authority.

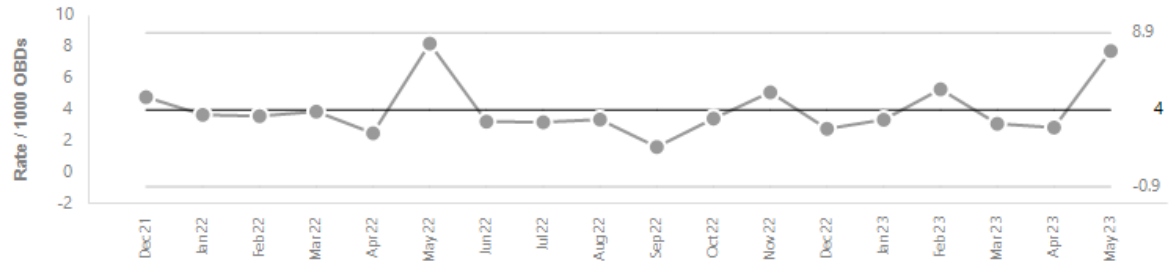
Of the 121 referrals submitted by LDA 47 (39%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were rated within the following headings:

- Physical Abuse
- Neglects and Acts of Omission
- Psychological Abuse
- Sexual Abuse
- Financial or Material
- Discriminatory Abuse

Areas of particular concern within the LDA Division during the period for this report have been Sunley Ward, Meadow ward and Church Ward. Of the 121 referrals submitted to WNC 27 were in relation to Sunley, 27 in relation to Church and 11 involved Meadow ward. There has been increased senior management overview of these wards and changes in ward management have shown positive changes in some areas. Incidents on these wards have involved allegations of 'Neglect/Acts of Omission' by staff, Sexual assault between patients and also repeated concerns raised by external agencies in relation to the care of a particular patient on Church.

LSSR



There were 94 referrals in total completed by the LSSR division. Of these referrals 58 (62%) in total were returned as needing NFA. 24 (25%) Section 42 enquiry reports were completed by the charity and the remaining 12 (13%) were completed by the Local Authority.

Of the 94 referrals submitted by LSSR 53 (56%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

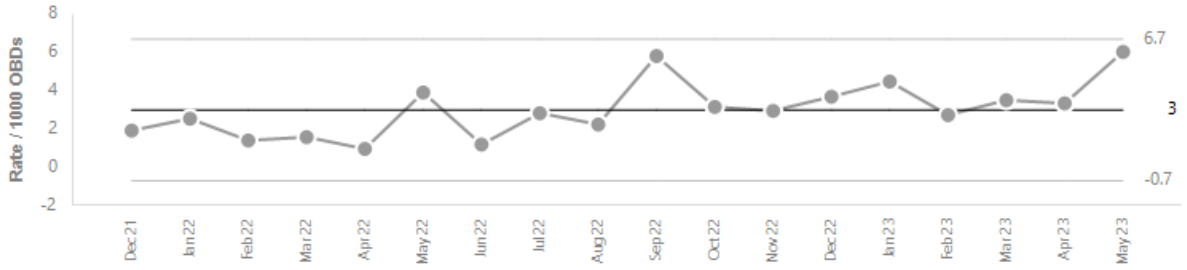
- Neglects and Acts of Omission
- Physical Abuse
- Sexual Abuse
- Organisational Abuse
- Psychological Abuse
- Financial or Material
- Self-Neglect
- External/Blank

Areas of high referral rates within the LSSR Division are Bayley and Heygate, this would be expected as these are the two PICU admissions where the admitting patients are more likely to be presenting with increased behavioural concerns related to their mental illness. Of the referrals sent to WNC in relation to these two wards the majority were closed as NFA by the local Authority: Heygate 21 referrals in total of which 16 (76%) and Bayley 23 referrals in total 17 (74%), this would indicate good evidence of clear protection and safety plans when the referrals were submitted to WNC.

Silverstone ward submitted 13 referrals in total of which 10 were related to one patient. This patient has been agreed as inappropriately placed by all agencies working with her and notice has been given by the charity. There are regular

fortnightly multi-agency meetings to discuss and review progress in regards to placement planning and this remains an ongoing piece of work to provide a suitable alternative placement.

MED



There were 131 referrals in total completed by the MED division. Of these referrals 77 (59%) in total were returned as needing NFA. 24 (25%) Section 42 enquiry reports were completed by the charity and the remaining 15 (11%) were completed by the Local Authority.

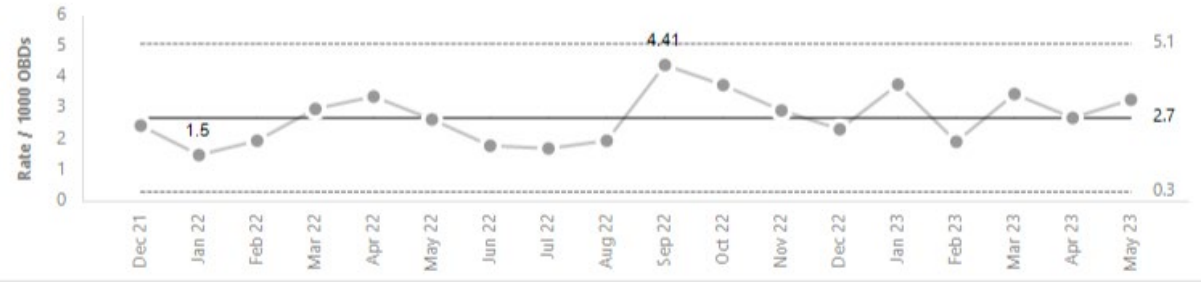
Of the referrals submitted by MED 50 (29%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

- Neglects and Acts of Omission
- Physical Abuse
- Sexual Abuse
- Organisational Abuse
- Psychological Abuse
- Financial or Material
- Self-Neglect
- External/Blank

Areas of high referral rates within the MED division have been Rose 28 (21%) and Fairbairn 21 (16%) the majority of these however have been returned as NFA at point of referral by WNC. Rose ward has been identified as an area of concern by WNC and the Northants ICB due to the high level of referrals submitted throughout the year. There has been increased senior management overview of Rose ward and recent changes in ward management has shown some positive changes already (better ability to provide assurance around the quality of care planning and safeguarding action plans and an improved relationship with WNC, as well as a reduction in SG episodes from near the UCL to the mean). Direct contact from senior divisional managers to WNC has also helped to share information candidly and further develop positive working relationships with our external partners.

NEURO



There were 118 referrals in total completed by the NEURO division. Of these referrals 80 (68%) in total were returned as needing NFA. 32 (27%) Section 42 enquiry reports were completed by the charity and the remaining 5 (4%) were completed by the Local Authority.

Of the referrals submitted by NEURO 42 (36%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

- Neglects and Acts of Omission
- Physical Abuse
- Sexual Abuse
- Organisational Abuse
- Psychological Abuse
- Financial or Material
- Self-Neglect
- External/Blank

Areas of high referral rates within the Neuro division have been Allitsen 24 (20%) and Fenwick 22 (17%). Fenwick ward had 13 (54%) and Allitsen ward had 15 (69%) returned as NFA by WNC. There has been a number of concerns relating to unpredictable interactions between patients which are usually closed by WNC as NFA due to teams ensuring ongoing safety plans are put in place. Concerns in Neuro services have identified an increasing number of unobserved falls and associated injuries which have been discussed with the falls co-ordinator to improve care plans when this is an identified risk. As part of a falls CQI, several aspects of falls management including risk assessments, have been revised.

CAMHS

There is no separate graph for CAMHS as they are now part of the LSSR division but the figures below are only for CAMHS.

There were 38 referrals in total completed by the CAMHs division with a significant increase between January and March 2023 with eleven incidents being referred out.

Of these referrals 23 (60%) in total were returned as needing NFA from external safeguarding partners with a number of concerns being managed within the charity through HR processes and a thematic review being undertaken looking at security and staff support when incidents occur which incorporated a number of referrals. 7 (18%) Section 47 enquiry reports were completed by the charity.

Of the referrals submitted by CAMHs 32 (84%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

- Neglects and Acts of Omission
- Physical Abuse
- Sexual Abuse
- Organisational Abuse
- Self-Harm

Of significant concern this year was the sad death of a CAMHs patient following a suicide attempt and a second incident involving a large number of staff being suspended and subsequently dismissed following inappropriate restrictive practices with one young person. Investigation outcomes and learning following these incidents has been shared and incorporated into practice within CAMHs.

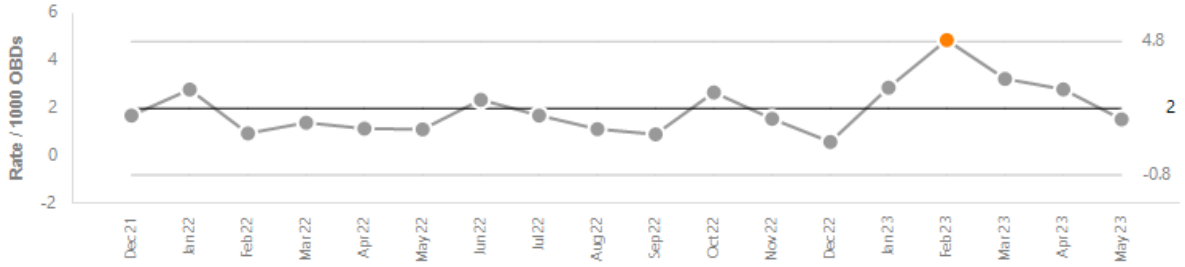
CAMHS has remained a challenging division in regards to safeguarding incidents. Safeguarding figures reduced during the earlier part of this review period but this was in direct correlation with a plan to stop admissions, data collected since admissions restarted in September 2022 identifies a steady increase in incidents being reported. There are monthly meetings with NHS commissioners and the Northants Designated Officer to review and monitor open safeguarding incidents. We received feedback from the Northants Safeguarding Children's Partnership in relation to the assurance review undertaken in December and also the Section 11 Audit submitted in November 2022 and we have responded with an action plan with 3 actions that were completed.

The key theme for Safeguarding within CAMH services during this review period has been a significant increase in Incidents of self-harm by patients when on enhanced observations. Due to a number of similar concerns occurring, there is now increased vigilance and support being offered to CAMHS including current Rapid Improvement Monitoring to include targeted action plans and senior level of scrutiny.

Satellite Sites

All investigations within Essex and Birmingham are completed by the local area teams, however charity staff do ensure patient safety plans are put into place and work collaboratively with external partners to ensure sec 42 enquiry reports are completed.

B’HAM



There were 81 referrals in total completed by the B’HAM division. BCC’s team do not always respond in a timely manner in relation to outcomes of the referrals that the charity makes to them, this means that a number of incidents remain as open for longer than one should expect. This does not reflect the work undertaken by the charity to ensure patient safety when incidents occur. Regular meetings are being set up with partners within the Birmingham City Council Safeguarding teams to ensure joint overview of new and outstanding safeguarding incidents.

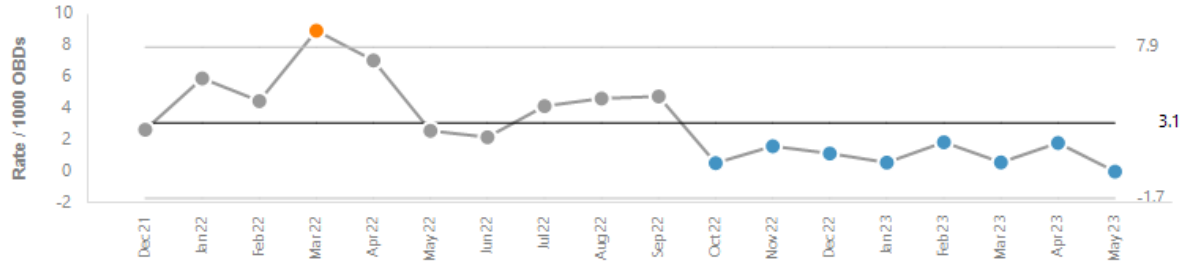
Of the referrals submitted by B’HAM 37 (46%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

- Physical Abuse
- Sexual Abuse
- Psychological Abuse
- Neglects and Acts of Omission
- Self-Neglect
- Organisational Abuse
- Domestic violence

Referral rates within Birmingham are generally evenly spread across the wards with a slight higher number being reported on Moor Green and Speedwell wards. The majority of concerns in Birmingham remain open as the Local Authority Safeguarding team are significantly delayed in responding to and closing incidents, however the division ensures safeguarding plans and actions are put in place to maintain patient safety.

ESSEX



There were 57 referrals in total completed by the Essex division. Essex safeguarding team do not always respond in a timely manner in relation to outcomes of the referrals that the charity makes to them, this means that a number of incidents remain as open for longer than one should expect. Currently of the 57 referrals completed between April 2022 and March 2023, 15 remain open with 42 being closed by the Essex safeguarding team. Monthly meetings occur with the Essex local authority safeguarding team to review open incidents.

Of the referrals submitted by Essex, 17 (30%) were related to Staff to Patient concerns.

The categories of abuse for these referrals were as follows:

- Physical Abuse
- Sexual Abuse
- Neglects and Acts of Omission
- Psychological Abuse
- Self-Neglect
- Organisational Abuse
- Financial or Material

Frinton ward had the highest number of referrals with 18 (32%) with the reset spread out fairly even amongst the other wards. Essex local safeguarding team take responsibility for completing all investigations, monthly meetings continue and the closure rate for incidents has improved.

Community Wards

There were 4 referrals completed by Winslow. The four incidents involve different patients and there are no obvious themes. Two incidents were closed as NFA by the local authority.

The categories of abuse for these referrals were as follows:

- Physical Abuse 1
- Psychological Abuse 1
- Allegations of Abuse by staff
- Verbal Aggression

Community Partnerships

There were 2 referrals completed by Community Partnerships. Both incidents were in relation to concerns involving external staff/organisations and not related to concerns raised within the charity or against its own staff. Each local authority is responsible for completing Section 42 enquiry reports as appropriate in line with their own protocols and processes.

Review

Links with external partners have continued to be strengthened with the safeguarding teams in Northampton and the satellite sites; monthly meetings have occurred with external colleagues in Birmingham, Essex and Northampton to discuss and review current safeguarding themes and issues, this closer integrated working has improved working relationships with external partners and ensured candid sharing of information and concerns.

Monthly meetings occur in Essex alongside the relevant local authority safeguarding team to review and monitor all safeguarding incidents reported out by the charity. Previous monthly meetings taking place with Birmingham City Council ceased taking place due to lack of resources within BCC, however a link-worker has now been allocated from BCC and monthly meetings are to be restarted which should allow for closer working relationships going forward.

The weekly divisional safeguarding meetings have continued with Heads of Nursing as well as social workers and ward managers. Generally these internal meetings have improved the timely submission of investigation reports and outcomes to the relevant Local Authority however there is an increasing amount of requests for extensions being made. External partners have highlighted this increase in delayed submissions, most recently in a meeting with NHSE (Safeguarding) and as such this is an area where the safeguarding team continue to monitor and challenge within divisions. The use of Datix for monitoring safeguarding incidents and recording actions completed within the weekly safeguarding meetings is still not occurring as a matter of course. This will be addressed by SG team attendance at nursing meetings, bolstering the weekly SG team meeting by training the new Quality Matron and General Manager roles in the SG process and by SG being part of the new biweekly incident triage meeting.

There continues to be incidents where HR investigations are completed aside to safeguarding investigations which has resulted in staff being returned to face to face duties without the safeguarding investigation being completed which has resulted in concerns being raised by the safeguarding team (on occasion staff have needed to be re-suspended due to the nature of the allegations against them). HR attendance at the weekly divisional safeguarding meetings has overall been proactive and positive when responding to safeguarding concerns involving staff.

A number of Northamptonshire Safeguarding Adult Board (NSAB) related audits have been completed throughout the year as per collaborative guidelines and expectations. Generally the outcomes of these audits have evidenced a slow improvement by the charity to involve patients and carers/families in safeguarding investigations. There are still areas where the charity needs to improve during

investigations with regards to better liaison with the local authority, carers and the need to keep within expected timescales, particularly in regards to agreeing ToR for Serious Incidents that are also agreed as meeting Section 42 threshold. Also, the use of Advocacy to support patients when safeguarding incidents occur.

There is also clear evidence that documentation of incidents needs to improve and the engagement of staff during investigations needs to improve, i.e.: staff not responding in a timely manner to requests for reflective accounts of incidents. Review of investigation reports has also noted that the use of the term 'capacity' has been used inappropriately when making the decision not to include the patients voice and views within investigations.

Regular quarterly meetings have continued with NHSE (safeguarding) and has involved both a targeted action plan following a review in Jan 22 and also completion of the Midlands safeguarding Assurance Framework (SAF), which is reviewed and completed by the charity's Safeguarding Lead. We have been able to review and respond to all areas ensuring we met the Green rating for all areas of the SAF. Due to recent changes in the SAF format we have reviewed and completed this and are working towards again reaching green in a small number of areas. Feedback on the charity's completed MDSF has been positive by NHSE and other partners, due to the assurance offered by the charity in these review meetings it has been agreed that they will now be held Bi-Yearly instead of quarterly.

Following submission of the completed Self-Assessment Challenge to the NSAB earlier in the year a Challenge Session was convened by the NSAB in April 2022, the outcome of this was positive with NSAB partners confirming the progress made by the charity in offering assurance to external partners that safeguarding was being addressed and responded to appropriately.

The Section 11 Audit under the Children Act (1984) was completed in November 2022 and submitted to the Northants Safeguarding Children's Partnership (NSCP), the RAG rating for this framework was very positive for the charity resulting in the eventual action plan highlighting only 3 areas for improvement. We are still waiting for a date for the Check & Challenge session with the NSCP.

A CAMHS assurance review was conducted by our Northants ICB partners in December 2022 with verbal feedback being very positive in regards to the care and support offered to the young people we support. We are waiting for formal written feedback which will initiate any necessary internal action plans.

The Internal Audit Final Report was published in October 2022 and identified there was Limited Assurance that safeguarding arrangements and the application of safeguarding practices within the divisions are embedded in practice for all disciplines and staff. The role of the safeguarding team in relation to developing and implementing new processes was highlighted as positive but that there needed to be an improvement in the organisational culture to ensure that there is a consistent approach to protecting patients by all staff from the risk of abuse.

The key themes for Safeguarding during this review period have been:

- Neglect/Acts of omission in relation to patient care when there are lapses in patient agreed observations
- An increase in staff sleeping on duty
- Delays in reporting safeguarding incidents due to poor information (RiO/Datix)

2023/2024 Safeguarding Focus

Actions form part of a SG Improvement Plan overseen by CASC.

The THRIVE programme has introduced the roles of Quality Matrons and General Managers to the divisions and the RACI matrices and processes for SG have been modified to enable clearer roles and responsibilities with a focus on timeliness of reporting. More responsibility needs to be taken divisionally for ensuring that investigations and final reports are completed and submitted on time as continued delays and extension requests draws negative scrutiny from external partners (this does not include reports which need to be delayed due to unexpected changes). The use of Datix needs to be fully integrated within the weekly divisional safeguarding meetings to ensure all tracking information in relation to investigation is in one place.

Whilst there is evidence that some referrals are being completed by non-social workers, it would appear that the majority of staff are not practising in line with the current safeguarding policy and responsibility for reporting and referring safeguarding incidents is still expected to be the responsibility of social work. The Safeguarding team plan to support increased responsibility on all staff by delivering training/support direct to ward managers to support their knowledge and understanding of ‘Safeguarding is Everyone’s Responsibility’. It has also been noted that CQC notifications are not being sent out promptly at the time of the referral thereby delaying sharing relevant information with partners. The safeguarding policy clearly highlights the need for the CQC notification to be completed at the same time as the referral is submitted, responsibility for this lies within the divisions and should be checked in the weekly divisional safeguarding meetings.

The charity needs to improve its practice to ensure that we are Making Safeguarding Personal (MSP). Investigators need to ensure that they actively involve patients and carers when conducting investigations. There should be clear evidence of the patient’s views within the report. Divisions should also ensure that investigation outcomes are shared as appropriate with patients.

Advocacy involvement is an ‘opt-out’ when safeguarding referrals are submitted, as such ALL patients should have access to advocacy if a safeguarding incident occurs and throughout any subsequent investigation.

Further interventions will be provided by the safeguarding team in relation to conducting investigations and ensuring targeted actions and outcomes are completed. The safeguarding team have developed training which will be offered to staff who are new to completing investigations, we will also mentor and support new investigators to complete reports.

Safeguarding Training

Level 3 Safeguarding training is offered to all qualified practitioners within the charity and all staff in CAMHs as per the intercollegiate document requirements. Feedback from staff has contributed to the quarterly reviews of the training package by the safeguarding team alongside the L&D team. The training incorporates how to identify safeguarding incidents, response expectations as well as system processes such as how to make a referral and Datix recording. Dates are planned in advance and sessions are delivered onsite in the satellite sites. The training is delivered by a member of the L&D team and a safeguarding practitioner to ensure that clinical practices and expectations can be discussed fully.

Twelve months ago the Level 3 training take up was well below the expected KPI of 90% and was sitting at the low 80%, the training was delivered solely face to face. A recovery action plan was developed between the safeguarding team and L&D and involved developing the training into two parts: face to face and E-Learning alongside targeted work with managers to identify staff who were out of date with a focus of increasing the training uptake. Face to face training has been sustained at 90% for the last 4 months and E-Learning has reached 95% in March 23.

Outcome Measures:

- All reports will be submitted on time (Safeguarding Administrator to keep overview)
- Communications with investigators and progress made will be easily evidenced within the Datix record (Safeguarding Administrator to keep overview)
- MSP - Evidence of patient and carer involvement in all reports (Audit of reports)
- Evidence of Advocacy involvement (Audit of referrals and finalised reports)
- New investigators will feel confident in undertaking investigations and completion of reports (Safeguarding Practitioners to track in their divisions).

Safeguarding Practitioner support will continue across all divisions. They offer planned interventions with staff such as safeguarding supervision, help with writing reports, and support with individualising patient care plans as well as meeting face to face with patients when incidents have occurred. They provide safeguarding Level 3 training in partnership with the L&D team as well as the Safeguarding Navigator training which is developing a number of staff across the charity with increased knowledge of safeguarding practices and processes to help support colleagues and patients understand ‘what happens next’ when a safeguarding incident occurs. Plans to initiate Action Learning Sets has had to be put on hold due to the amount of work the practitioners are currently undertaking.

During 2023/ 2024 the focus of the safeguarding team will be to support all staff to develop in their confidence in identifying and responding to safeguarding concerns, through focused group sessions, 1:1 work, mentoring and modelling the processes and tasks when a safeguarding incident occurs.

In order to achieve this we will:

- Continue with the training recovery action plan to ensure that staff attendance does not decrease and increases with staff attendance increasing to 95% by end of quarter 3.
- Safeguarding ‘what now’ interactive training to be offered to all ward managers and senior managers within divisions. This will include walking managers through a case study and getting them to identify what should happen next in terms of processes, patient, carer and staff support. The aims for this mode of training is to provide managers within divisions and on wards with the working knowledge and understanding of safeguarding processes to be able to support staff on their wards and areas with direct input.
- Safeguarding Navigator training opportunities to be increased to offer a higher level of understanding of safeguarding responsibilities and actions to unqualified staff who do not attend the L3 training. The aims of this training will provide ward based staff with an increased knowledge of safeguarding processes, these staff will then support colleagues on the ward with the practical responses needed when safeguarding incident occurs.
- Safeguarding Practitioners to offer planned drop-in sessions in all wards and areas to speak with staff who have recently completed their L3 training, the focus will be to discuss any concerns staff have in relation to relating learning into practice and to offer reflective and forward focused support and supervision – the aim for this is to improve staffs ability to respond effectively to safeguarding incidents and ensure application of learning into practice
- Action Learning Sets to be set up in all divisions, these will initially be facilitated by the safeguarding practitioners and will encourage staff to discuss and agree safer ways of working going forward – the aims of this will be, for ward staff to develop and identify agreed actions for responding to safeguarding incidents or issues related to patient safety. The longer term aim is for ward staff to facilitate and manage these sessions themselves once confident enough.

Lastly I need to note that the practitioners have been proactive and supportive in all areas of the charity and should be acknowledged for their hard work and resilience in supporting staff colleagues and patients when safeguarding incidents have occurred. Their flexibility to include night and weekends visits as well as regular visits to provide support and training to the satellite sites has ensured that all staff within the charity have access to their knowledge and expertise.

Margaret Mills, Named Professional for Safeguarding

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time.

Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report
Section 1 – General:

The Board of St Andrew's Healthcare can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a Responsible Officer. Dr Sanjith Kamath was appointed Responsible Officer (RO) on 1 May 2018.

Action from last year: Nil Comments: Nothing further to add Action for next year: No current actions

2. The Designated Body provides sufficient funds, capacity and other resources for the Responsible Officer to carry out the responsibilities of the role.

Yes/~~No~~ [delete as applicable] Action from last year: Nil Comments: Nothing further to add Action for next year: No current actions.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the Designated Body is always maintained.

Action from last year: Nil Comments: All new starters continue to be added to GMC Connect and a local database is also maintained. Action for next year: No current actions.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The organisation's Medical Appraisal and Revalidation policy and the Responding to Concerns policy was updated in September 2021 following an update on the MAG (Medical Appraisal Guide) triggered by the Covid pandemic. **Comments:** The policy is next due for renewal in September 2024, but any updates in the interim are presented to the medical body through the quarterly peer group and relevant training. More significant updates will be communicated directly through the weekly medics meeting and monthly Medical Advisory Committee (MAC). **Action for next year:** No specific actions, but any pressing updates will be communicated prior to the next policy update as described above

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To consider repeating the benchmarking audit subject to capacity of Northampton General Hospital (NGH) staff.
Comments: Due to the ongoing workforce challenges post-pandemic limiting the capacity of NGH staff, this is unlikely to be feasible, so alternatives will be considered.
Action for next year: An internal audit to take place, to look at compliance of appraisers with seeking key supporting information for appraisals and the timeliness of appraisals being signed off

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locum and fixed term contract doctors continue to be able to access the weekly CPD and case presentation programmes. Locum doctors continue to be provided with supporting information if requested for their own appraisals, which are organised through external Designated Bodies under their individual Responsible Officers.
Action for next year: To continue current processes

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]
Action from last year: To continue to maintain no approved missed appraisals in the upcoming appraisal cycle.
Comments: Approved missed appraisals have occurred in this cycle following maternity leave for one doctor and a period of illness and subsequent unfortunate death of one doctor.
Action for next year: To continue to maintain no approved missed appraisals in the upcoming appraisal cycle.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated by the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: see above; action plans put in place where appropriate
Comments: see above; action plans put in place where appropriate
Action for next year: to maintain understanding of the reasons for approved missed appraisals and put in place appropriate action plans to mitigate against them.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: nil
Comments: This policy along with the Responding to Concerns policy was updated in September 2021. Any significant changes prior to next update in September 2024, will be communicated directly to the medical body through the weekly medical meetings and MAC
Action for next year: to next update policies in September 2024

9. The Designated Body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To monitor appraiser numbers carefully in order to increase or maintain the current numbers of appraisers, noting the dependency on retention and recruitment factors.
To increase / maintain appraiser numbers, particularly for non-Consultant doctors. There is currently only one non-Consultant appraiser. Efforts have been made to recruit further non-Consultant appraisers, but without success.
Comments: Two new appraisers were trained during the year, however three appraisers left the Charity during the same period.
Action for next year: To monitor appraiser numbers carefully in order to increase or maintain the current numbers of appraisers, with a focus on non-Consultant doctor appraisers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To maintain appraiser peer network meetings in their current remote form with a focus on encouraging appraisees to improve quality in line with the current medical appraisal guidelines.
To focus on quality improvement and leadership development of doctors.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: The quarterly appraiser peer network meetings have been maintained remotely. The focus has been on appraisers supporting appraisee development through reflection with a decreased burden of administrative activities. Appraisal feedback continues to be collected from appraisers and appraisees via the Clarity appraisal toolkit and is reported as appropriate.
Action for next year: To maintain appraiser peer network meetings in their current remote form with a focus on encouraging appraises to improve quality in line with the current medical appraisal guidelines.
Comments: Ongoing embedding of the career development section of the job planning process
Action for next year: To maintain focus on quality improvement and leadership development of doctors through PDPs.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To continue to report to the Board on an annual basis through the relevant process.
Comments:
Action for next year: To continue to report to the Board on an annual basis through the relevant process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	59
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	64
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	3
Total number of agreed exceptions	3

The total number of appraisals undertaken during the period (64) includes doctors who had left the organisation by 31 March 2023. There were three agreed exceptions to not undertaking an appraisal during the period: one doctor was on maternity leave, one doctor was off sick and a third doctor joined St Andrew's shortly before the appraisal year end.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

> **Action from last year:** To continue to make any recommendations to the GMC as appropriate, with the goal of protecting patient safety and supporting the remediation of doctors, as required.
> **Comments:** The 'Dealing with concerns with doctors' policy prescribes the intervention of a Decision Making Group (DMG) chaired by the Medical Appraisal Lead and discussion between the RO and the Employer Liaison Advisor (ELA) as necessary
> **Action for next year:** To continue to make any recommendations to the GMC as appropriate, with the goal of protecting patient safety and supporting the remediation of doctors, as required.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

> **Action from last year:** To continue to notify doctors promptly of revalidation recommendations.

Comments: Doctors are notified by email of their revalidation recommendation shortly after a meeting between the RO and the Medical Appraisal Lead. This meeting is held in good time before the revalidation date and systematically monitored. Any further discussions required in relation to the revalidation recommendation are arranged, as required to discuss the need for deferral. Non-engagement is managed in a preventative manner by alerting doctors to the efforts that need to be made to support their revalidation, as well as providing more direct support to doctors in relation to appraisal, e.g. informal training / support regarding appraisal / revalidation processes and / or support & training with use of the Clarity toolkit. This has proved effective inasmuch as no non-engagement decisions have had to be made.
Action for next year: To continue to notify doctors promptly of revalidation recommendations.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To continue current reporting processes and to support doctors in their use of data.
Comments: Notwithstanding some recent structural reorganisations within the Charity, the organisation continues to operate a ward-to-board clinical governance framework, led on by Consultants and nurse leaders on individual wards which is reported up through the divisional structures via the Clinical Directors and Deputy Medical Director.
Improved data reporting technologies and dashboards have continued to develop and enhance the degree to which doctors can lead on clinical governance activities on their wards. Doctors receive regular feedback through the medics meeting and Medical Advisory Committee (MAC) on these updates in order to encourage doctors to use data to support clinical decision making. This includes patient feedback data collected through the MyVoice (a Patient Reported Experience Measure) portal, which doctors are encouraged to review to support ward community meetings.
Action for next year: To continue current reporting processes and technological improvements to support doctors in their use of data

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To continue the current process of issuing line manager statements, monitoring complaints and soft intelligence on doctors' conduct and performance which are also presented at the appraisal meeting.
To maintain current processes and assess the impact of job planning.
Comments: In addition to the processes of last year, the Medical Appraisal Lead continues to monitor any complaints (as well as compliments) received about doctors and will organise a Decision Making Group (DMG), as appropriate, in

order to determine any further necessary actions to maintain patient safety. The impact of job planning is yet to be fully evaluated.
Action for next year: To maintain current processes and explore the impact of job planning

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To maintain current processes and update subject to any wider national changes.
To review the impact of updating Good Medical Practice (GMP) criteria and communicate to the medical body and update policy, as necessary.
Comments: the updated GMP criteria are yet to come into force, but are likely to place more emphasis on doctors' emotional intelligence and sensitivities in dealing with different social groups. Communication re the planned changes have already been communicated to the medical body. Such communication will continue as these developments progress.
Action for next year: To communicate the updated GMP criteria and their implications for practice, appraisal and revalidation, and update policies, as necessary.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: To continue current reporting processes
Comments: Relevant information is now presented through the appropriate Board process
Action for next year: To continue current reporting processes

5. There is a process for transferring information and concerns quickly and effectively between the Responsible Officer in our organisation and other Responsible Officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: To continue current processes, including those described in the comments below.
"Doctors' connections are also reviewed using the GMC Connect online dashboard. Any concerns about the doctor's fitness to practice (FTP) and/or restrictions on practice, are reviewed on the GMC website, which has access to FTP meetings".
Comments: Current process involves requesting a Medical Practice Information Transfer (MPiT) form from a doctor's previous employer as soon as their prescribed connection to our Designated Body is in place. This form allows transfer of relevant information from one RO to another RO and to act on any relevant concerns in a prompt fashion.
Action for next year: To continue current processes as described above.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (ref GMC governance handbook).

Action from last year: To continue current processes, subject to any national updates.
Comments: The current process involves informing a doctor of any allegation or complaint at the earliest opportunity and offering them the opportunity to bring a representative with them to any HR meetings if they wish. The DMG includes representatives from clinical and non-clinical fields aimed at ensuring the greatest possible degree of impartiality.
Action for next year: To continue current processes, subject to any national updates.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To continue current process.
Comments: All checks are undertaken prior to employment and for locum doctors involves checks completed by their agency.
Action for next year: To continue current process.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- Enhanced use of technology to support clinical governance

- Efforts to increase non-Consultant Doctor appraisers continue.
- Efforts to reduce the administrative burden of appraisal and revalidation with a greater focus on well-being and development through reflection (both written and discussion-based)
- Greater support given to doctors to ensure appropriate engagement in appraisal and revalidation processes to reduce the risk of non-engagement or deferral
- Greater emphasis on leadership development through job planning and career development processes

Actions still outstanding
Re-audit of appraisals against the benchmark of doctors at Northampton General Hospital is to be considered in the upcoming year. This will be dependent on the capacity of both organisations to be able to undertake this. Alternatively, an internal audit of appraisers will be pursued.

Current Issues
There is ongoing increased focus in appraisal meetings on exploring the appraisees' well-being, which is reflected in changes made on the Clarity toolkit. Appraisers are also encouraged to increase focus on quality improvement and leadership development in doctors via the generation of higher quality PDPs and the job planning process.
Improved data reporting technologies and dashboards have enhanced the capacity for doctors to lead on Clinical Governance activities.

New Actions:
Assessing the impact of the job planning process and revised Good Medical Practice criteria on Doctors' conduct and performance

Overall conclusion:
In the 2022-2023 appraisal cycle, working life is gradually recovering from the effects of the Covid pandemic, although wellbeing, retention and recruitment issues, persist. Appraisal meetings have remained largely remote, as per the preference of appraises, offering greater flexibility. A similar hybrid approach remains in CPD courses. The internal CPD programme remains remote to support wider attendance.

Four cycles of the peer review process have now been completed which shows a plateauing off of improvement in meeting key quality ward metric criteria.

Future areas to review will be the impact of the job planning process and revised GMP criteria.

No doctors have been referred to the GMC.

Section 7 – Statement of Compliance:

The Board of St Andrew's Healthcare has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief Executive or Chairman (or executive if no board exists)]

Official name of Designated Body: St Andrew's Healthcare

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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