CHARITY NO: 1104951
COMPANY NO: 5176998

BOARD OF DIRECTORS – PART ONE

MEETING IN PUBLIC

Friday 27 May 2022 at 9.30 am

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

		Info / Dec	LEAD		Page No.	Timing
1.	Welcome and Apologies	Information	Paul Burstow		*3*	*09.30*
Administration						
2.	Declarations of Interest	Information	Paul Burstow		*4*	*09.31*
3.	Minutes from the Board of Directors Meeting in Public on 24 March 2022	Decision	Paul Burstow	✓	*5-13*	*09.32*
4.	Action Log and Matters Arising	Information & Decision	Paul Burstow	✓	*14-15*	*09.35*
Chair's Update						
5.	Chair Update, incorporating: • Annual Fit and Proper Declaration	Information & Decision	Paul Burstow		*16-18*	*09.40*
Executive Update						
6.	CEO Report	Assurance	Jess Lievesley	✓	*19-26*	*09.45*
Committee Assurance Reports						
7.	**Committee Updates** • Quality & Safety Committee (12/4) • Audit & Risk Committee (19/4) (inc. Risk Appetite approval) • Research Committee (4/5) • Pension Trustees (5/5) • People Committee (12/5)	 Assurance Assurance & Decision Assurance Assurance Assurance	 David Sallah Elena Lokteva Stanton Newman Martin Kersey Paul Burstow	 ✓ ✓ ✓ ✓	*27-53*	*10.05*
Break 10.35 am to 10.45 am						
Quality						
8.	CQC Inspection, Report and Actions Update	Assurance	Andy Brogan	✓	*54-57*	*10.45*
9.	Quality Improvement System Support and Buddying Workstreams Update	Assurance	Andy Brogan & Julie Shepherd	✓	*58-77*	*11.05*
10.	Safer Staffing Report	Assurance	Andy Brogan	✓	*78-96*	*11.25*
Finance						
11.	NHS Improvement Annual Solvency Commitment	Decision	Kevin Mulhearn	✓	*97-98*	*11.35*
Assurance						
12.	Board Assurance Framework	Decision	Duncan Long	✓	*99-111*	*11.40*

Break 11.50 am to 12.00 am						
Operations						
13.	Integrated Quality & Performance Report, incorporating: • Quality scorecard • People scorecard • Finance overview • IT Security overview	Assurance	Anna Williams, Kevin Mulhearn, Dr Sanjith Kamath & John Clarke	✓	*112-136*	*12.00*
Patient / Carer Voice						
14.	Divisional Presentation (including patient voice): Community Partnerships	Information	Dr Sanjith Kamath (Cat Vichare)	✓	*137-151*	*12.25*
Break 12.55 pm to 13.00 pm						
Matters Arising / Discussion Topic						
15.	Research Strategy and Strategy Implementation Plan.	Decision	Stanton Newman	✓	*152-179*	*13.00*
Regulatory						
16.	Data Security & Protection Toolkit (DSPT) pre-submission approval	Decision	John Clarke	✓	*180-184*	*13.20*
Any Other Business						
17.	Questions from the Public for the Board	Information	Paul Burstow		*185*	*13.30*
18.	Any Other Urgent Business (notified to the Chair prior to the meeting)	Information	Paul Burstow		*186*	*13.33*
19.	Date of Next Meeting – Tuesday 26 July 2022	Information	Paul Burstow		*187*	*13.35*
Meeting Closes at 13.35 pm						

Welcome and Apologies

(Paul Burstow – Verbal)

Declarations of Interest

(Paul Burstow – Verbal)

Draft Minutes from the Board of Directors Meeting in Public on 24 March 2022

(Paul Burstow)

CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Great Hall, Main Building,
St Andrew's Healthcare, Northampton

Thursday 24 March 2022 at 09.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
Ruth Bagley (RB)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Jess Lievesley (JL)	Interim Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Andy Brogan (AB)	Chief Nurse
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director
In Attendance:	
John Clarke (JC)	Chief Information Officer
Rupert Perry (RP)	Lead Governor
Kevin Mulhearn (KM)	Finance Director
Alex Trigg (AT)	Director of Estates and Facilities
Oliver Shanley (OS)	Advisor to the Board
Anna Williams (AW)	Director of Performance
Holly Taylor (HT) Item 12	Director of Learning & Development
Laura Agnew (LA) Item 12	Deputy Director of Estates & Facilities
Rutendo M'tumbi (RM) Item 16	Nurse Manager, Bracken Ward
Tom Bingham (TB) Item 17	Director of Communications
Melanie Duncan (Minutes)	Board Secretary
Apologies Received:	
Stanton Newman (SN)	Non-Executive Director
David Sallah (DS)	Non-Executive Director
Duncan Long (DL)	Company Secretary

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting open to attendance by the public. Apologies received from Stanton Newman, David Sallah and Duncan Long were noted.		
ADMINISTRATION			
2.	**Declarations Of Interest & Quoracy** All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose. The meeting was declared quorate.		
3.	**Minutes Of The Board Of Directors Meeting, held in public, on 25 January 2022** The minutes of the meeting held on the 25 November 2021 were **AGREED** as an accurate reflection of the discussion.	**DECISION**	

4.	**Action Log & Matters Arising** The following actions were reviewed; 24.08.21 **05** – Safe Staffing Report CLOSED 25.11.21 **01** – Integrated Quality & Performance Report CLOSED 27.01.22 **01** – Pensions Scheme Act 2021 CLOSED	**DECISION** **DECISION** **DECISION**	
CHAIR'S UPDATE			
5.	**Chair Update** PB provided a verbal update to the Board, expressing his thanks to JL for his time as Interim CEO for the Charity, and noting that OS would be taking over as the next Interim CEO in June. Meanwhile, the recruitment process for the new CEO continued, with interviews being held the following day. PB further outlined the work on culture which the Board would be focussing on in the coming months, noting that the culture shift would need to be Charity-wide, with support from the buddying organisations critical to its success. The recent joint Board and Court meeting proved to be a valuable session, with the discussions about the implications of the changing mental health landscape being a useful exploration of risk appetite within the Charity. Thanks were also extended to AO, with appreciation from the Board, and good wishes for the future in her new role. The Board **NOTED** the update.		
EXECUTIVE UPDATE			
6.	**CEO's Report** JL presented his report, which was taken as read, and highlighted the improvement work being undertaken within Women's Services. There were ongoing challenges, however, the shift in culture and staff engagement was evident. A re-inspection was anticipated in the coming weeks, with the wider Charity culture work and approaches to change also being addressed. JL acknowledged the recent Good rating from the CQC for Community Partnerships. JL extended thanks to the team and noted the excellent feedback from the service users and carers. JL further outlined support being offered to a local lottery funded dementia charity, Pink Rooster, with St Andrew's looking forward to working with them. EL enquired regarding the retention rates of staff and timescales for outcomes as a result of culture work being done in NHS Trusts, and wanted to know how the learning from this could be assimilated by the Charity. JL replied that there were no figures released regarding staff retention. He added that NHFT were also progressing along the same process, and that the model had proven impact as a ground up approach was adopted, with support for change leaders. JL agreed to speak to Julie Shepherd, Improvement Director with regard to metrics and would share accordingly. PB noted that People Committee would also look at the data on staff turnover and retention. RB raised a question regarding the risk of delay in transfers of care. She also asked about the programme of culture change. JL replied that the Charity has been in discussions with commissioners about delayed transfers of care and that our regulators were also sighted. He added that the Executive team had spent time on the wards, helping to address the challenges which required targeted work. PB noted the recent rating for Community Partnerships and commented that learning could be taken from this, especially the way in which new service models developed by the Charity had been adopted by commissioners. He added that there were changes anticipated in 2023 with regard to CQC	**JL**	**27.05.22**

	inspections as both adult social care and integrated care systems will be in scope. The Board **NOTED** the update		
7.	**East Midlands Board Paper in Common** JL presented the paper which was taken as read, noting that it was the latest Board Paper in Common which set out the areas of progression within the Alliance. JL further commented that the Board would now draw down investment opportunities, and that focus was on workforce issues, with CAMHS being a challenge nationally. He added that there were plans for a further joint Board development session soon. JL noted the inclusion of the Partnership Agreement, with the recommendation being to adopt and sign. There was a detailed discussion regarding the partner organisations, potential investment opportunities and the due diligence undertaken. JL commented that the Charity's legal team had reviewed the document, noting that the agreement addressed strategic concerns and working collaboratively and that the investment opportunities would not have been observed without the partnership being in place. There were further discussions regarding competition law and the implications. MK updated that training within this area was currently being undertaken. PB commented that the Health and Social Care Act also noted this, and that there were amendments expected regarding this in the health Bill currently before Parliament, and that further advice would be sought as time progressed. The Board **AGREED** to enter into the Partnership Agreement	**DECISION**	
Finance			
8.	**NHS Improvement Annual Solvency Commitment** AO presented the paper which was taken as read, noting that these were a series of self-declarations which the Charity were required to make, with a deadline of 31st March. The declarations required were identical to the previous year. AO noted particular attention to the continuation of services element, elaborating that this had proved more challenging than in previous years, but that the sign off by the Auditors of the going concern had helped greatly. AO further updated that the Director's Self Declaration and Fit and Proper processes were currently being undertaken. AL observed that in future, being furnished with an outline of the financials would give further assurance in order to facilitate sign off. KM agreed with this. The Board **AGREED** to the sign off of the Commitment	**DECISION**	
QUALITY			
9.	**Quality Improvement System Support and Buddying Workstreams Update.** AB gave a verbal update, noting that due to illness, Julie Shepherd was unable to attend the meeting. The progress of the Workstreams was noted with particular highlight given to the progression of reduced observations and CQI. Lessons learned continued to receive focus. AB commented that sustainability would be key over the coming year, with the progress in Women's Services being well received. PB thanked AB for the update and noted that forward plans were key to success and looked forward to receiving assurance reports from the Quality and Safety Committee. The Board **NOTED** the update.		

10.	**CQC Report and Actions – Progress Update** AB presented the update which was taken as read. He noted that the rating received by Community Partnerships reflected the leadership in situ, and that the additional reporting requirements had been a challenge at all levels within the Charity. AB then outlined the format of the QIP (Quality Improvement Plan) meetings, and noted that there were 5 actions from the plan due for closure, with the plan currently on target. PB noted that there were 97 open actions within the plan, and asked AB for a sense of progress against the actions. AB replied that the plan was working to target, and that actions were not closed without evidence of completing being observed. AL enquired if the timeline aligned with the budget, which KM confirmed that it did. SK added that the regulator required evidence as assurance regarding the closing of actions on the plan. He also noted that admissions were now being undertaken, with assurances being extended to partners. PB asked if any actions were of concern, with AB replying that staffing was the main one, but would be addressed in detail further within the Agenda. The Board **NOTED** the update		
11.	**Safer Staffing Report** AB presented the report which was taken as read, noting that the format and content was consistent with NHS reporting. AB added that the report included details of fill rates, correlations of staffing levels to incidents, and was formulated for all audiences. As a result of the report, no immediate concerns were noted. AB explained to the Board how staff levels were calculated, along with skill placement and safeguarding training. Other highlights included action cards on the wards, a consistent reduction in incidents and the delivery of e-rostering. EL thanked AB and asked questions regarding the challenging shifts and what, if any elements were missing from the report, in order for it to become an assurance report. AB replied that there continued to be significant challenges around staffing, with those wards categorised as red, triggering the action card protocols, which gave clear indications on what steps to take in those incidences. With regard to assurance, AB asked the Board what they would like to see in order to gain further assurance. He added that the report would be presented after consideration at QSC in at its next meeting. JL noted that the report gave a good indication of the action card process, along with the Executive review of them; with the Operations Hub enabling a Charity-wide view of staffing. The introduction of Allocate reflected the acuity in relation to staffing. This work would be crucial, hence the deadline being brought forward. RB asked for accompanying commentary against the red rated wards in future reports and wanted to know if the new model would allow for staffing adjustment more quickly. Regarding the overall staffing rate, RB wanted to know if the data had been compared with other comparable organisations. AB replied that the template was an agreed NHS format, and that the fill rate was a crude measure, and that establishment figures should be agreed by the Board with 6 monthly reviews. No comparisons had been made with the data as yet. AL wanted to check if Allocate would mean that staff would move more quickly. AB confirmed that this would be the case, resulting in more flexibility, this had been evident in the previous month. SK added that the Hub also monitored staffing levels, which were communicated to Executives.		

	AT asked if there was any support that could be given by the enabling functions. AB replied that there were systems in place for all teams to work together. SRW enquired if the staff were engaged with the initiative. AB replied that this was as yet not a universal engagement. 3 of the Neuro wards however, were completely engaged in the process. It had been observed that the language used was beginning to change, indicating the right trajectory. PB summarised and thanked AB and Chloe Annan, welcoming the level of candour within the report, and noting that mitigations and actions needed to be specific, with the QSC providing assurance in future. He added that improving staff retention rates would be important in the coming months. The Board **NOTED** the update		
MATTERS ARISING / DISCUSSION TOPIC			
12.	**Workbridge Strategy** HT and LA joined the meeting and presented the report which was taken as read. HT gave the background to the project and outlined the benefits that the service users gained from attending Workbridge. LA gave background from an Estates and Facilities perspective, highlighting the work that had been done to improve the surroundings. The café had recently been awarded an environmental health 5 star rating, whilst priorities had been addressed, resulting in the project anticipating increased profitability. AO noted the break-even point in what had been a challenging 3 – 5 years. HT responded by noting that 50 learners were making use of the service, which in turn resulted in a degree of caution regarding timeframes. AL asked to what extent was Workbridge marketed to the public. LA replied that plans were in place to increase marketing. Social media was currently being used, but it was evident that the service required further input. Signage had been refreshed along with promotions with Daily Bread. AL also asked about the income generated by the service. HT replied that at the moment, the service was self-funding, however, grants were being considered, and it was hoped that a re-launch would help to facilitate these. AB commented on the mixed use of the function currently, with some service users attending over many years. HT replied that this was being addressed and that it would not be considered a respite service, but a stepping stone for work for users. JL added that the system had progressed and Workbridge needed to do so in tandem with those changes, but in a sustainable fashion. RB noted the better outcomes required from the service and asked how the process had progressed. HT replied that consultation was now in week 7, and had generally been well received with each individual being taken into account. PB thanked both HT and LA and noted the recovery principles of the service, concluding that an update should be given to the Board via the QSC in future. The Board **NOTED** the update		
ASSURANCE			
13.	**Committee Updates** <u>Pension Trustees</u> MK presented the update, which was taken as read. AL asked if any impact had been seen on the financials as a result of the Ukraine conflict. MK replied that the number of investments which could be affected were small, with a short term impact felt in the markets. SRW added that the inflationary risk had previously been hedged resulting in no obvious effect.		

	The Board **NOTED** the update <u>Quality Safety Committee</u> The update was taken as read with no further questions. The Board **NOTED** the update <u>People Committee</u> EL asked about the limited assurance level noted in the report with regard to culture. PB replied that this was a borderline assessment, and that the next meeting would address the wider programme with regard to the soft aspects of culture. AL asked if the 51% engagement score was at the right level. MK replied that an average score was between 55% and 60%, however, engagement scores had reduced globally. Plans were in place to address this. JL added that it was easy to attribute the score to the impact of Covid, however, the challenges were sector wide. The Board **NOTED** the update		
14.	**Governance Oversight Group Update** AO presented the update, outlining the work done to date. AO also presented the Authority Matrix and outlined the underlying principles. It was agreed to circulate the Matrix to the Board for further consideration. AL commented on the delineation of committee roles of receiving and giving assurances to the Board as opposed to executive decisions. AT noted the ward to Board assurance process and asked what the route of dissemination back to wards was. AO explained that this was now demonstrated in a revised structure diagram. PB noted that the Authority Matrix would be returned to Board for decision and approval. The Board **NOTED** the update	**KM**	**27.05.22**
OPERATIONS			
15.	**Integrated Quality & Performance Report** AW presented the report which was taken as read and highlighted those areas of note. AL asked why the statement of little or no data was used in some instances of ward level data. AW explained that certain levels were so low that they did not present concern. JC asked about the Covid data and if Covid sickness had reduced. AW confirmed that it had, and that that dis-aggregation of data was now showing this. AB asked if there was any data regarding attrition versus new starters. AW agreed to look into the measure. MK commented that the voluntary turnover figures showed that staff were moving to WorkChoice, which has resulted in consideration being given to a more flexible option on substantive roles. EL asked how the upper and lower control limits were established. AW replied that they mirrored those within the NHS, as well as looking at mean averages from the previous 18 months. EL enquired further as to whether they were at an acceptable level. AW commented that comparators to the previous 6 months did show this, and would be underpinned by the current analysis on Model Hospital data being undertaken. AB added that sickness levels would also be benchmarked as the Model Hospital data allowed for a more		

	considered approach. AW noted that targets were being set in order to be challenging. SK added that the data was being looked at for incidence reporting in particular; analysis together with the wider Charity view would give a whole picture and wider intelligence. PB noted that People Committee would benefit from receiving the data on staff turnover, along with information on the targets being set. A waterfall chart showing how the turnover impacts on staff would be helpful. KM presented the Finance section of the report which was taken as read. He reported that the budget had been achieved on 6 consecutive months, giving a positive position. February occupancy was below expected levels, however, the cash balances were better than forecasted. As a result the year end levels would be as expected. KM updated that the budget process would begin in April in order to be ready for ratification by the Board in July, with support from Ernst and Young on the refinancing project. AL asked what levels of security were in place for IT especially with the heightened risk of cyber activity as per advice from GCHQ. JC confirmed that security was in place and was adequate. The Board **NOTED** the report		
PATIENT/CARER VOICE			
16.	**Divisional Presentation** RM gave a presentation on how blanket restrictions on Bracken ward had been addressed within a co-productive environment, including feedback from the patients involved. SK gave wider context, noting that there were no increases in violence, Serious Incidents or Safeguarding incidents since the beginning of the project. AB asked what the staff feedback was, and how did they feel with blanket restrictions in place. RM replied that it was a case of assessing the risk of each restriction and considering individual cases if required. Staff had found it to be a challenge initially, however, now that it is apparent that removing them works, there is wider acceptance. JL thanked RM and noted the trauma informed care session recently run on the ward, and the cultural challenges which resulted in the blanked restrictions being in place initially. This was an example of therapeutic care demonstrating recovery. PB asked what needed to be done to stop the restrictions from returning. RM replied that regular team review would help, along with the inclusion of the patients' views. EL asked the Executives if this was a one ward initiative. SK replied that this was a Charity-wide programme of restriction reduction. A focussed approach was required on Bracken in particular, however, this was being adopted across all wards. The Board **NOTED** the presentation		
PEOPLE			
17.	**Lead the Change** MK presented the background to the programme, highlighting the behavioural drivers and the role of the Board in ensuring its success. TB gave a presentation noting that the initiative supported the Charity strategy and interlinked with other projects.		

	OS stressed the need for co-production, encouraged by Board involvement, and asked what the target organisation type was. TB agreed noting that this work would be part of the second phase. JC asked if the group of change leaders reflected the organisation. TB replied that the BAME community was not represented, but that it was anticipated that active recruitment would mitigate this. AB commented that it was important as the majority of night staff were from the BAME community. PB noted that People Committee would retain a line of sight on the programme. The Board **NOTED** the presentation		
ANY OTHER BUSINESS			
18.	**Questions from the Public for the Board** No questions were received for the Board.		
19.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** There was no other Business notified.		
20.	**Date of Next Meeting :** Board of Directors, Meeting in Public – Friday 27th May 2022		

Approved – 27th May 2022

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Paul Burstow
Chair

Action Log and Matters Arising

(Paul Burstow)

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

Meeting in Public	ACTION	Owner	Deadline	Open / Closed	STATUS
24.03.22 **01**	**Safe Retention metrics** JL agreed to speak to Julie Shepherd, Improvement Director with regard to staff retention metrics being used within NHFT as part of the culture model, and would share accordingly.	JL	27.05.22	Open	**27.05.22**
24.03.22 **02**	**Governance update – Authority Matrix** Following the presentation of the new Charity Authority Matrix, it was agreed that it would be circulated to the Board for further consideration and feedback. Once collated, the Matrix was to return to Board for decision and approval.	KM	27.05.22	Open	**27.05.22** – (MD Update) Meeting arranged KM/MD on 22nd June. Matrix to be considered as part of the Governance Project.

Chair Update
incorporating:
Annual Fit & Proper Declaration
(Paul Burstow)

Paper for Board of Directors	
Topic	Fit and Proper Persons Annual Declaration
Date of meeting	Friday, 27 May 2022
Agenda item	**05**
Author	Duncan Long, Company Secretary
Responsible Executive	Paul Burstow, Charity Chair
Discussed at previous Board meeting	27 May 2021
Patient and carer involvement	Not required for this process
Staff involvement	Not required for this process
Report purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	None previously

Report summary and key points to note

All current Board members and those who have director level responsibility and regularly attend Board have submitted annual declarations satisfying the requirements within the Fit and Proper Person Regulations 2014 (Regulation 5 of the Health and Social Care Act 2008), demonstrating that all are of good character and meet the requirements.

The following checks have also been undertaken by the Company Secretary in accordance with the Charity's Annual Declarations process, from which no issues of note have emerged:

- Confirmation of all Directors in scope for the 2022 declaration process, incorporating Related Party Transactions; Public Contract Regulations; Reportable Gifts; Audit Declaration and self-declaration for other incidents or relevant matters.
- Review of appointment checks completed on any newly appointed Directors that are in scope
- Individual insolvency register
- Disqualified directors register
- Search of Charity Commission Register of Removed Trustees
- General internet search

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

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

Appendices

None

Paper for Board of Directors

Topic	CEO Board Update
Date of Meeting	Friday, 27 May 2022
Agenda Item	**6**
Author	Jess Lievesley, Chief Executive (interim)
Responsible Executive	Jess Lievesley, Chief Executive (interim)
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	
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

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

Appendices -

CEO Report

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

1. Quality

- **Summary of Women's CQC inspection**
  The Care Quality Commission (CQC) re-inspection of the Charity's Women's service was carried out in two parts. Most wards were re-inspected between the 5-8 April with a return to our LSSR Division between 26-28 April 2022, where the remaining four wards were inspected. Throughout the inspection various Nursing Staff, members of the wider Clinical Team, Divisional Leaders and patients were interviewed with feedback received that these were broadly positive interactions.

  High Level feedback provided by CQC received on the 22 April 2022 did not result in any escalations or enforcement actions and included positive reflections on the progress they had observed since the last inspection. Some concerns have been received regarding rotation and disposal of medication, gaps in observation records (along with an acknowledgement of the current EObs pilot), variances in progress around Least Restrictive Practice and a Privacy & Dignity concern identified on one Medium Secure Ward.

  Open dialog has been in place between St Andrew's and the CQC throughout the inspection which enabled the Charity to respond in a timely fashion to questions raised. We expect to receive a draft report towards the end of May or in early June.

- **PREMS and My Voice – Patient reported experience measures**
  We have seen a small increased response rate during March and April. This continues to be an area of focus and we are promoting increased uptake directly with service users as well as with ward and divisional leaders.

  The Research Team has offered to support in reviewing the My Voice process, with the aim to increase response rates and ensure that data is used to inform meaningful change, a meeting has been arranged to progress this.

  At this stage IT kit availability appears to be a contributory factor so we are working to increase access through other means to support improved engagement and feedback.

  Receiving this feedback from those who use our services is a key priority for the organisations and an important part of our quality strategy.

- **Implementation of Allocate**
  The project has been accelerated to reflect the importance of safe and effective rostering of all of our teams. It will now launch on 12 June, with the first live payroll on 30 June. Additional resources have been allocated to support the overall programme, particularly in the HR/payroll domain.

Allocate will help us train and build our first rosters on 2 May. After this our Workforce Leads, with support, will be setting up rosters and migrating the data from Kronos. On 23 May we will begin to train all Roster Managers on how to build their first roster and this will be followed up with authoriser training.

After 12 June, we will return to set the auto rosters up for each ward and build the SafeCare acuity into the system. This will be completed over July/August.

The WorkChoice and agency staff module is ready to be built, with the data gathering exercise complete. It will go live at the same time as the rostering. There are significant opportunities to change the way we book and manage our temporary staff in this and we are focusing on including the Workforce leads in this work.

Kronos and the clocks system will not be used from the 12 June. We will be training Roster Managers to use 'Attendance Manager' within the Allocate software.

2. People

- **Culture**
  The objective of our Lead the Change Programme is to co-produce a way forward that defines the culture we need and creates the environment for our staff to deliver high quality care for our patients every day

  We have commenced our *Discovery* Phase:
  - We have appointed 95 Change Leaders from our workforce
  - We have held our first face to face workshops
  - Appointed an internal leadership team
  - Approved additional resource to support the project
  - Change Leaders will be interviewing the Board
  - Change Leaders will be facilitating patients, carers and employee focus groups
  - We will undertake a culture diagnostic survey

- **Sickness and absence management**
  Aggregated sickness is currently 7.23% against a target of 6%. Whilst this is reducing, the aggregated figure can occlude the real challenges of sickness within some clinical areas that are higher. As a consequence and as we now come out of a prolonged period responding to absence driven by Covid we hope to demonstrate continued progress in this area over coming months.

  We have an absence project focusing on how we manage our absence more effectively including Manager training, automating return to work process and reviewing all non-patient facing clinical time to ensure this is in line with the model

- **Recruitment and retention**
  Recruitment and retention remains an area of priority within the Strategy for the organisation and as the People Committee observed, whilst recruitment remains as strong as it possibly can be in the current employment market, this alone is not delivering a growth in the net position of our workforce and therefore our attention is equally focusing on the retention of existing colleagues.

3. System working

The Charity continues to engage positively with our system partners through the work of the East Midlands Alliance, as well as drawing upon support from our NHS colleagues as

part of the 'Buddy' arrangements led by Northamptonshire Healthcare NHS Foundation Trust to support our Quality Improvement program.

Our Director of Strategy continues to represent the Charity in the local Integrated Care System Mental Health Collaborative and we are taking the opportunity to share expertise and identify those areas where we can benefit the local communities and system priorities.

4. Charity Strategy and Board Assurance

The Board Assurance Framework has been developed and a draft approach is being presented at the May Board meeting for comment. A Strategy Milestone Tracker will inform the BAF for the strategy delivery risk, enabling progress oversight for each strategic priority area. The first full BAF will be reviewed at the July Board.

The Senior Responsible Owners for each of the seven strategic priority areas are planning and delivering against the relevant objectives and milestones and progress is being monitored and scrutinised through the Executive via the Strategy Milestone Tracker and a robust check and challenge process.

5. Provider collaboratives

Our partnership role within the three principle Provider Collaboratives across the Midlands (IMPACT Adult & Children and Reach Out) continues to position the Charity as a key partner to support the collective ambition of the region to deliver highly effective and efficient clinical pathways of care. As members of the Boards for all three areas we continue to actively contribute to the strategic direction for future services and the best possible methods to deliver improved clinical outcomes.

Given our shared value base and commitment to working in a collaborative and partnership orientated way, the Charity has been welcomed as an integral component of care delivered within the region.

6. Finances

Whilst the Charity finances will be covered in more detail later in the agenda, the headline position and matters that will be of particular importance to the Board are set out below;

- **Year End 2021/22 Financial Performance**
  The Charity reported a £12.3m deficit for the year ending 31 March 2022, reflecting the downside impact of the various occupancy restrictions (COVID, CQC and Staffing) encountered during the year. However, the yearend deficit was better than the re-forecast presented to the Board in September 2021 by £2.2m (£3.7m operationally) and the financial recovery plan was achieved each month which we believe provides confidence in the achievement of the 2022/23 budget approved in March 2022.

- **Qtr1 2022/23 Financial Outlook**
  In April 2022 we saw our largest increase in occupancy for several years, although the closing occupancy was slightly behind plan, mainly due to external factors and delays from commissioning authorities. This allowed 98% achievement of anticipated

income, but with positive movement in costs we reported a £0.1m improvement to the budgeted net deficit for April 2022.

For the next quarter we expect this trend to continue. Occupancy growth is critical to achieving the financial budget and we are seeking to recover the position, notwithstanding factors outside of our control. CQC have recently reduced the approval criteria for wards under S31 restrictions (allowing one admission per ward per week without CQC approval) and this will assist the continued occupancy growth.

- **Credit Facility Refinance update**
  Work is underway to secure our revolving credit facility with the banks, who are responding positively to the emerging picture regarding the CQC re-inspection, and we are hopeful of being able to secure the level of investment required. Meetings with perspective banks are scheduled for week commencing 23 May 2022 and we are currently on track with the approach and timelines previously advised.

- **Cost Efficiency Plan**
  Departmental efficiency programmes to support the budget achievement of 2022/23 are in progress and will continue to be monitored to ensure timely and full financial impact is achieved.

  Once the bank refinance work is concluded in Qtr1, our CFO will be leading the work to improve the wider efficiency of the Charity, with particular focus on the centralised costs, Charity overheads and the level of fixed costs. This is a critical area that is essential for the Charity to remain competitive going forward and to effectively implement the Strategy. This is also critical to ensure the Charity is agile to the cost inflation risk in 2023/24, particularly when our current utility hedge ends, and we will be exposed to cost pressures.

- **External Stakeholders**
  Existing bank relationships are positive and both Barclays and HSBC recognise the important navigation of the 2021/22 financial year, improved position at year end compared to the financial forecast and with no risk to the bank covenants during the year.

  NHSE/I continue to monitor financial performance monthly and expressed concerns about the confidence in the financial recovery plan during a meeting with the Charity, mainly due to the historic failure to achieve annual budgets and we continue to work proactively with them to increase visibility of the work we are doing to strengthen our position

  Both the banks and NHSE/I are aware of the significance of the CQC re-inspection of the Woman's Services and how critical this is to support external confidence from bank. The outcome of this report will determine their requirements moving forward.

  .

7. Communications and engagement

- **Long Service Awards**
  270 Long Service awards have been presented since September (celebrating a total of 3,885 years' service between then) with a further 70 confirmed attendees for next event on Monday 13 May.

- **Care Awards and Annual Awards in May**
  We recently celebrated our Q4 CARE Awards finalists and winners, with a ceremony held in our main building with a live link to Birmingham and Essex. The winners were Silverstone Ward for Compassion, Simon Callow, IT Deputy Director for Accountability, Jacek Wozniak, Logistics Assistant for Respect and Coedan Lloyd, HCA for Excellence.

  Next on the Awards calendar is our Annual Awards event, which will take place on Monday 30 May at the Park Inn, Northampton and will include the following awards categories:

  - Inspirational Individual
  - Team / Ward of the Year
  - Making a Difference
  - Compassion
  - Accountability
  - Respect
  - Excellence
  - Charity Executive Committee Award
  - Outstanding Achievement
  - Carers Champion
  - Anne Ford Volunteering Award
  - One Charity Award

- **Freedom to Speak Up Guardians**
  In 2019 we followed in the footsteps of many NHS Trusts and appointed a group of Freedom to Speak Up Guardians, who offer independent support and advice to staff who would like to raise concerns. Since this time, the team has expanded from four to eleven members and are represented in all sites across the Charity. We have recently appointed a Lead Guardian, Laura Dorrington, who will oversee the team and work to remove any barriers that stop our staff speaking up.

- **Leadership event**
  Our Leadership event, held on 28 April at the Park Inn in Northampton, was attended by leaders from across the Charity. Attendees had the opportunity to focus on the seven key strategic priorities that we have identified for our 2022-2027 Strategy, and consider how they can help to ensure that we are delivering our charitable purpose of promoting wellbeing, giving hope and enabling recovery wherever possible.

- **Executive Engagement**
  The Spring / Summer *Jaffa Cake* sessions are now in progress, and they will focus on the key themes / feedback from past sessions and the actions underway and planned. This time, all sessions are available both in-person and online (via Teams). It is hoped this will ensure even greater attendance and a chance for all staff to share their thoughts.

- **Headfest**
  As part of Mental Health Awareness Week, we have shared our expertise with the general public by co-hosting the county's very first mental health festival, Headfest at the Royal & Derngate Theatre in Northampton.

  The project has been run in partnership with BBC Northampton, Northamptonshire Healthcare NHS Foundation Trust (NHFT) and the University of Northampton, and has featured a full week of mental health related workshops, talks, presentations and films, including screenings of I'm Not Mad I'm Me, filmed within the Charity.

  This important work has played a significant role in progressing our strategic aims around promotion and partnership and working more directly to support the communities in which we are based and providing stewardship in the field of mental healthcare.

  Media coverage of the event included:

  Everything you need to know about Headfest in Northampton during Mental Health Awareness Week | Northampton Chronicle and Echo
  Northampton's Royal & Derngate to host week-long mental health festival | Northampton Chronicle and Echo

  In addition, Phil Credland – a former outpatient in our Veterans' Complex Treatment Service, spoke to BBC Radio Northampton's Breakfast show as well as BBC Look East. He was featured on both the 6pm and 10pm news bulletins.

- **Mental Health Awareness Week sessions**
  As well as Headfest, we have had several staff-only events as part of Mental Health Awareness Week. Held virtually and open to all staff at all our hospital sites, sessions have included a talk from guest speaker Haseeb Ahmed – a blind man who has broken world records for his running – as well as sessions on loneliness and other topics hosted by our Employee Networks.

- **International Nurses Day**
  International Nurses Day is celebrated annually on 12 May; the date is significant as it is the birth anniversary of Florence Nightingale, the founder of modern nursing.

  We have encouraged all our nurses to share their #BestofNursing story, to highlight why they love the profession so much. As a small thank you, we have also created and distributed a special notepad gift to all our registered nurses; it is a little useful item which we hope will remind our nurses of the amazing job they do for our patients.

- **Other Media coverage**
  A particular recent highlight has been St Andrew's Consultant Psychiatrist Dr Alexei Titievski featuring on regional BBC programme Look East. The producers wanted to cover his efforts to support Ukraine which has dominated the headlines,

  Alexei was born in Ukraine and obviously upset by the war, was given a month away from the Charity so he could facilitate the creation of four field hospitals in the conflicted country. The Chronicle and Echo and Northants Live also ran his incredibly inspiring story.

The beginning of the month kicked off with BBC Northampton covering the positive CQC Report for the Community Partnerships Service in its bulletins. The story was also picked up in the Business in the Midlands, Wellbeing News, TeaTalk Magazine, the Healthcare Newsdesk, Need To See it News and All Post News.

Off the back of that story, the External Communications team had been in touch with a client user, who admitted she had been struggling with the Ukraine headlines. Nicola Crooks. who lives with complex post-traumatic stress disorder (CPTSD), has been using the Veterans' Complex Treatment Service and agreed to share her story which was picked up in local newspapers Chronicle and Echo, The Lincolnite and in the national publication Charity Today.

Liz Ritchie, our resident media expert has once again, been giving her professional opinion on healthcare issues in national publications. This month she provided some insight to Stylist magazine about how people are struggling to get back to 'normal' now Covid restrictions have been lifted in the UK.

She was interviewed for a Mothers' Day piece in Take a Break magazine about the positive benefits of motherhood. The red top magazine has a readership of nearly half a million people.

We reissued former builder Simon Austin's Aspire story in March where he spoke about his passion for mental health nursing and that was covered in Northants Live. Lesley Deacon, one of our most-longest serving members of staff, had her moment to shine when her story was published in the Chronicle and Echo and Charity Today celebrating her Ruby anniversary with the Charity. The Nursing Times has also requested an interview with her, so watch this space.

Spreading our wings towards the end of the month, we managed to penetrate the press in Luton with Luton Today running the story we put out about how our veterans service helped bring a former solider "back to life".

Phli Credland's inspiring story, which also highlighted St Andrew's signing the Armed Forces Covenant, was also picked up by Northants Live, Tea Talk Magazine, Business in the Midlands, South East Online, Healthcare Newsdesk, Wellbeing News, AllPost News, Daily Business Now, Business in the News, Charity Today and the Chronicle and Echo.

Neuro Rehab (NR) Times have covered the upcoming Brain Injury – Time for Change in Northamptonshire? Conference on 19 May, which will focus on two key areas of the Time for Change report. Produced by the All Party Parliamentary Group on Acquired Brian Injury, the report identified a number of areas where change is vital to benefit the lives of survivors and to protect future generations. Dr Keith Jenkins, Dr Keith Jenkins, consultant clinical neuropsychologist at St Andrew's, will be speaking at this prestigious event.

Committee Updates

Quality & Safety Committee
Audit & Risk Committee
Research Committee
Pension Trustees
People Committee

Committee Escalation Report to the Board of Directors

Name of Committee: Quality and Safety Committee (QSC)

Date of Meeting: 12 April 2022

Chair of Meeting: Professor David Sallah

Significant Risks/Issues for Escalation:

- Staffing levels and vacancies were highlighted as an area of risk, specifically within the CAMHS division. The introduction of Allocate would address some of the problems through more effective scheduling, but it would have to be underpinned with recruitment.
- Safeguarding level 3 mandatory training was lower than required and that this area remained an area of focus, with localised training being offered to address the shortfall in completion.
- The impact of Delayed Transfers of Care on patients care and outcomes.

Key issues/matters discussed:

- **Physical Healthcare update - Essex**

  The committee were provided with an update on Physical Healthcare, providing information on key areas for alert and assurance, along with a focus on the PH provision within Essex. The committee were informed of the return of podiatry services to the Northampton site.

  The committee highlighted that further work was required on the accuracy of some data within the report, specifically assessments on admission data.

- **Safer Staffing**

  The committee received its first safer staffing update and whilst the update was undergoing development it would, in future be provided for assurance. The committee were made aware that staffing levels and vacancies were highlighted as an area of risk, specifically within the CAMHS division. The introduction of Allocate would address some of the problems through more effective scheduling, but it would have to be underpinned with recruitment.

  The report highlighted that safeguarding level 3 mandatory training was lower than required and that this area remained an area of focus, with localised training being offered to address the shortfall in completion.

- **Quality Account – update**

  The committee reviewed the latest draft version of the 2021-2022 Quality Account and discussed what the three priorities for the account could be. The final draft is to be shared with the committee ahead of a focussed “page turning” exercise in May, ahead of submission to Board for approval.

- **LSSR Division deep dive**

  The deep dive was presented by the division and noted. The division’s presentation focussed on the key areas for assurance as requested by the Committee, including

principal function; CQC ratings; areas of good practice; areas of concern and action plans in place. Discussions covered the apparent resistance to change highlighted within the division's SWOT analysis, the division's use of CQI processes and the benefits seen at a divisional level, as well as the focus on staffing levels and occupancy.

- **Executive Medical Director report**

  The committee noted the EMD report that included updates on Covid; Quality Improvement; the impact of Delayed Transfers of Care and the technology being used to support clinicians. The Committee requested a further paper on the impact of Delayed Transfers of Care.

- **Chief Nurse report**

  The committee noted the Chief Nurse report, which included further updates on Clinical Supervision, Handovers, Professional Nurse Advocacy, Safer Staffing and the centralised AHP function.

- **Quality Improvement Plan and Women's Service CQC progress**

  The quality Improvement plan and progress update on the CQC related actions for the Women's and Men's services were presented together and noted, along with discussions around the Buddy Workstreams. The committee were informed that all bar one of the previously reported outstanding actions had been closed in line with the agreed and robust closure assurance process.

  Discussions also focussed on the work being done within the Buddy Workstreams and that discussions were taking place on an exit strategy for the buddying arrangements and how the learning and continued collaboration would continue in to the future under business as usual.

- **Serious Incidents**

  The serious incidents in the last period were reviewed, noting the continued improved position of investigations and reports and that all were on track and within deadline.

- **Integrated Performance Report**

  The Integrated Performance Report was received that highlighted the quality performance indicators and progress made over the last 2 quarters as indicated within the reported metrics. Benchmarking and associated targets are planned to be included for the next QSC meeting and the work being done on these would improve the quality of reporting and the granular state of reported data.

- **Covid-19 update**

  The committee noted the latest Covid update that highlighted the latest Covid statistics for positive patients and wards/areas in outbreak. The removal of restrictions in the community, with the resulting increase in infection rates was having an impact on the cases being seen within the Charity. The committee was assured that access to LFT kits was sufficient and that these were still being used across the Charity.

- **Infection, Prevention and Control update**

  The committee noted the IPC update paper and acknowledged the significant progress that has been made across the Charity in relation to IPC. NHSEI had acknowledged this also, with the Charity moving to an Amber Support rating.

- **Quality and Safety Group (QSG) – incorporating Mental Health Law Steering Group**

  The Quality and Safety Group report was received and noted, highlighting the change in reporting structure of the meeting, that now had two parts; one covering Quality and the

second covering assurance and clinical audit. The report also now included an update from the MHLS Group.

The committee raised concerns over the change to the QSG and that this had not been discussed at the committee, nor approval sought. The change in meeting structure of the Group should have been agreed by the Committee in advance.

The committee also raised concerns over the merging of the MHLS Group update, requesting that this returns to a direct update to the QSC to ensure that the Board retains a clear line of sight over the MHA via the MHLS Group reporting directly to QSC.

Decisions made by the Committee:

- **QSG –** approvals, the Committee agreed:
  - The Clinical Effectiveness Strategy was now seen as business as usual and as such the separate reporting and monitoring process should come to an end
  - The disbanding of the former Clinical Audit Group (now covered directly within the second element of the QSG)
  - The approval of the 2022/23 Clinical Audit programme.

Implications for the Charity Risk Register or Board Assurance Framework:

- Material Risk deep dive review of Regulatory Compliance Risk – on-going bi-furcation of original material risk into clinical and non-clinical related risks.

Issues/Items for referral to other Committees:

- QSC to be kept informed on discussions and papers at People Committee surrounding Culture.

Issues Escalated to the Board of Directors for Decision:

- None

Appendices:

- None

Committee Update Report to the Board of Directors

Name of Committee: Audit and Risk Committee

Date of Meeting: 19 April 2022

Chair of Meeting: Elena Lokteva

Significant Risks/Issues for Escalation:

Whilst there has been significant progress with the improvements required over the risk management system, and the Committee is satisfied with the progress being made, the Committee remains very conscious that current risk management system can provide the Board with partial assurance only.

Key issues/matters discussed:

1. Grant Thornton

Grant Thornton presented the committee with the external audit plan and process, along with an update on progress to date. The plan is currently ahead of schedule and there were no matters that required raising at this time. The annual fees were acknowledged as being in line with the approved tender.

2. Finance

The committee received a paper outlining the Accounting Policies currently applied to the Charity and confirmation that there were no changes expected in the current financial year.

3. Risk

ARC received detailed risk updates which highlighted the key focus areas within risk, including risk register review status, operational risks, on-going actions, material risks, and KPIs. The Committee also reviewed the 6 monthly risk management self-evaluation that provides assurance over progress with the on-going development of the Charity's Risk Management System (primarily the introduction of the new Datix risk system) as well as the alignment of the planned work within the function with the Governance Project actions.

The current Material Risk Register was reviewed and of the 20 current material risks, 18 have been reviewed in detail with the Executive Responsible, in line with the agreed schedule. One material risk was retired relating to Estates, one new Finance risk was proposed as material, 6 material risks have seen a reduction in their residual risk score, and no risks have seen an increase in their risk score.

The new Charity Risk Appetite Strategy was presented for approval ahead of submission to Board and subject to a number of minor amendments to terminology, the strategy was approved. One finalised at Board, the risk appetite strategy will be applied across all levels of the Charity's Risk Management System, including Strategic, Material and Operational Risks.

4. Internal audit

The Committee reviewed the current internal audit update covering published reports, audit actions dashboard and progress versus IA annual plan and following an update from the IARM, noted that there were 4 overdue actions at this point in time. These were all being addressed by the Responsible Executive in conjunction with the IARM.

One Internal Audit report was published since the last meeting, rated as "adequate" relating to the Charity processes surrounding the DSPT submission. All field work relating to the remaining 2021/22 audit assignments has been finished and reports are in draft format and under review with management.

ARC received and considered a paper on the proposed IA Annual Plan for 2022/23, which outlined the number of audits and the assignment areas that once completed would be adequate to provide the required level of assurance over the Charity's internal control environment. The proposed plan included an in-house element of audits, as well as a number or proposed assignments that could be completed using a third party co-source arrangement. The committee approved the in-house element and requested that a clear plan regarding the co-sourcing element (including funding) should be presented to ARC in July.

5. Counter fraud

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

The Committee also received the proposed LCFS Annual Plan for 2022/23, which after review and discussion was approved.

6. IT Applications and services – Business Continuity Plan review

The Committee received and noted IT and Cyber Security update that covered the on-going work relating to the impact of the global Kronos outage, future business continuity actions for IT and the ISO27001 Re-validation. The Charity were successful in achieving its re-validation with no findings of significance.

7. Board Assurance Framework

The Committee received the new format of the Charity's BAF, along with the process that will be introduced to identify and manage the principal risks associated with the delivery of the Charity's new Strategy and strategic objectives. A series of meetings and workshops were being undertaken with management to finalise the suite of strategic risks, the associated controls and assurances ahead of July ARC. The BAF process and template was approved for presentation to Board.

Decisions made by the Committee:

- Approved the current accounting policies
- Approved the proposed risk KPIs for reporting operational risk
- Approved the Charity Risk Appetite Strategy for submission and approval at Board
- Approved the internal audit plan for 2022/23 (subject to further discussions on the need for additional co-sourced assignments)

- Approved the BAF process and template ahead of presentation to the Board

Implications for the Charity Risk Register or Board Assurance Framework:

Five new operational risk related KPIs are to be adopted for future ARC reports, along with two further KPIs for measuring completed actions versus overdue actions and the quality of assurance provided.

Further work is being completed on the principal strategic risks that are to be incorporated within the new BAF template. These will be presented at the July ARC ahead of submission to July Board.

The new Charity Risk Appetite was approved, ahead of submission to Board. Once final approval is obtained, the risk appetite strategy will be applied across all levels of the Charity's Risk Management System, including Strategic, Material and Operational Risks.

Issues/Items for referral to other Committees:

- Executives and the Governance Project should give consideration as to how assurances would be covered between the Finance Committee and ARC, including whether attendance by appropriate members at each committee is required.

Issues Escalated to the Board of Directors for Decision:

- Charity Risk Appetite Strategy

Appendices:

- Appendix 1 - Charity Risk Appetite Strategy

St Andrew's Healthcare

Risk Appetite Strategy

For internal discussion purposes only

19 April 2022

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Context

The UK Corporate Governance Code states that “The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives”. This means that at least once a year, St Andrew’s Healthcare Board should consider the types of risk they may wish to exploit and/or can tolerate in the pursuit of the Charity’s objectives. This helps demonstrate to all our key stakeholders, including service users and their families, our regulators and our staff that there are clear and effective processes for managing risks, issues and performance across the Charity.

Currently, St Andrew’s Healthcare defines risk appetite as “the amount of risk that we are willing to seek or accept in the pursuit of long-term / strategic objectives”. Effective Risk Appetite is key to achieving effective risk management and should be considered before risks are addressed.

We recognise it is neither possible nor desirable to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and that we may need to consider and/or accept a certain degree of risk where it is in our and ultimately our service users’ or staffs’ best interests i.e., where taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our service users, system partners, staff and visitors.

We carry out analysis, make judgements, take decisions, provide services and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We must therefore view risks holistically, assessing interdependencies to provide a more rounded assessment of risk, finding a better balance between the potential benefits of managed risk taking and avoidance of risk.

Risk management within St Andrew’s aims to achieve the optimum balance between quality of care, treatment and rehabilitation of service users, and the provision of services which are safe by optimising use of resources and identifying prioritised risk control action plans. Therefore, an approach to risk appetite which puts the quality of care and the safety of service users and staff at the centre, but recognises the requirement for a degree of speed, especially in today’s climate, has been considered to support clear decision making and accountability for our Charity.

In conclusion, risk appetite within St Andrew’s aims to prevent failure caused as a consequence of excessive risk-taking and ensure that Executive Management and the Board are taking the right risks for success (e.g. to maintain or enhance service users safety, quality of care and experience, to maintain performance within an appropriate use of resources, and to deliver improved outcomes for patients and deliver Value for Money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances across our Charity to help drive management action and facilitate informed decisions.

Risk appetite at St Andrew’s Healthcare is:

- set by the Board;
- aligned with our strategy and corporate objectives and embedded into key business processes;
- linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control;
- not a single, fixed concept. There will be a range of appetites for different risks and these appetites may vary over time; in particular the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances change, such as, periods of increased uncertainty or adverse changes in the operating environment (for example in response to COVID-19); and
- reviewed once a year, or sooner if circumstances dictate.

Aims and Objectives

Why do we need Risk Appetite?

Increasing pressures, both internally and externally driven across the health and social care system, may mean that our staff may need to take decisions they may not have taken previously, or needed to have taken as quickly. The focus on maintaining the statutory duty of patient safety and quality of care remains at the fore and our Board, Executive Team and management may have to make difficult decisions to balance quality, finance and operational performance.

The Board is ultimately responsible for deciding the nature and extent of the risks it is prepared to take. The Charity's approach to risk appetite is a key element of the Board's strategic approach to risk management as it explicitly articulates their attitude to and boundaries of risk. When used effectively it is an aide to decision making and provides an audit trail in that it supports why a course of action was followed.

Risk appetite also provides clear expectations for staff and managers regarding the management of risk. It allows for controlled risk taking; evidencing preparedness to take risk appropriately.

Purpose / benefits / importance of Risk Appetite

A well-articulated risk appetite statement is a critical part of the Charity's overall risk governance process. The purpose of risk appetite is to articulate what risks the Board are willing or unwilling to take in order to achieve the Charity's strategic objectives. The purpose of stating risk appetite within the Charity's is therefore to:

a) Create transparency and consistency for the type and level of risks that the Charity undertakes to achieve strategic and operational goals. Risk appetite provides awareness and an overall view of our risk profile, giving context to our risk position and exposure.

b) Help steer decision making across the organisation by providing a position against which potential decisions can be tested and challenged. Risk appetite provides freedom for prudent decision-making within agreed risk boundaries by:
   i. Providing early warning where risks are outside of limits (yet still within risk capacity and well within legal requirements)
   ii. Creating a "freedom" that promotes flexibility and accountability to management and operations
   iii. Making sure a breach triggers internal actions designed to escalate and respond before it threatens the reputation and viability of the Charity
   iv. Eliminates excessive risk aversion by articulating preference for risk taking
   v. Defines thresholds for risk taking that optimise risk and reward
   vi. Helps integrate risk taking and performance management
   vii. Assists with the definition of risk metrics throughout the Charity's risk management system that support day-to-day business operations
   viii. Defining escalation and reporting procedures related to pre-set levels

c) Drive risk behaviour and set the tone for the organisation's risk culture.

Key Terminology

Risk Appetite Pyramid

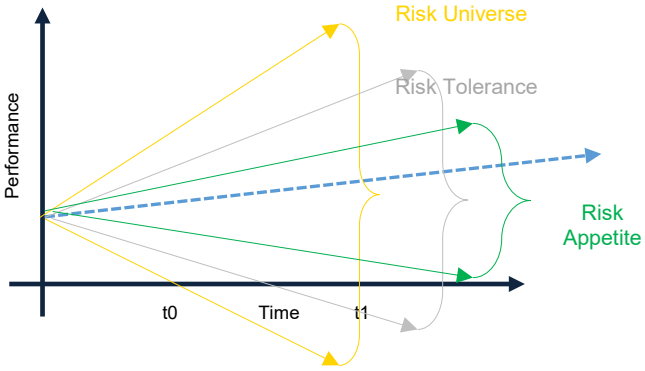
Risk Appetite and Risk Tolerance set boundaries of the level of risk St Andrew's Healthcare as a Charity (and the underlying departments and divisions), are prepared to accept throughout the course of ongoing operations. Establishing these parameters should facilitate management's ability to set a proportionate response to risk in the context of business objectives.

Having a defined risk appetite strategy helps management to consider how much risk is appropriate in the course of performing its activities and can be used to assess and prioritise the management of risks that are determined to be outside of the agreed appetite and tolerance set by the Charity Board. This document creates a common language and understanding with regards to the Charity's attitude to risk. Relevant definitions for Risk Appetite and Risk Tolerance, and other related terminologies, are tabulated below:

Risk Capacity	The maximum amount and type of risk the Charity can assume / is able to support in pursuit of its objectives given its resources, operational environment and obligation.
Risk Appetite	The amount and type of risk the Charity is willing to accept in the pursuit of objectives. Risk appetite is the aggregate level and types of risk that St Andrew's executive management and Board is willing to assume within its risk capacity to achieve business objectives. Risk appetite is usually encompassed in practice through standard operating procedures, policy and guidelines.
Risk Tolerance	The acceptable level of deviation from a standard or objective delineated through the use of limits, policies, and delegation of authorities. The Charity's tolerance for risk relates to the degree to which performance can deviate from expected outcome and still be considered within an acceptable range from a risk perspective. Risk tolerance determines the maximum risk the Charity is willing to take for a particular activity / objective, or category of risk. Exceeding a risk tolerance (especially for a Strategic or Material risk) will typically act as a trigger for corrective action at the executive level, immediate notification to the Board, and a fulsome review of the underlying causes of the high-risk exposure or significant variation from expected performance.
Risk targets	The optimal level of risk that the Charity wants to take in pursuit of a specific business goal. This is usually based on the desired return or outcome, the risks implicit in trying to achieve the organisations' strategy and related returns and the ability to managing the related risks.
	The thresholds to monitor for the risk exposure or performance deviating from the target i.e., that actual risk exposure does not deviate too much from the risk target

Operationalising Risk Appetite

When risk appetite is defined rigidly it can impede innovation and make an organisation overly cautious. It can also fail to reflect the complexity and diversity of decision making required.



Risk Universe - All the risks that the organisation might face.	The full range of risks which could impact, either positively or negatively, on the ability of the organisation to achieve its long term objectives.
Risk Tolerance - Those risks that, Charity might just be able to put up with.	The boundaries of risk taking outside of which StAH is not prepared to venture in the pursuit of its objectives.
Risk Appetite – Risks that the Charity actively wishes to engage with	The amount of risk that an organisation is willing to seek or accept in the pursuit of its long term objectives.

Application and usage

Due to the nature of our services, and the duties we are mandated to perform, St Andrew's Healthcare acknowledges that a one-dimensional (overly adverse and heavily quantitative and directive) approach to risk appetite would not drive the right results. Therefore, in keeping with our culture to empower and trust decision makers, to drive consistency and enable staff to take well calculated risks and make accurate risk trade-off decisions to improve delivery when opportunities arise (and identify when a more cautious approach should be taken to mitigate a threat), the Charity has adopted a largely qualitative approach to risk appetite.

The aim is for risk appetite considerations to be an intrinsic part of both our risk management and business processes, not seen as something separate or extra. In many areas this is already happening:

Business processes

To ensure that the Charity's day-to-day activities are well managed and that decisions are well controlled within local circumstances, risk appetite considerations are an intrinsic part of how we do business; with the aim of improving organisational performance. Therefore, in some instances, for example from an operational perspective, risk appetite reflects the constraints that are already placed on staff in the organisation. For example, risk-reward trade-off discussions and/or appetite/tolerance limits are:

- Embedded within operating limits; delivery targets/KPIs; standing financial instructions (SFIs) / delegated financial limits and processes by which revenue and capital expenditure are committed to; and other delegation of authority arrangements i.e. delegated decision and oversight levels.

- An integral part of strategic and financial planning. For example, the annual budget prioritisation process is linked to our business planning cycle which allows an overview of financial and other types of risk.

- Built into impact assessment processes, and considered within any Decision-Making Frameworks/Models, and within programmes and projects (at the very outset of project conception, within the formal decision-making process and throughout delivery) actively guiding management to assess the level of risk beyond which programmes and projects would not be considered viable.

Risk processes

A high-level qualitative Risk Appetite Statement structured around the Charity's key risk categories / principal risk types (known as domains). St Andrew's Healthcare expresses its risk appetite using statements against nine key risk domains:

- Quality,
- Safety,
- Compliance,
- Research and development,
- Reputation,
- Performance and service sustainability,
- Financial sustainability,
- Workforce
- Partnerships & innovation

In drafting the Charity's risk appetite across these nine domains, reference has been made to the Good Governance Institute's Risk Appetite for NHS Organisations Matrix (see Appendix 1). As a guide for setting risk appetite, and to find out if individual risks fall within an acceptable tolerance range, risk appetite is considered against the Charity 5x5 Risk Matrix

The Executive will continue to monitor risks top down to ensure appetite is within tolerance range, that actions taken to reach target levels of risk are achievable and met, and/or that changes in one risk category do not unwittingly compound others.

The approach to risk appetite also provides a way of steering risk appetite/tolerance discussions bottom up and should ensure consistency of approach for the Charity as a whole, including in day-to-day service delivery and the delivery of programmes and projects. Departments and Divisions will continue to own, respond to, monitor and communicate risk management information bottom-up as articulated within the Charity Risk Management Framework. Risk Appetite levels will be further linked to wider Risk Management Framework in two key ways:

- Link of Risk Appetite level to target risk scores so that there is a clear calibration between the two
- Alignment of Risk Appetite level to risk escalation level

St Andrew's Healthcare Risk Appetite Strategy

St Andrew's Healthcare (The Charity) recognises as a healthcare provider that risks will inevitably occur in the course of providing care and treatment to service users, employing staff, owning, leasing and maintain premises and equipment, and managing finances. As a result, it endeavours to establish a positive risk culture within the organisation, where unsafe practice is not tolerated and where every member of staff feels committed and empowered to identify and correct and/or escalate system weakness.

The Risk Appetite Statement provides the Board's appetite for risk taking and tolerances and is mapped against the Strategic Objectives. This clear understanding of the Board's tolerances and appetite for risk taking is necessary to steer and influence the development of appropriate risk mitigation strategies and systems of controls. The Charity's Risk Appetite Strategy has been developed taking into consideration the following key aspects of risk:

1. No risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of stakeholders, including service users, staff and system partners.

2. Risk appetite is not a single fixed concept, and St Andrew's Healthcare recognises the complexity of decision-making in providing services and the inherent risks associated with those decisions.

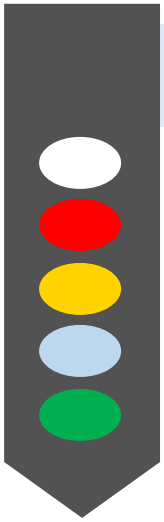
3. The amount of risk the Charity is prepared to accept or be exposed to (its risk appetite) will vary according to the perceived significance of risks; timing (it may be more open to risks at different points in time); and regulatory or legislative constraints. As such it acknowledges that each case requires the exercise of judgement and that appetite levels may need to be reassessed and amended (i.e., increased or decreased) either temporarily or permanently to reflect new or changing circumstances.

4. The approach to risk appetite is therefore based on the premise that trade-off conversations and a consideration of the counterfactual is undertaken when assessing risk on a case by case basis. This provides a flexible framework within which it can find an appropriate balance between risk and reward and make agile decisions and find a balance between boldness and caution in connection with risk. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour. In this sense, risk appetite should be used as a guide or a necessary 'check and challenge.'

5. When balancing risks, the Charity will tolerate some more than others. For example: It will seek to minimise avoidable risks to patient safety in the delivery of quality care and have a very low appetite for risk in this area; whereas in the case of research and development we are prepared to take managed "moderate to high risk" on the proviso that the following 'check and challenge' has been undertaken:
    - An assessment of what and where the current risks are
    - That the potential future impact has been understood and agreed
    - Rapid cycle monitoring is in place to enable swift corrective action should things go wrong
    - Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e., whether it will lead to an increase or reduction in other categories of risk);
    - Cost–benefit analysis and stated preference is undertaken
    - Reliability and validity of data used to make the assessment has been considered

- Counterfactual risks have been considered to ensure management apply any learning before taking the risk;
- We can demonstrate significant and measurable potential benefits (i.e., enhanced efficiency and/or value-for-money delivery)

The table below shows the reader the thought process of the user at a certain Risk Appetite Level – The extent of risk appetite, the associated risk tolerance level, the ideal risk management approach and the residual risk score which warrants an escalation to the Board of Directors.



Risk Appetite Level as per GGI	Extent of Risk Appetite	Risk Tolerance Level	Risk Management approach	Escalation to Board if Residual Risk Score is
0 - Avoid	No Appetite	Zero Tolerance	Highly Cautious	09
1 - Minimal	Low Appetite	Low Tolerance	Cautious	12
2 - Cautious	Moderate Appetite	Medium Tolerance	Conservative	12
3 - Open	High Appetite	High Tolerance	Confident	15
4 - Seek / Mature	Significant Appetite	Very High Tolerance	Confident	15

Risk Appetite Statement and Tolerance Ranges

In addition to the strategy above and based upon the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix (Appendix 1), the Board has developed several risk appetite statements and indicative tolerance ranges. These risk appetite statements and indicative ranges are provided against 9 risk categories (or risk domains) and are reviewed annually by the Board:

High-level Statements and range of Risk Appetite Levels

Risk Domain / Category	Risk Appetite Level	Extent of Risk Appetite	Risk Tolerance	Risk Management Approach	Residual Risk for Escalation to Board	Risk Appetite Statement
Quality	1 Minimal	Low Appetite	Low Tolerance	Cautious	12 or more	The provision of high-quality services is of the utmost importance for the Charity. The Charity acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a "**LOW RISK APPETITE"** for risks which may compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact quality, could have catastrophic consequences for our patients.
Safety	1 - Minimal	Low Appetite	Low Tolerance	Cautious	12 or more	The Charity holds patient and staff safety in the highest regard. We have a **"LOW RISK APPETITE"** for matters which may compromise safety, however recognising that individual risk tolerance may on some occasions go above this if it is in the best interests of patients to accept some therapeutic risks to encourage and improve patient recovery and to achieve the best outcomes. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk. N.B. Key to keeping patients and staff safe is the condition of the estate. We are committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and do not represent a health and safety risk.

Risk Domain / Category	Risk Appetite Level	Extent of Risk Appetite	Risk Tolerance	Risk Management Approach	Residual Risk for Escalation to Board	Risk Appetite Statement
Regulatory / Compliance	2 Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more	We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them. We have a "**MODERATE RISK APPETITE"** on matters relating to Regulatory compliance.
Research and Development	3 Open	High Appetite	High Tolerance	Confident	15 or more	We have a "**HIGH RISK APPETITE"** for Clinical Innovation that does not compromise quality of care and patient safety. The Charity has a HIGH appetite for risks associated with innovation, research and development in order to take forward our vision in relation to the new treatments, developments of new models of care and improvements in clinical practice that support the delivery of our person centred values and approach. The Charity will only take risks when it has the capacity to manage them and is confident that there will be no adverse impact on the safety and quality of the services provided.
Reputation	2 Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more	The Charity will maintain high standards of conduct, ethics and professionalism at all times. We have a "**MODERATE RISK APPETITE"** for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.
Performance and service sustainability	2 Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more	We have a "**MODERATE RISK APPETITE"** for risks which may affect our performance and service sustainability and are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient safety and quality improvements as long as patient safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19) which may result in lower performance levels and unsustainable service delivery for a short period of time.

Risk Domain / Category	Risk Appetite Level	Extent of Risk Appetite	Risk Tolerance	Risk Management Approach	Residual Risk for Escalation to Board	Risk Appetite Statement
Financial Sustainability	2 Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more	The Charity is indirectly entrusted with public funds and must remain financially viable while safeguarding the public purse. The Charity has no appetite for accepting or pursuing risks that would leave the organisation open to fraud or breaches of financial procedures. We strive to deliver our services within our budget and financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care, according to a "**MODERATE RISK APPETITE"**. We will ensure that all such financial responses deliver optimal value for money.
Workforce	2 Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more	The Charity is committed to recruit and retain staff that meet its high-quality standards and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximise the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring the Charity remains a safe place to work. We have a "**MODERATE RISK APPETITE"** for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a HIGH level of risk on some occasions to support patients. N.B. We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our Values i.e. unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely, nor any incident or circumstances which may compromise the safety of any staff members or group.
Partnerships	3 Open	High Appetite	High Tolerance	Confident	15 or more	The Charity is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a "**HIGH RISK APPETITE"** for partnerships which may support and benefit the patients in our care. For example, the Charity has a high appetite for risks associated with innovation and partnership with industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Charity will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.

Appendix 1 - Good Governance Institute's Risk Appetite for NHS Organisations Matrix

Risk Levels → Key Elements ↓	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
'More for Less' Overhead Optimisation = Financial / VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM is still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Bureaucracy Busting Compliance / Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Pathways Innovation / Quality / Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology development used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Patient Innovation / Quality / Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology development used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

Appendix 1 - Good Governance Institute's Risk Appetite for NHS Organisations Matrix (contd.)

Risk Levels → Key Elements ↓	0 Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	3 Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	5 Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Growth Including Community and CJS Finance / VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM is still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
People Innovation / Quality / Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems / technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology development used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny / interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

Committee Escalation Report to the Board of Directors

Name of Committee: Research Committee

Date of Meeting: 04 May 2022

Chair of Meeting: Stanton Newman

Significant Risks/Issues for Escalation:

- R&I Strategy and Implementation plan to be forwarded to the Board for final approval and sign off
- Board needs to consider the integration of Higher Education Activities into this committee and possible rename the Board subcommittee - Education and Research Committee.

Key issues/matters discussed:

- Confirmation that, once the Strategy has been approved by the Board, the Research Committee will evolve into two Committees: Board Research & Innovation Sub-Committee which will provide assurance to the Board and Operational Research & Innovation Committee. ToRs for both new Committees under discussion and subcommittee formed to prepare these for approval.
- Presentation by Professor Kevin Browne, University of Nottingham and member of the Research Committee. Presentation focussed on the Programmes in Forensic Psychology at the University. 25 of the 140 students so far in the D.Forens.Psy course either have been employed, or had placements, at STAH.
- Professor Browne advised the Committee of two new posts that could be a potential joint collaboration with STAH.
- Presentation by Dr Justine Anthony on her PhD that was jointly funded by STAH and Loughborough University and concluded in 2021. Justine is now conducting a new project with the aim to provide a Physical Activity Toolkit for on the wards.
- Thanks to Paul Wallang who will be leaving the Charity at the end of May.

Decisions made by the Committee:

- Committee approved the Research & Innovation Strategy and Implementation plan to be forwarded to the Board meeting in May

Implications for the Charity Risk Register or Board Assurance Framework:

None

Issues/Items for referral to other Committees:

None

Appendices:

None

Committee Update Report to the Board of Directors

Name of Committee:

Meeting of Directors of St Andrew's Pension Trustees Limited

Date of Meeting:

5 May 2022

Chair of Meeting:

Martin Kersey

Significant Risks/Issues for Escalation:

- None

Key issues/matters discussed:

- Trustee training day receiving training from external advisors on:
  - Pensions legislation
  - ESG investment strategy and considerations
  - Long-term objectives
  - Valuation assumptions
- Discretionary pension increase for May 2022
- Preliminary assumptions to enable actuary to run initial valuation results

Decisions made by the Committee:

- Agreed to the Charity's proposal of a 1% discretionary pension increase for pension earned before April 1997

Implications for the Charity Risk Register or Board Assurance Framework:

- No change for Pension Risk on the Risk Register

Issues/Items for referral to other Committees:

- None

Issues Escalated to the Board of Directors for Decision:

- None

Committee Escalation Report to the Board of Directors

Name of Committee:

People Committee

Date of Meeting:

12 May 2022

Chair of Meeting:

Paul Burstow

Significant Risks/Issues for Escalation:

- Sickness absence remains high at 8% in March with notable variations in the levels across service lines and professional groups, with patient facing services generally experiencing higher levels of sickness absence – a project group has been established to ensure targeted resource to address absence levels.
- A deep-dive by the Committee into workforce planning explored the reasons why non-patient facing shifts for March show a significant variance from the 25% budgeted headroom at 42.5%. An overview of the mitigating circumstances for March and actions to understand and address the underlying causes were presented to the Committee including the roll out of Allocate and the absence project.

Key issues/matters discussed:

People Plan update

The Committee reviewed the refreshed people plan for 2022/23 focusing on 8 core pillars and the actions to be taken over the coming year. The pillars include:

- Culture and Engagement *(feedback to rename Culture, Behaviour and Values)*
- Staffing
- Organisation Design
- Wellbeing
- Managers' Capability
- Career Paths and Flexible Working
- Pay and Benefits
- Learning and Development.

The Committee agreed the plans set out for each pillar but asked for further work to be done to set out the strategy beyond 2022/23. The Committee also asked for further work to be undertaken to develop the Culture, Behaviour and Values pillar of the strategy to ensure that there was a clear articulation of the change the charity was seeking to make over the next 3-5 years and how this would support quality improvement and staff recruitment and retention. The Committee also considered the draft key success measures and targets and agreed that they needed to be refined to capture both a charity wide picture as well as maintaining a line of sight on unwarranted variation between service lines.

Workforce Planning deep dive

- The Committee were provided with a forecast for Nurse and HCA recruitment to meet the 95% establishment target highlighting the management focus required on retention.
- For Nurses based on the current vacancy gap of 66 Whole Time Equivalents (WTE) the charity will meet an establishment of 96% by March 23. This includes 2 cohorts of 22 International Nurses during the year.
- For HCAs based on the vacancy gap of 277 WTE the charity will reach 95% establishment by February 23. This relies on transferring 100 WTE HCAs from WorkChoice to permanent flexible contracts, a Project Manager has been appointed to commence this piece of work.
- Both forecasts are based on historic turnover, which is not increasing. Improving staff retention to the target of 12% agreed for 2022/23 will enable the charity to meet the establishment target by September
- An analysis of non-patient facing shifts for March shows there is currently significant variance from the 25% budgeted headroom (consisting of annual leave 15%, training 4% and sickness 6%) where we are currently at 42.5% and this trend has been the historical positon over the last year.
- The staffing action plan provided an overview of the key actions to address this including the roll out of Allocate (e-rostering) and the absence project improving productivity in this area.
- The Committee noted the relationships between the charity's performance on managing patient facing time, the turnover rate, productivity and the workforce recruitment pipeline.

Culture programme - update on Lead the Change

- As part of the charity's quality improvement programme the Committee received an update on the Lead the Change programme where we are following the NHSE/I Culture and Leadership Tool with 4 stages: Discovery (identifying the issues), Design (developing our change work streams), Delivery (implementing the changes) and ongoing Evaluation (measuring success).
- Since its launch in February 2022 the charity has appointed 95 Change Leaders with backfill agreed at 1 day per month for clinical roles, held three face to face workshops, approved additional resource to support the programme and commenced the 'discovery phase' where Change Leaders are having discussion groups with their teams to start exploring the key issues. The discovery phase also includes Change Leader led board interviews, patient and carer focus groups and a charity wide culture survey diagnostic ensuring a co-produced approach.

Culture diagnostic survey

- The Committee heard that a tender exercise has been undertaken to identify the best culture diagnostic provider to work with the charity. Seven companies were contacted and from this Heidrick and Struggles (previously Senn Delaney leadership consulting group) were recommended.
- Heidricks and Struggles have significant experience in the OD/culture field. In the UK they have a wide range of clients including the NHS and other charities.
- The Committee heard that additional information had been requested by the Executive Team including a testimonial from a healthcare client they had worked with, which was in progress. The Committee agreed that the decision whether or

not to proceed with the proposed contractor would be taken in the light of a review of testimonial and other information.

Staffing

- An update on Safer Staffing was provided noting future reports will proceed to the Quality and Safety Committee.

People KPIs

- The charity wide KPI targets for 22/23 were agreed as follows with the Committee requesting that division level targets are developed to address current variations in performance across and within divisions:

KPI	Target 22/23
Voluntary Turnover	12%
Permanent Fill rate Qualified Nurses	95%
Permanent Fill rate HCAs	95%
Sickness monthly %	6% (no change)
Agency Spend	5% (no change)
Mandatory training	90% (no change)
Your Voice Engagement	60%

- Key highlights shared were (March data): sickness remains a management priority and is above target at 8%, voluntary turnover has increased slightly to 14.7% with a waterfall chart shared with the Committee to show the additional impact of involuntary turnover and 'net' transfers to WorkChoice on headcount.
- Agency spend (2%) and mandatory training (92%) are within target at with ILS positively increasing to 96% in March.

Health and Safety

- There were 90 staff injuries in March, 54 of which were stated within Datix as caused by violence, a reduction compared to February.
- RIDDOR incidents in 2021/22 show a significant improvement EoY in comparison to 2020/21. Overall RIDDORs were down by a third and for serious injuries sustained by staff, this is down by over 50%.
- There were four RIDDORs reported to the HSE in March 2022.
- H&S are working closely to support the triaging process of incident reporting to reduce miss-reporting.

Reporting groups

Updates were provided from the following:

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

In line with the governance review reporting for the BENS and Carers Group has progressed to the Quality and Safety Committee.

Decisions made by the Committee:

- The People Plan was approved in the context of it being a strategic action plan for 2022/23. The Committee agreed that the charity wide strategic ambitions need to be set out in a 3-5 year strategy.
- A further update will be provided to the Executive Team on the culture diagnostic survey and following their recommendation, Committee approval is delegated to the Chair and Executive HR Director.
- The refreshed 2022/23 charity wide KPI targets for voluntary turnover, nurse fill rate and HCA fill rate were agreed (with divisional targets to be reviewed).
- The Reputation Management deep dive was deferred to the November Committee meeting.

Implications for the Charity Risk Register or Board Assurance Framework:

- The absence People KPI is above target with monthly sickness at 8% with variation across divisions and professions. An analysis of patient facing shifts found a significant variance from the 25% budgeted headroom at 42.5%
- Mandatory training BLS (85%), Safeguarding L3 (89%) and Safety Intervention Training (MAPA) (85%) are below the 90% target.

Issues/Items for referral to other Committees:

- In line with the governance review the report on Safer Staffing will now proceed to the Quality and Safety Committee.

Appendices: None

Paper for Board of Directors

Topic	CQC Report and Action – Progress Update
Date of Meeting	Friday, 27 May 2022
Agenda Item	**8**
Author	Kristi Alibone, Cheryl Harrington & Laura Dorrington
Responsible Executive	Andy Brogan, Chief Nurse
Discussed at Previous Board Meeting	Progress against CQC actions on the Quality Improvement Plan were discussed at the Board meeting on 24 March 2022
Patient and Carer Involvement	Co-production activity across all three 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 Priority Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Updates have been discussed at the Charity Executive Committee meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

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

The Quality Improvement Plan (QIP) continues to be monitored on a weekly basis, with input from all divisions and support functions.

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

Eight CQC related QIP actions due to have been completed by March are going through final assurance processes. 72 further CQC related QIP actions are currently in progress with improvements being embedded across the divisions. Focus remains on collating sufficient evidence to move these through closure.

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

Appendices -

CQC Report and Actions – Progress Update

ALERT:

The actions following the inspections of Men's and Women's services in summer 2021 continue to be overseen and monitored by the weekly Quality Improvement Plan (QIP) meeting. There are 75 related actions which remain open with the ongoing internal assurance process to embed actions, provide assurance and identify evidence.

Of the remaining actions, 9 were due for closure at the end of March and a further 2 for April which have gone overdue. Work to provide assurance of completion is actively underway.

The complexities of the process in place, in order to provide evidence to close actions has been challenging. There are a number of actions where closure has been delayed because of this. These are currently being addressed and validated. Lessons have been learned and the process is currently being reviewed to improve efficacy.

ADVISE:

The following table gives a breakdown of the number of actions aligned to the relevant CQC regulations by division and current progress state.

	LSSR			LD ASD			MEDSC			Charitywide		
	Closed	Completed awaiting sign off	Embedding	Closed	Completed awaiting sign off	Embedding	Closed	Completed awaiting sign off	Embedding	Closed	Completed awaiting sign off	Embedding
Regulation 10 Dignity and Respect	2		1				3			2		
Regulation 12 Safe care and treatment	2		26	4		12	1		10			
Regulation 13 Safeguarding service users from abuse and improper treatment	1			2			1					
Regulation 16 Receiving and Acting on complaints						1						
Regulation 17 Good Governance		4	2	1		2		1	1			3
Regulation 18 Staffing			2		2			1	3			2
Regulation 9 Person Centred Care			2			5						
Total	5	4	33	7	2	20	5	2	14	2		5
Key;												
Closed												
Completed awaiting sign off												
Embedding												

Following the re-inspection of the Women's Service in April 22 and the subsequent draft report which will ensue, this will provide the opportunity to review further against any outstanding Quality Improvement actions and enable targeted interventions as required.

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

ASSURE:

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

Fifteen CQC related actions from the QIP have been completed and closed in this reporting period. These related to dignity and respect, safe care and treatment, and Safeguarding service users from abuse and improper treatment. Improvements noted in restrictive practices, environmental improvements to our seclusion areas including use of CCTV and provision of additional furnishings, as well as increased awareness of closed cultures.

Eight CQC related actions from the QIP have been completed and are currently going through the assurance process to finalise and close. These actions relate to dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance and staffing; and included improvements to, privacy and dignity during enhanced support interventions, staff interventions when dealing with patients in distress, further improvements to enhanced support and observations of patients, along with record keeping. Improved adherence with code of practice in relation to seclusion and long term segregation. Significant improvements to mandatory training attendance, improvements to divisional level governance and an increase in leadership visibility. Improvements to staffing based on the implementation of MHOST and the Operational Hub, with associated increase of monitoring and supporting corrective action.

There is a notable willingness, from all disciplines, in engagement of the immense Quality Improvement activity that has been underway.

The Quality and Safety Committee is provided with full oversight of the Charity QIP.

Alliance /IMPACT Quality Improvement Progress

A report from the Quality Improvement Director providing an overview will be presented to the Board. Each of the workstreams is progressing well and plans are progressing; this has resulted in a Draft Patient Safety Strategy being developed, processes for learning lessons reviewed and implemented, and a Change Leaders programme commenced. The pandemic and capability of the buddy workstream leads to physically visit services initially slowed progress but traction and progress has increased as restrictions and the number of outbreaks have decreased.

Paper for Board of Directors

Topic	Quality Improvement System Support and Buddy Workstreams Update
Date of Meeting	Friday, 27 May 2022
Agenda Item	**9**
Author	Julie Shepherd/Andy Brogan
Responsible Executive	Andy Brogan
Discussed at Previous Board Meeting	Updates previously provided and discussed at the Board meeting on 27 January.
Patient and Carer Involvement	A number of these items have been discussed with patients and carers, as part of the Quality Improvement Workstreams on the ward.
Staff Involvement	A number of these items have been discussed with staff as part of the response to improving quality and responding to the CQC inspections through focus groups and via the improvement workstreams.
Report Purpose	Review and comment ☒ Information ☒ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S ☒ E ☒ C ☒ R ☒ W ☒**
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☒
Committee meetings where this item has been considered	Updates have been discussed at the Charity Executive Committee meetings and weekly Quality Improvement meetings.

Report Summary and Key Points to Note

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

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

Appendices -

St Andrew's Healthcare Charity Board Meeting 27 May 2022

Quality Improvement System Support and Buddy Workstreams Update

Purpose of the Report

The purpose of this report is to provide an update and assurance to the Board on the progress of the workstreams. This report provides information on the work that has been undertaken by the workstreams.

Analysis of the Issue

Following the CQC inspection and rated Inadequate for their Women's inpatient services and Requires Improvement for Men's services on their Northampton campus during 2021, the East Midlands Mental Health Alliance organisations agreed to support St Andrew's Healthcare on their Quality Improvement journey.

Proposal

The East Midlands Mental Health Alliance are working in partnership with NHSI/E both nationally and regionally and have provided funding during 2021/22 to enable this support programme; further funding has been applied for to support this work continuing during 2022/23.

It is recognised both regionally and nationally the importance of the mental health inpatient services that St Andrew's provide, and the risk posed by the concerns raised by the CQC in relation to quality of care. Northamptonshire Healthcare Trust (NHFT) has been identified as the Buddy Trust. NHFT Chief Nurse has taken on the role of Improvement Director for St Andrew's. This is funded by NHSI/E and enables NHFT to provide support internally to enable the Chief Nurse to undertake this role.

A formal buddy relationship structure has been put in place as part of the governance for the programme. There is a monthly Buddy Forum meeting, which is chaired by Northamptonshire Healthcare Trust CEO. The CEO from St Andrew's and other senior leaders from the Charity, including the Chairs and quality NEDS from each of the two organisations. There is also representation from Midlands region NHSE/I. There are a series of other workstream meetings, which include a Touchpoint Meeting where all the workstreams come together with the Improvement Director and St Andrew's Chief Nurse. The aim of this meeting is to share the work that each of the workstreams are doing, looking at interdependences, and it is an opportunity for the workstreams to ask for help and support from each other. There are also meetings with each of the workstreams and the Improvement Director.

The Buddy Forum last met in April. Usually at each meeting there is a deep dive into a workstream and an update on each of the workstreams and the overall work of the Buddy relationship (please see Appendix 1- overall plan of the page update that was presented at the meeting). There was a deep dive in March of two of the workstreams both led by Derbyshire Healthcare; these are appropriate enhanced observations and fundamentals of care. The presentation was well received by members

of the Buddy Forum and provided assurance that work is progressing. Derbyshire Healthcare have been able to undertake visits to the wards at St Andrew's working with staff at service level. The April meeting saw the presentation of a review of the workstreams, and it is proposed a deep dive will be held in relation to the lessons learnt workstream in May.

During the height of the last wave of Covid there was a risk to the progress of workstreams due to the capacity of staff in all organisations, and Covid outbreak numbers at St Andrew's meant staff from other organisations, including the Improvement Director, could not visit the St Andrew's site.

Each of the workstreams have reviewed the risks to deliver their programme and have been updated on each workstreams plan on the page. The plan on the page risks were also reviewed and a new risk was added in relation to the lack of engagement by St Andrew's staff. This is not just related to the St Andrew's Workstream Leads but links to the workforce Safeguarding Training on MHOST. The Workstream Touchpoint meetings allow the Improvement Director, Chief Nurse and St Andrew's to raise issues in a timely manner. With the example given the Chief Nurse was able to champion the training and increase uptake.

Detailed below is some of the areas of work that have been progressed via the workstreams, this does not cover all the workstreams or all of the work that has taken place. Appendix 2 provides further information

The Culture workstream has supported two Change Leaders' Workshops at St Andrew's. The programme is moving into its Discovery phase. During April and May, this phase will gather information and data, this will then inform themes. The Change Leaders Programme has a pivotal role in the Culture change at St Andrew's. The programme has had a positive response in the Charity. There are several strands of work underway at St Andrew's in relation to changing the culture. The culture change is an important aspect to ensure that the changes that St Andrew's are making, via their Quality Improvement Programme, are embedded into practice. The Improvement Director still sees the biggest risk for the Charity is ensuring changes made become business as usual.

Derbyshire, who leads on two of the workstreams, (as detailed previously in the report) have taken a practical approach to working with staff at ward level, from Healthcare Assistants to Ward Managers to understand how staff see the issues and areas for development. Derbyshire provide live feedback to staff; this has been well received and has made a positive difference.

The Workforce Safeguarding Workstream lead from NHFT and NHSE/I has now completed her full review and will be feeding back her findings to St Andrew's with recommendations; this is an assessment that has been developed by NHSE/I to review the workforce issues in an organisation. There has been sharing of good practice from NHFT on governance and Board reports, a review and further development of relevant policies.

The Patient Safety Workstream, which is led by NHFT, is progressing steadily now, both organisations have attended each other's incident meetings (for NHFT this is known as the IAM meeting), NHFT have supported on developing a Patient Safety Strategy, which is in draft form. There are regular meetings to share good practice. Other work being developed is the Patient as Partners in patient safety and human factors.

The Communications Workstream is heavily involved in the Culture Workstream and to a lesser extent in other workstreams,

The Lesson Learnt Workstream has been slow to get going due to Covid, staff capacity and not being able to attend site at St Andrew's, they now have a detailed plan, which the Improvement Director has reviewed.

The Buddy Forum had commissioned a review of the workstreams as we move into 2022/23, the Chief Nurse (St Andrew's Healthcare) and the Improvement Director are meeting with each of the workstreams to review progress and review the role and workplan for each of the workstreams for the coming year. This review was presented to the Buddy Forum at its April Meeting. The proposal to continue with all workstreams apart from the Quality Improvement Workstream, as well as continue with the national work from NHSI/E Mental Health Improvement Team was supported.

To support the application by NHFT on behalf of the East Midlands Alliance to NHSI/E (regionally and nationally) for further funding for 2022/23 a set of exist criteria have been developed, which have been agreed by the Buddy Forum. These were submitted to NHSE/I and can be found in Appendix 3.

Once the outcome of the recent CQC reinspection of Women's services on the Northampton campus is fully known then the workstreams will review their workplans to ensure they continue to align with the work that is required to support St Andrew's on it quality journey.

The Improvement Director continues to work both with the Executive Team and operations to support quality improvement work at St Andrew's. The Improvement Director supporting St Andrew's in the review of their Quality Improvement plan and continues to support staff at ward level in their improvement journey.

The Improvement Director has raised with St Andrew's CEO and exec that she sees the biggest risk to be embedding the changes that have been put in place over the last six months into business as usual. St Andrew's have a record of making changes following CQC inspections, but they don't become business as usual. St Andrew's are very aware of this risk and are acting on it. Work is underway to mitigate the risk to sustainability going forward. This includes the development of a revised Quality Improvement Structure building on the Crystal Project developed by Northamptonshire Foundation NHS Trust, Patient Safety Strategy and Quality Strategy due to be completed in June 2022, and the introduction of Quality Matrons to continuously monitor quality in the Divisions.

St Andrews & NHFT Buddy Forum – Overall Programme Plan on a Page

Date:29/3/03/2022 V4
Updated By: Julie Shepherd

1. Programme Governance & Key Roles

Executive Lead	Julie Shepherd/Andy Brogan
Project Leads	
Comms Lead	
Other key leads	

Governance Arrangements

- The programme is accountable to NHFT Quality & Governance Committee on behalf of the board and the St Andrews Quality and Safety Committee.
- Refer to the agreed governance structure for the accountability and reporting for the Buddy forum and the risk management group

2. Background & Strategic Context

Background
St Andrews Healthcare (SAH) Northampton site woman's and men's services have undergone a CQC inspection with poor outcomes.

Rationale for Change
To ensure that patient and their families at St Andrews received high quality, safe services that meet their outcomes

Strategic Context

Vision

Objectives

3. Non-financial Benefits, Outcomes & Quality Metrics

Outcome

The overall outcome is that there will be targeted workstreams to increase the overall CQC rating for St Andrew's and demonstrate evidence of quality improvement. Work will also take place to recognise and strengthen the good work that exists and build on this to increase the overall rating. One of the programme outcomes is for both trusts to share/best practice between St Andrew's Healthcare and NHFT., as well as the wider members of the East Midlands mental Health Alliance

Key Performance Indicators

Improvement in St Andrew's Healthcare CQC rating both service level and Organisation wide. Each work stream will have a series of KPI

4. Programme Workstream

There are a number of work streams that will contribute to the overall programme of work. The programme has been split into key strands that will be reported as individual workstreams. It is recognised that this programme requires flexibility and these workstreams may change.

Workstream	Lead	Project/Workstream Description
Workforce Safeguards	Jane Avery **(NHFT)** Chloe Annan **(STAH)**	St Andrew's to ensure that it delivers a workforce model. Has sufficient suitable qualified, competent, skilled, and experienced staff to meet care and treatment needs safety and effectively to patients. Using an approach that reflects current legislation and guidance where it is available and should have a systematic approach to determining the number and range of skills
Patient Safety	James Mullins **(NHFT)** Jenny Kirkland **(STAH)**	Review and implement the appropriate elements of the NHS good practice patient strategy, delivery a vision of continuous improvement to ensure that St Andrew's delivering and enabling a culture of safe, high quality care to its patients and their families.
Fundamentals of care	Vicki Baxendal Tracy Holtom Karen Billyead **Derbyshire Healthcare** Jodie Maloney **(STAH)**	All staff to understand their role in relation to delivering safe high-quality care to patients and families. What safe high quality of care looks like within their services, including management of risk, their accountability and responsibility, record keeping, communication for safety, professional curiosity.
Appropriate use of enhanced observations	Vicki Baxendale, Tracy Holtom, Karen Billyead **Derbyshire Healthcare** Dan Cox-stone **(STAH)**	Ensure the use of evidence based enhanced observations based on risk assessment, using a positive risk culture approach, enabling least restrictive practice, empowering patients, and carers, ensure patients dignity and privacy is always at the forefront.
Culture of patients' safety and high-quality care	Fiona McNamee, Fiona Illingsworth **LPT/Nottingham Healthcare** Rebecca Cowell **(STAH)**	Develop from board to ward a culture of patient safety and high- quality of care is paramount
Embedding lessons learnt into practice	Mark Halsall Lucy Kent **Lincolnshire Partnership Foundation trust** Dean Robinson **(STAH)**	Ensure that learning from within St Andrews and external is shared to inform practice, this learning can be from a positive or negative source
Communications as an enabler	Dionne Mayhew Kamy Basra **NHFT/LPT** Faith McMath **(STAH)**	This work stream will not only look at communication across the charity to support each workstream but also sharing best practice across the alliance mental health trust and with the buddy relationship
Quality improvement as an enabler	Lyn Williams **Nottingham Healthcare** Andy Brogan **(STAH)**	St Andrews across the charity from board to ward develop a shared vision of quality improvement, ensure that they have the skills and knowledge that support high quality care
Quality improvement-CQC	Julie Shepherd **(NHFT)** Jenny Kirkland **(STAH)**	Quality improvement is a journey that never stops, has to be drive for the need to deliver high quality safe services that deliver patient outcomes it is important that the CQC as the regulatory for healthcare comes on that journey with St Andrews
Primary Secondary Drivers	Lyn Williams **Nottingham Healthcare**	

5. Risks, Constraints and interdependencies

Risk	Mitigation	Score
Funding of programme does not meet need requirements	Initial funding for each workstream identified for this finance year, bid to NHSI/E. Each workstream to review costs for 2022/23	4x3 =12
Lack of engagement by St Andrews staff	Regular touch point meetings with workstream leaders an with Chief Nurses (NHFT and St Andrews), review of workstreams continued requirements and needs as 6 months into project and charity has moved forward	3x3=9
CQC rating does not improve	Review of report to ensure workstreams cover all areas and wider, regular review of workstreams and impact, including KPI	5x3=15
Lack of alliance members involvement and commitment and conflicting proprieties	Regular touchpoint meetings with Alliance organisation leads and improvement director	4x2=8
Workstreams don't deliver to timescales	Review of workstreams progress against timelines and KPIs. Meeting structure to in place to support this with STAH, workstream leads and improvement director	4x3=12
Lack of capacity to deliver against this workstream due to Covid level 4 NHS escalation	To monitor capacity and progress of this and escalate to Buddy forum if this becomes a significant risk to the workstream for either party	3x3 =9

Constraints

Interdependencies

All workstreams are interdependent, as they are cross cutting, it is important there is a consistent co-ordinated approach that support this, this potential risk is mitigated via the workstreams leads meeting, thus not identified as a overall project risk at this present time. Communications workstreams in contact with all workstreams

6. Highlights/For Information

Since last meeting the following actions have been delivered

- NHSI/E MH Improvement Directorate agreed work continues to progress on Safer staffing, restrictive practice, risk assessments and data quality. These areas of work will align and work with each workstream.
- Finance meetings having taken place to establish where funding is being pulled from and how this is going to be spent within the individual workstreams.
- Positive discussions Nationally and Regionally to discuss funding for 22-23
- Microsoft team's sharing platform for workstream leads created to enhance collaboration amongst the workstreams.
- Co-produced care plan pilot initiated on Women's wards
- CRM handbooks have been reviewed and distributed
- DHCFT have recruited Assistant Director for Special Projects to support enhanced observations workstream.
- In partnership with the cultural workstream, ST Andrews have over 30 change leaders and the first workshop is due to take place shortly.
- Governance process rapidly being developed for Women's wards (pilot, as response to CQC report)
- MHOST training was planned but did not go ahead due to poor take attendance, these are being rescheduled and it is being explored to see if St Andrews staff could access NHFT MHOST training, this delay in training could have a impact on the effective use of the tool.
- Patient safety managers from both organisations are now linked and we will be exploring and will be working together
- Models to present 9 workstreams in a more digestible way have been created and being tested with workstream leads with aim to provide framework to communication strategy
- Progress is slow in some workstreams due to both alliance organisations and St Andrews capacity, review of workstreams to be undertaken to ensure workstreams are the right ones moving into 2022/23
- Workstreams have reviewed their risks and updated plan on pages.

7. Communication & Stakeholder Engagement

Nothing to report in this area at present, the comms workstream with include communication with Alliance members and within STAH and NHFT

Appendix 2

Buddy Relationship Accomplishments

Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Appropriate use of Enhanced Observations

Since commencing the Buddy Relationship between St Andrew's and DHCFT, the following accomplishments have been made in relation to the Appropriate Use of Enhanced Observations workstream:

- A ward accreditation system has been developed and is due to be piloted in May 2022.
- Clinical Risk Management (CRM) handbooks have been developed, independently reviewed and introduced to the wards for both new starters and established members of staff.
- Enhanced Observation policy has been updated and independently reviewed.
- Additional training on Enhanced Support has been included in the Charity induction for new starters.
- OxeHealth is due to be piloted within specific wards at St Andrew's to enable clinicians to plan patient care and to intervene proactively to help patients.
- A Quality Improvement PDSA cycle is currently underway to determine if Enhanced Care Support plans will be used as part of the handover process to support accurate handover of relevant patient risk information.
- An Operations Manager has been recruited for the 's Service to support managing sickness, recruitment and staff retention.

Northamptonshire Healthcare NHS Foundation Trust

Fundamentals of Care

St Andrew's HEALTHCARE

Since commencing the Buddy Relationship between St Andrew's and DHCFT, the following accomplishments have been made in relation to the Fundamentals of Care workstream:

- Staff have reported a decrease in restrictive practices and have stated that they believe there has been a positive culture change.
- A Co-produced Care Plan pilot has been initiated on the Women's wards and Care Plans are being updated with patients during ward round.
- A PDSA cycle is being piloted to improve handover of risk and current management plans by staff reviewing the patients PBS plan during handover and making reference to whether a patient is green, amber or red in their plan.
- Regular training sessions have been introduced on the wards known as 'Training Tuesday'; these sessions include incident reporting and the Power of Language. These sessions welcome patient collaboration.
- Co-produced language standards are now live and have been circulated across the organisation.
- Clinical Risk Management (CRM) handbooks have been developed, independently reviewed and introduced to the wards for both new starters and established members of staff.
- A Quality Improvement project focusing on improving handover across the organisation is currently underway.
- Your Voice Action Plans are now reviewed by individual teams and follow up meetings within divisions have to be arranged to allow staff to ask questions and comment.
- A "My Voice" tablet is being used on wards to allow patients to share their experiences of the care they have received.
- A flow chart has been devised for administrators to take the My Voice tablet to community meetings for patients to use – this information then syncs with a dashboard for measuring for improvement.
- A "Safeguarding Navigators" role has been developed and they are currently being recruited. Specific training for the Safeguarding Navigators has also been developed and is underway.
- An Operations Manager has been recruited to support managing sickness, recruitment and staff retention.

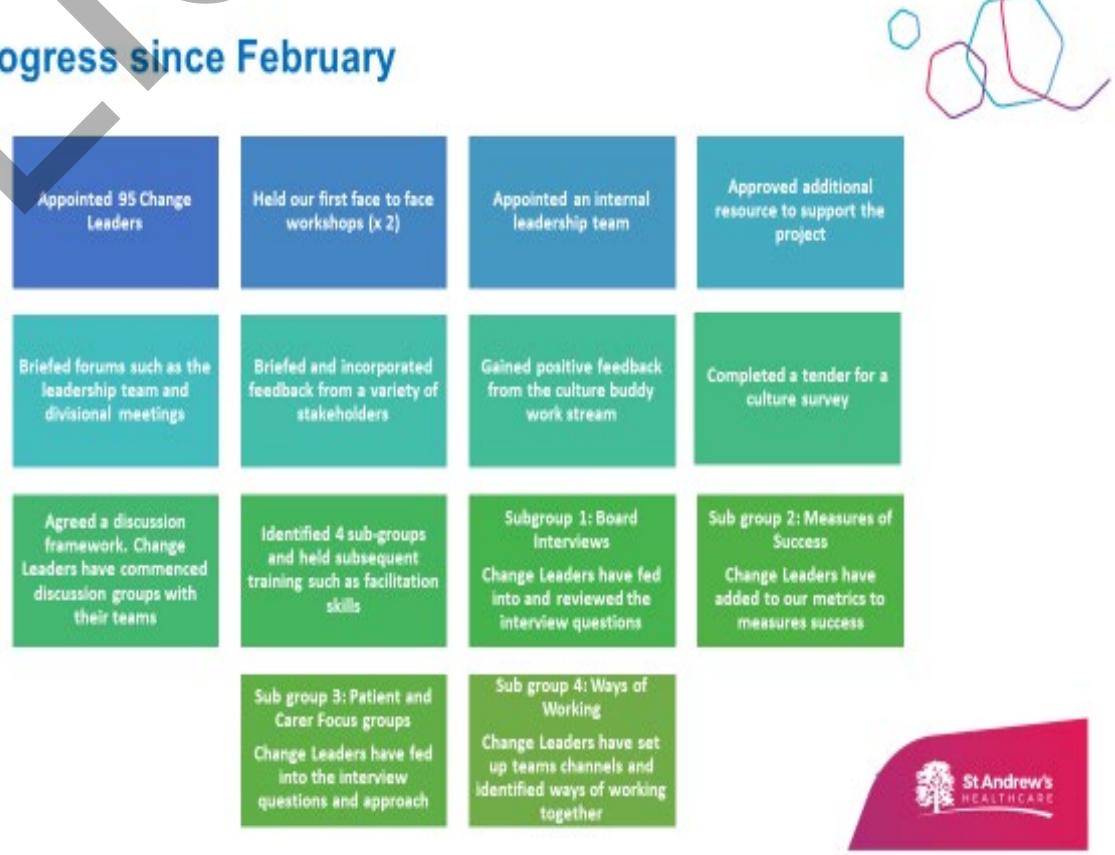
Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Culture of Patient Safety

Since commencing the Buddy Relationship between St Andrew's and LPT, the following accomplishments have been made in relation to the Culture of Patient Safety workstream:

- Lead the Change cultural transformation programme commenc
- 96 Change Leaders volunteered.
- Programme kick off commenced.
- Initial themes for improvement identified, via staff survey and listening events.
- Interviewing our Board members to commence shortly.
- OD Professional being recruited to support programme.



Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Communication as an enabler

Since commencing the Buddy Relationship between St Andrew's, NHFT and LPT, the following accomplishments have been made in relation to the Communication as an enabler workstream:

Programme Newsletters

Established internal and external newsletters focused on quality improvement

Two issues distributed to date: March 2022 and April 2022


LEAD THE CHANGE

Newsletter April 2022

Great progress on quality and wellbeing improvement

Dear Colleagues

Culture Change

Played instrumental role in shaping the Lead the Change programme, delivering workshops and liaising with Change Leaders

Workforce Safeguards

Leading comms on three core workforce projects:

- Roll out of MHOST model
- Implementation of Allocate eRostering
- Absence management project

Women's wards

Supported culture focused activities – 6Cs project – and raising awareness of meetings for all Women's staff with senior leadership

Leadership Visibility

Continuing to deliver 'Jaffa Cakes with Jess' sessions

Running Leadership Forum 28/04/22

New 'Managers Need to Know' toolkit

Next Steps: CQC Readiness

We are in the process of establishing best practice for CQC visits:

Room preparation
Leadership posters/digital signage
Our Vision posters/digital signage
Helping staff prepare

Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Embedding Lessons learnt

Since commencing the Buddy Relationship between St Andrew's and LPFT, the following accomplishments have been made in relation to the Embedding Lessons Learnt workstream:

- Reviewed present processes, systems for identifying lessons in both organisations.
- St Andrew's adopting the Safety Maters Bulletin from LPFT.
- Questionnaire created and distributed to all staff, live till 4 May to gain feedback from staff on how we can improve the way we embed lessons learnt within St Andrew's Healthcare.
- First PDSA cycle to be implemented in May creating a "Learning" meeting in Neuropsychiatry division where learning from complaints, SIs, incidents etc. is brought together, the issues identified and discussed and a quality improvement plan developed, this is to address silo working and multiple individual action plans that do not really address the more complex issues that will prevent further incidents and complaints.
- The feedback from the questionnaire will be used to spread the outcome of the meeting. Evidence of distribution and discussion at the frontline will be expected.

Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Workforce Safeguards

Since commencing the Buddy Relationship between St Andrew's and NHFT, the following accomplishments have been made in relation to the Workforce Safeguard workstream:

- Development of safe staffing policy and procedure.
- E-Roster implementation plan.
- Safe staffing escalation procedure and action cards.
- Monthly safe staffing report and fill rates to Board of Directors.
- Appointment of substantive Safer Staffing Matron.
- Flexible working policy.
- MHOST training delivered to first cohort.

Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Patient Safety

Since commencing the Buddy Relationship between St Andrew's and NHFT, the following accomplishments have been made in relation to the Patient Safety workstream:

- Work has commenced on the St Andrew's patient safety strategy paper to be presented to the Charity's Board.
- Review and refresh of incident reporting and management procedures.
- Buddy attendance and sharing of Internal Assurance Meetings learning and processes.

Northamptonshire Healthcare NHS Foundation Trust

St Andrew's HEALTHCARE

Quality Improvement as an Enabler

Since commencing the Buddy Relationship between St Andrew's and Nottinghamshire Healthcare Foundation Trust, the following accomplishments have been made in relation to the Quality Improvement as an Enabler workstream:

- QSIR V training in place, facilitated via NHFT ICS.
- QSIR P training in place, facilitated via Notts ICS.
- QSIR A accreditation in place, via Mixed Methods, QSIR National Team.
- QI Board development session planned for July 2022.
- Bi-monthly QI forum meeting.
- Bi-monthly STAH/ Notts HC collaborative peer to peer/ master class sessions.
- LifeQI budgeted for, with an anticipated go-live date of July 2022.
- Budget approvals to increase QI staffing capability (2 x Improvement Leads and 1 x Co-ordinator).
- QI Design Huddle PDSA cycle to commence July 2022.

St Andrew's East Midlands Mental Health Alliance Improvement Programme

Exit Criteria

Version 2

Exit Criteria

The exit criteria has been based on the Quality and Safety concerns raised in the CQC visit to female and male wards on the Northampton St Andrew's site in June 2021.

The overarching exist criteria is – demonstrable sustainable improvements whereby St Andrew's Healthcare no longer requires designated peer support, underpinned by the following milestones:

- St Andrew's have no services that are rated inadequate by CQC or have any enforcement notices from the CQC.
- Workforce safeguards annual establishment review has been undertaken in line with national guidance to support safe staffing, to align with financial planning, and to be managed via St Andrew's governance processes, reporting to St Andrew's public board March 2023. The right workforce with the right skills at the right time is in place to deliver quality, safe care, delivering the right outcomes for patients.
- A Quality impact Assurance and Equality impact Assurance process is in place that provides assurance that any changes to service establishments do not have a negative impact on both patient and staff safety and wellbeing.
- There is evidence that St Andrew's Healthcare continue to build on the links that the improvement programme has supported with other mental health organisations and within the Northamptonshire ICS. There is also a responsibility for these organisations to enable this.
- There is a plan in place to sustain quality and there is evidence to show that quality is sustained, which a part of it ensures there is governance of quality that follows best practice across the NHS.

Exit Criteria

- Development and delivery of the culture Change Leaders' programme. Integral to the programme is the co-production of change with Change Leaders from across St Andrew's, with the core objective to "co- produce a way forward that defines the culture needed and creates an environment for staff to deliver high quality care to patients every day".
- Developing and sustaining a positive culture of reporting and management of incidents and near misses, learning and improving practice.
- The NHS national patient safety strategy and associated guidance is implemented across the Charity.
- Clinical staff understand their role in relation to delivering safe high-quality care to patients and families, what safe, high quality of care looks like within their services, including management of risk, their accountability and responsibility, record keeping, communication for safety, professional curiosity.
- There is an evidence based enhanced observations based on risk assessment, using a positive risk culture approach, enabling least restrictive practice, empowering patients an carers, ensure patients' dignity and privacy is always at the forefront. This will be measured by patient feedback, appropriate care planning, sustained reduction in enhanced observations, seclusions and restraints.
- St Andrew's to have a lesson learnt process in place that takes learning from incidents, other organisations and best practice.
- There is a lesson learnt process in place that can be evidenced to have changed practice, improving safety, quality and wellbeing for patients and staff. This should include learning from incidents, patient feedback, complaints, national, regionally . This should evidence from ward to board.

Workstreams 2022/23

St Andrew's has sufficient suitable, qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively to patients. Using an approach that reflects current legislation and guidance where it is available
AND should have a systematic approach to determining the number and range of skills.

All staff to understand their role in relation to delivering safe high-quality care to patients and families. What safe high quality of care looks like within their services, including management of risk, their accountability and responsibility, record keeping, communication for safety, professional curiosity.

Review and implement the appropriate elements of the NHS good practice patient strategy, delivery a vision of continuous improvement to ensure that St Andrew's delivers an enabling culture of safer, high-quality care to its patients and their families.

Ensure the use of evidence based enhanced observations based on risk assessment, using a positive risk culture approach, enabling least restrictive practice, empowering patients and carers, ensure patients dignity and privacy is always at the forefront.

Workstreams 2022/23

Develop from board to ward a culture of patient safety and high- quality of care is paramount.

Ensure that learning from within St Andrew's and externally is shared to inform practice. This learning can be from a positive or negative source.

St Andrew's across the Charity from board to ward develop a shared vision of quality improvement and ensure that they have the skills and knowledge that support high quality care.

This work stream will not only look at communication across the Charity to support each workstream but will also share best practice across the Alliance Mental Health Trust and the buddy relationship.

Paper for Board of Directors		
Topic	Safer Staffing Report	
Date of Meeting	Friday, 27 May 2022	
Agenda Item	**10**	
Author	Chloe Annan – Safer Staffing Matron	
Responsible Executive	Andy Brogan, Chief Nurse	
Discussed at Previous Board Meeting	Yes – March 2022	
Patient and Carer Involvement	Aspects of Safer Staffing have been discussed with patients, where appropriate to do so, within community meetings on the ward.	
Staff Involvement	Staff across all divisions are regularly engaged with in order to review Safer Staffing levels on wards and ensure we are having the right clinical conversations. Divisions have helped provide the narrative in the report.	
Report Purpose	Review and comment Information Decision or Approval Assurance	☐ ☒ ☐ ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐	
Strategic Priority Area	Education and Training Finance & Sustainability Service Innovation Quality Research & Innovation Workforce, Resilience & Agility Partnerships & Promotion	☐ ☐ ☐ ☒ ☐ ☒ ☐
Committee meetings where this item has been considered		

Report Summary and Key Points to Note

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

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

Assurance:

Staff continue to refer to our Safer Staffing Policy and Procedure, which includes a concise staffing escalation plan to follow should there be challenges. The introduction of the Clinical Ops Hub has, over the last few months, helped us maintain oversight of these challenges both operationally and clinically. The Senior Manager on Site (SMoS) takes a lead role in ensuring co-ordination, deployment, response and recording via the daily site report.

All divisions now have qualified contingency plans in place, which are regularly updated as ward acuity and clinical needs change. Some of these contingency plans include plans to open up the door between wards that are next to each other, so that qualified resource can be temporarily shared. These are only implemented if there is insufficient qualified provision to redeploy. These plans have helped guide our night site co-ordinators in their decision making and deployment.

As a result of CAMHS, in particular, experiencing some significant qualified shortages over the past few weeks, the division has introduced 'Taster shifts' throughout the months of April and May. These have been scheduled days where they have identified good regular qualified coverage and are encouraging other qualified nurses from across the Charity to come and spend some time on the CAMHS wards, out of numbers and shadowing. It is hoped that this will enable individuals to experience CAMHS for themselves, ask any questions and gain some wider understanding of the CAMHS service. In addition to this they are continuing with their flexible recruitment drive and putting support plans in place for every newly qualified nurse.

The Board is asked to:

- Review the position of our safer staffing in line with the requirement to publish staffing data.
- Review and acknowledge the increased workforce risks and support the mitigating actions identified throughout.
- Note the work undertaken to date and ongoing work to develop an evidenced approach to decision making, and to ensure compliance with the Developing Workforce Safeguards recommendations.

Appendices -

Safer Staffing Report

Executive Summary

The purpose of this report is to provide assurance on the current position across all sites and wards, in accordance with the National Quality Board (NQB) guidance and the Developing Workforce Safeguards. This report focuses on reporting Safety and Quality data over the last three months and staffing fill rate data for all wards against the Charity's agreed Safer Staffing levels for the period of March and April 2022.

We continue to experience some challenges with our staffing levels, due to a number of factors; including but not limited to, Covid absences, high absences rates overall, numbers of no shows and the current establishment gap. The report describes how the Charity responded to mitigate some of these shortages, where these occurred. The report provides the board with assurance on how safer staffing is being managed across the Charity.

1. **Background**

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

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

2. **Safe Staffing Daily Oversight and Monitoring**

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

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

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

3. **Staffing Fill Rates for March and April 2022**

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

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

In the longer term, the Charity is recruiting additional Site Co-ordinators. They will be based in the Clinical Ops Hub and take over this day to day role from our CNLs and NMs, allowing them to focus on providing direct patient care.

Fill Rates & Divisional Risk Summary:

ASD/LD:

March:

	Day		Night		
Directorate	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
ASD & LD	**102.3%**	**95.3%**	**98.2%**	**102.8%**	**93.4%**
ASD Acorn	71.6%	95.0%	104.9%	100.3%	111.1%
ASD Berry	101.4%	122.1%	104.1%	116.1%	138.2%
ASD Brook	114.0%	86.6%	105.4%	99.2%	111.1%
ASD Fern	98.8%	72.9%	98.8%	95.2%	125.0%
ASD Garden Cottage	96.3%	93.7%	99.9%	65.7%	97.4%
ASD Marsh	101.5%	93.1%	105.9%	104.4%	50.0%
ASD Meadow	80.5%	93.8%	103.8%	77.7%	95.2%
ASD Sycamore	145.9%	85.3%	93.4%	103.1%	
LDD Church	112.6%	109.4%	118.0%	112.2%	82.3%
LDD Hawkins	92.4%	72.9%	74.5%	119.3%	70.1%
LDD Oak	92.1%	122.5%	89.4%	112.9%	90.0%
LDD Sunley	129.9%	80.3%	105.3%	93.1%	92.5%
MMH Wantage Cottage		108.6%		97.4%	53.2%
Total	**102.3%**	**95.3%**	**98.2%**	**102.8%**	**93.4%**

April:

	Day		Night		
Directorate	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
ASD & LD	**99.9%**	**100.6%**	**94.8%**	**103.8%**	**92.6%**
ASD Acorn	69.2%	86.8%	102.4%	86.2%	100.0%
ASD Berry	79.7%	137.4%	106.8%	100.4%	96.3%
ASD Brook	111.8%	88.6%	102.0%	94.1%	102.2%
ASD Fern	92.9%	102.8%	101.0%	126.0%	111.1%
ASD Garden Cottage	81.8%	88.3%	74.1%	53.0%	120.0%
ASD Marsh	109.2%	105.2%	106.4%	122.8%	67.5%
ASD Meadow	98.5%	103.6%	101.4%	81.3%	88.3%
ASD Sycamore	137.7%	86.0%	105.2%	103.3%	100.0%
LDD Church	112.4%	113.1%	104.9%	107.4%	86.7%
LDD Hawkins	89.2%	79.8%	77.7%	146.6%	78.7%
LDD Oak	78.8%	122.7%	76.4%	113.8%	90.0%
LDD Sunley	124.2%	82.4%	111.0%	90.1%	92.9%
MMH Wantage Cottage		110.5%		102.1%	100.0%
Total	**99.9%**	**100.6%**	**94.8%**	**103.8%**	**92.6%**

The division has had an improved staffing picture over the last couple of months. Total fill rates for HCAs have sat consistently above 95% throughout March and April, across both days and nights. There has however been some night qualified fill rate challenges in April, with both Oak and Hawkins having fill rates less than 80%. Both of these wards are planned to have two qualified staff at night, but there have been times when this second qualified has had to be redeployed to support qualified provision across the division, and also to support CAMHS where there are particular challenges in this area. Hawkins have been able to mitigate some of this risk by their ability to increase the ratio of HCAs at night to backfill. Neither of these wards have implemented any clinical action cards as a result of this.

Acorn have been flexing down throughout March and April due to a reduction in their clinical acuity and enhanced support, hence their reduced fill rates. The division's ability to regular review and take steps to reduce wards staffing requirement, where clinically safe to do so, has enabled them to support their wards with increased acuity and staffing needs above their baseline.

Birmingham:

March:

	Day		Night		
Directorate	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Birmingham	**103.9%**	**119.4%**	**91.9%**	**153.9%**	**100.7%**
MMH Edgbaston	114.5%	89.6%	65.0%	164.3%	98.1%
MMH Hawkesley	82.5%	88.6%	123.0%	120.6%	99.8%
MMH Lifford	116.3%	128.3%	103.6%	102.4%	98.4%
MMH Moor Green	107.6%	140.3%	111.8%	196.1%	100.0%
MMH Northfield (Old Lifford)	77.7%	155.1%	99.8%	143.3%	106.2%
MMH Speedwell	98.0%	97.8%	97.9%	96.2%	100.0%
WMH Hazelwell	106.5%	154.4%	126.7%	205.7%	97.7%
WMH Hurst	139.2%	126.6%	62.9%	217.6%	106.7%
Total	**103.9%**	**119.4%**	**91.9%**	**153.9%**	**100.7%**

April:

	Day		Night		
Directorate	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Birmingham	**102.9%**	**115.4%**	**95.2%**	**146.8%**	**104.1%**
MMH Edgbaston	116.4%	85.8%	74.7%	153.3%	98.4%
MMH Hawkesley	83.9%	96.4%	120.0%	108.7%	106.4%
MMH Lifford	128.2%	116.3%	95.5%	142.4%	100.0%
MMH Moor Green	99.6%	137.8%	106.9%	191.7%	100.0%
MMH Northfield (Old Lifford)	72.1%	150.1%	93.8%	141.8%	106.7%
MMH Speedwell	102.5%	105.3%	130.3%	94.1%	100.0%
WMH Hazelwell	101.5%	121.3%	132.2%	150.5%	145.8%
WMH Hurst	128.6%	127.8%	61.8%	242.8%	92.7%
Total	**102.9%**	**115.4%**	**95.2%**	**146.8%**	**104.1%**

Total fill rates for the Birmingham site sat above 90% for qualified and unqualified staff for the month of March, and of April this position improved with the total fill rates above 95%.

Qualified fill rates have remained a consistent challenge for Northfield in the day, and both Hurst and Edgbaston at night. Hurst and Edgbaston are the only two wards on the site that are planned to have two qualified staff at night, and as result support is redeployed from these wards when needs are either unfilled or there is absence across the other wards. Correlating HCA fill rates for these wards show that they have been able to mitigate some of this risk by increasing their number of HCAs in place of these qualified staff. The Birmingham night site co-ordinator has also increased their presence on wards at night when required to reduce any potential clinical impact. No clinical action cards have been implemented across the site.

CAMHS:

March:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
CAMHS	**83.4%**	**111.8%**	**73.3%**	**148.4%**	**116.6%**
CAM Billing Lodge		4.4%		16.0%	
CAM Seacole Mixed Rehab	66.4%	84.4%	68.6%	120.0%	100.0%
CAM Sitwell Boys MSU	72.6%	846.1%	117.0%	510.8%	429.0%
CAM Stowe Mixed Admissons	111.3%	89.2%	54.6%	132.5%	90.3%
Total	**83.4%**	**111.8%**	**73.3%**	**148.4%**	**116.6%**

April:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
CAMHS	**91.0%**	**118.4%**	**67.5%**	**147.2%**	**98.3%**
CAM Billing Lodge		5.1%		13.3%	100.0%
CAM Seacole Mixed Rehab	93.0%	88.2%	62.7%	102.7%	95.6%
CAM Sitwell Boys MSU	77.9%	941.0%	105.4%	538.1%	125.0%
CAM Stowe Mixed Admissons	102.1%	86.5%	53.5%	138.7%	90.0%
Total	**91.0%**	**118.4%**	**67.5%**	**147.2%**	**98.3%**

Billing lodge is planned for separately, however scheduled together with Sitwell; this is currently being explored by the division to confirm one way forward for this. This explains some of the anomalies in the fill rates for these two wards. Sitwell are showing significantly above planned both day and night for HCAs due to scheduling for Billing, and also some flex uplift due to increased acuity, occupancy and enhanced support since the baselines were set.

Whilst total HCA fill rates for CAMHS day and night have been above 100% for both March and April, the table highlights that qualified cover across the division remains a challenge. This is heightened at night time, where the fill rate for qualified was at 67.5%. This has had an impact on the Northampton site as a whole, as redeployment has often had to come from another division. In some cases the wards have been able to mitigate some of this risk by backfilling with HCAs, however this has not always been sufficient and has resulted in five clinical action cards being implemented within the last two months for 'Shortage of staff' and 'No Qualified on shift'. These action cards resulted in levels of enhanced support being reduced temporarily and restricting access to certain areas of the ward to help maintain levels of observation and safety.

CAMHS are currently supporting two patients that have recently reached the age of 18. Due to this, they are both having to be nursed separately from the ward environment and are both now on 2:1 observation levels due to being in extra care areas. This is putting additional pressure on the division, as a total of eight extra staff are required per 24 hours to support this. This has been escalated both internally and externally, with the need to find an alternative, more suitable placement urgently.

CAMHS have a current recruitment target of 5.2 for qualified nurses, and this is contributing to their challenges in reaching their planned qualified figure consistently, in addition to levels of absence. Recruitment are working closely with the division to try and close this gap, with a drive to offer flexible hours and contracts. This has seen an addition of two nurses in the pipeline.

A newly refined absence management process, including instances where staff refuse to move, has been implemented across all divisions. Some of the refusals to move CAMHS have experienced, are due to staff saying they do not feel competent or confident to work in this area. In response to this, the division introduced 'Taster Shifts' throughout the months of April and May. These are scheduled days where they have identified good regular qualified coverage and are encouraging other qualified nurses from across the Charity to come and spend some time on the CAMHS wards, out of numbers and shadowing. It is hoped that this will enable individuals to experience CAMHS for themselves, ask any questions and gain some wider understanding of CAMHS. For all of their existing nurses, support plans are being putting in place, which are being overseen by practice educators.

<u>CAMHS enhanced support levels</u>

(Note: This Enhanced Support Dashboard is not yet live, and remains in the 'testing' phase. However, this is due to be released for wider charity use by the end of May).

CAMHS are seeing a consistent increase in their enhanced support levels from February to April. This is contributing to some of their fill rate challenges. Some of their increases in enhanced support levels are resulting in temporary flex uplifts in their staffing requirements, due to being beyond their average/baseline. The division are reviewing the clinical justification for all of these regularly, including exit strategies and alternative management plans, and reducing these back down when clinically safe to do so. A proportion of this significant increase is attributed to their two over 18 patients, both of which are having to be managed on 2:1s out of the ward environment, due to safeguarding risks. This has been escalated externally with a view to urgently source alternative placements, following which their staffing requirement and pressure on the wards will immediately reduce.

Essex:

March:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Essex	**79.3%**	**139.2%**	**73.2%**	**119.4%**	**94.0%**
MMH Audley	62.7%	273.5%	63.1%	137.2%	89.0%
MMH Benfleet	102.2%	56.5%	55.4%	66.7%	
MMH Danbury	76.9%	118.2%	98.3%	120.4%	86.0%
WMH Colne	77.4%	154.9%	69.9%	177.0%	83.3%
WMH Frinton	68.3%	216.2%	70.1%	109.8%	88.2%
WMH Maldon	146.5%	83.5%	101.0%	79.8%	95.7%
Total	**79.3%**	**139.2%**	**73.2%**	**119.4%**	**94.0%**

April

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Essex	**80.0%**	**129.2%**	**77.6%**	**110.9%**	**102.3%**
MMH Audley	57.2%	206.4%	78.7%	109.2%	71.9%
MMH Benfleet	95.5%	77.2%	55.7%	95.7%	201.0%
MMH Danbury	88.1%	135.4%	102.3%	125.4%	101.2%
WMH Colne	74.5%	148.3%	82.4%	143.6%	81.7%
WMH Frinton	66.9%	216.1%	67.8%	114.2%	87.0%
WMH Maldon	153.8%	75.0%	104.8%	69.9%	120.0%
Total	**80.0%**	**129.2%**	**77.6%**	**110.9%**	**102.3%**

Essex have had consistent total fill rates for HCAs of above 100% over the last couple of months. Their area of challenge remains their qualified fill rate both day and night, although this has improved both day and night from March to April. No clinical action cards have had to be implemented as a result of these reduced qualified fill rates, and the site have been managing this well internally by ensuring redeployment to their most acute wards. The sites qualified MHOST requirement has increased from 57.5 to 60, due to the closure of Hadleigh ward and the opening of Benfleet, which has slightly increased their total qualified requirement.

Benfleet have a reduced qualified fill rate at night due to clinically agreeing to temporarily flex down their requirement for qualified nurses at night (from 2 to 1).

Low Secure:

March

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Low Secure & Specialist	**84.0%**	**101.4%**	**74.8%**	**120.8%**	**95.5%**
FMH - 37 Berkeley Close	37.5%	59.8%		64.7%	100.0%
MMH Berkeley Lodge	94.1%	151.2%	135.4%	126.0%	100.0%
MMH Heygate	80.6%	106.0%	62.7%	137.5%	90.3%
MMH Spencer North	113.8%	69.4%	99.7%	96.3%	110.0%
MMH Spencer South	93.5%	91.5%	107.9%	95.8%	105.2%
WMH Bayley	65.1%	105.1%	52.7%	138.2%	65.2%
WMH Naseby	86.2%	77.2%	47.6%	135.6%	80.6%
WMH Silverstone	73.3%	199.0%	72.8%	190.3%	128.6%
WMH Watkins House	95.7%	93.3%	98.3%	96.2%	90.9%
Total	**84.0%**	**101.4%**	**74.8%**	**120.8%**	**95.5%**

April

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Low Secure & Specialist	**83.3%**	**104.6%**	**74.3%**	**114.6%**	**92.7%**
FMH - 37 Berkeley Close		67.1%		64.6%	100.0%
MMH Berkeley Lodge	70.2%	104.3%	101.3%	91.2%	100.0%
MMH Heygate	70.4%	107.6%	52.7%	136.5%	92.6%
MMH Spencer North	96.2%	85.8%	99.1%	97.4%	100.0%
MMH Spencer South	93.9%	98.4%	108.9%	105.0%	99.4%
WMH Bayley	64.8%	108.1%	52.0%	138.1%	76.3%
WMH Naseby	102.5%	86.4%	51.2%	111.7%	84.0%
WMH Silverstone	83.6%	195.2%	86.9%	185.8%	90.0%
WMH Watkins House	92.4%	99.8%	97.2%	82.5%	100.0%
Total	**83.3%**	**104.6%**	**74.3%**	**114.6%**	**92.7%**

Low secure have consistently had total HCA fill rates of over 100% for both March and April. Their qualified position does remain an area of challenge with total day and night fill rates being fairly static across March and April. The total night qualified fill rate is at 74.3% for April, and is reflective of the division's requirement to have to move the second qualified on occasions to support provision across the division, and occasionally the site. This has been clinically manageable and no action cards have been implemented as a result of this.

Silverstone have a flex uplift in place both day and night, above their baseline, due to change in environment, enhanced support levels and acuity. This reflects why their day and night HCA fill rates are significantly above 100%. On the other hand, 37 Berkley close has been flexing down due to reduced clinical acuity, hence reduced HCA fill rates both day and night.

Medium Secure:

March:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Medium Secure	**96.7%**	**94.7%**	**86.2%**	**97.6%**	**83.6%**
MMH 23a The Avenue		103.2%		101.5%	100.0%
MMH Cranford	74.4%	118.8%	97.2%	103.9%	106.7%
MMH Fairbairn	112.7%	102.0%	105.1%	109.9%	113.3%
MMH Mackaness	66.3%	33.0%	78.9%	56.0%	
MMH Prichard	129.0%	98.2%	69.2%	141.5%	95.5%
MMH Robinson	105.2%	90.3%	101.0%	85.9%	103.8%
NPS Rose	111.0%	90.2%	110.2%	79.0%	94.0%
WMH Bracken	103.6%	97.0%	78.9%	93.6%	70.0%
WMH Glendale					100.0%
WMH Maple	76.9%	99.2%	106.4%	109.9%	64.5%
WMH Willow	92.5%	99.0%	66.1%	101.2%	65.2%
Total	**96.7%**	**94.7%**	**86.2%**	**97.6%**	**83.6%**

April:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Medium Secure	**96.1%**	**95.4%**	**90.8%**	**100.1%**	**97.4%**
MMH 23a The Avenue		105.7%		100.0%	66.7%
MMH Cranford	70.8%	139.7%	98.5%	119.0%	102.1%
MMH Fairbairn	105.1%	88.2%	100.0%	96.2%	101.7%
MMH Mackaness	73.3%	29.4%	100.9%	46.5%	22.7%
MMH Prichard	103.1%	102.8%	64.3%	125.7%	100.0%
MMH Robinson	129.5%	88.8%	102.9%	84.6%	106.3%
NPS Rose	131.5%	101.9%	123.5%	112.5%	97.9%
WMH Bracken	86.7%	101.8%	60.8%	96.7%	95.0%
WMH Maple	93.9%	96.1%	99.2%	124.7%	102.2%
WMH Willow	89.9%	110.2%	112.4%	99.1%	101.4%
Total	**96.1%**	**95.4%**	**90.8%**	**100.1%**	**97.4%**

Medium secure total HCA fill rates have improved from March to April, with fill rates for April being over 95% for HCAs both day and night. Their night qualified fill rate has also improved, with it being 86.2% in March and increasing to 90.8% for April. It is however still an area of focus for the division. Both Bracken and Prichard are planned to have two qualified staff at night, however the second qualified is more frequently having to be redeployed to support qualified provision across other divisions, in particular to support CAMHS. No clinical action cards have been implemented in MSU as a result of this in the last three months.

Fairbairn have been flexing down in the day due to reduced clinical acuity, resulting in reduced HCA fill rate of 88.2% in the day. Mackaness also continue to significantly flex down from baseline due to reduced occupancy (22.7% vs budget). On the other hand, Willow, Rose, Cranford and Prichard have flex uplifts in place, which is resulting in fill rates above 100%. These are being regularly reviewed by the division and Safer Staffing Matron to ensure these uplifts reflect current clinical acuity and requirement.

Neuro:

March:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Neuro	**94.2%**	**92.9%**	**93.6%**	**120.1%**	**96.5%**
NPS 38 Berkeley Close	0.0%	98.6%	9.7%	106.0%	93.5%
NPS Allitsen	97.8%	120.9%	88.7%	136.7%	100.0%
NPS Aspen	72.9%	94.9%	97.7%	137.6%	84.7%
NPS Berkeley Av 19		32.4%		56.0%	100.0%
NPS Cherry	71.2%	102.9%	102.8%	126.5%	100.0%
NPS Elgar	110.3%	112.4%	87.5%	139.3%	95.9%
NPS Elm	99.1%	91.9%	91.0%	108.9%	102.3%
NPS Fenwick	115.8%	82.7%	106.4%	108.8%	100.0%
NPS Redwood	89.3%	108.3%	95.8%	113.1%	99.6%
NPS Tallis	101.3%	95.3%	92.1%	164.9%	96.2%
NPS Tavener	87.8%	70.4%	83.5%	106.3%	89.9%
NPS Walton HD	105.5%	80.7%	100.4%	99.5%	96.8%
Total	**94.2%**	**92.9%**	**93.6%**	**120.1%**	**96.5%**

April:

Directorate	Day		Night		
	Fill Rate (Reg)	Fill Rate (HCA)	Fill Rate (Reg)	Fill Rate (HCA)	Occupancy % (Vs Budget)
Neuro	**98.0%**	**95.3%**	**98.7%**	**118.6%**	**95.8%**
NPS 38 Berkeley Close	0.0%	71.3%	18.0%	83.9%	50.0%
NPS Allitsen	94.8%	129.0%	100.1%	146.4%	91.7%
NPS Aspen	102.6%	98.7%	104.9%	143.8%	84.2%
NPS Berkeley Av 19		23.8%		66.2%	100.0%
NPS Cherry	78.4%	95.3%	94.5%	100.6%	100.0%
NPS Elgar	120.9%	130.6%	91.3%	141.3%	87.2%
NPS Elm	90.3%	95.6%	97.6%	103.4%	109.1%
NPS Fenwick	110.8%	93.1%	109.4%	107.7%	99.7%
NPS Redwood	92.3%	105.6%	95.4%	97.5%	87.5%
NPS Tallis	103.5%	94.2%	103.6%	176.6%	109.0%
NPS Tavener	92.9%	77.5%	87.6%	96.1%	94.0%
NPS Walton HD	107.1%	84.3%	103.4%	111.0%	101.0%
Total	**98.0%**	**95.3%**	**98.7%**	**118.6%**	**95.8%**

Neuro's total fill rates for both qualified and HCAs have improved consistently from March to April, with total fill rates for April now being above 95% for all grade and shift type.

38 Berkeley close is showing a 0% fill rate for qualified staff in the day due to a scheduling discrepancy. Number 38 and 19 the Avenue are planned to have one qualified shared between then, however the planned requirement of one is on 38 Berkeley Close, however the division have been scheduling this person to 19 The Avenue. This has now been amended and will reflect accurately in future reports. In addition, both 38 Berkeley Close and 19 the Avenue have been flexing down from their base number day and night, due to a reduction in occupancy and clinical acuity, hence their reduced fill rates.

Allitsen, Aspen, Elgar and Tallis all had temporary flex uplifts in place for periods of time during April, hence some of the fill rates being above 100%. These were due to increases in enhanced support, NGH admissions and changes in clinical acuity.

4. **Right Staff**

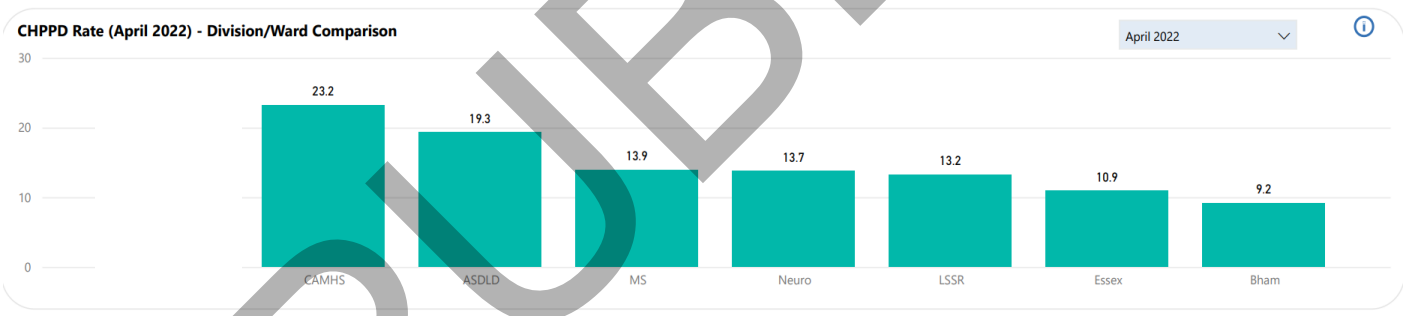
In accordance with NQB guidance, Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to all patients at all times. There are three key components to achieving this; evidence-based workforce planning; professional judgement and being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

4.1 Reporting on CHPPD

A further NQB recommendation is that organisations are able to compare local staffing with peers, taking into account of any underlying differences. NHS trusts currently report this in the form of Care Hours Per Patient Day (CHPPD). From May 2016, CHPPD has been the principal measure of nursing and healthcare support worker deployment; providing a single, consistent metric. From 1 April, we have had the capability to now also report this metric, although we continue to explore the most useful way to display this information.

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

Divisional CHPPD comparison April 2022



This table compares the actual Care Hours Per Patient Day (CHPPD) delivered within each division for the month of April as a whole. Although CAMHS have some significant challenges with their fill rates, CAMHS as a division do still continue to provide the highest rate of CHPPD, however this is reflective of the higher levels of acuity and enhanced support within this division currently.

In addition, when applying the MHOST, different descriptors are used within each division that most suit their patient group and level of security. The CAMHS descriptor has different multipliers when scoring dependency, so when scoring a patient a level 4 for dependency, this has a higher multiplier than a level 5. This is different to other descriptors and reflects the specific needs of this patient group.

Moving forward, the display of CHPPD in this way will include a direct comparison of Actual CHPPD provided vs Planned CHPPD.

5. **Right Skills**

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

5.1 Mandatory Training Figures

Division	Jan-2022	Feb-2022	Mar-2022	Apr-2022
ASD & LD	92%	92%	91%	90%
Birmingham	94%	93%	93%	92%
CAMHS	92%	91%	90%	90%
Essex	95%	95%	95%	94%
Low Secure & Specialist Rehab	93%	92%	93%	92%
Medium Secure	92%	91%	91%	89%
Neuro	93%	91%	90%	90%
Charity Total	**93%**	**92%**	**92%**	**92%**

*ASD & LD and Neuro – rounded to 90% for April, they are 89.5%>

Overall the Charity's total mandatory training compliance has remained fairly static at 92% for the last three months. However, there has been a slight decrease across most divisions when comparing March to April. One of the key factors contributing to this includes the high number of training no shows across the Charity. There have been occasions across the sites whereby staff have been pulled off training in order to support immediate staffing requirements on the ward. This has been highlighted in Learning & Development group with an agreement that moving forward, the weekly clinical training schedule is to be included within the remit of the Clinical Ops Hub. This will help ensure oversight of the training need versus immediate scheduling and clinical demand.

Area of Strength
ILS continues to be an area of strength for Charity wide compliance. This figure has remained fairly static for the last few months and is currently at 95%. Infection control compliance Charity wide also remains high at 98%.

Risk Area
Safeguarding level 3 face to face training remains in focus. Charity total compliance as of April 2022 is 84%, which is only a 2% increase since these figures were reported in March. The E-learning Safeguarding level 3 compliance is however higher at 92%. The Learning and Development Team are currently exploring how to replicate the recent success with ILS figures, within Safeguarding compliance.

BLS and SIT (renamed MAPA) are below target and are also in focus for improvement.

5.2 Recruitment Update

As at the end of April the Charity level in-patient RN establishment ratio stood at 85.85%, with the gap to full establishment being 72 RNs. The HCA establishment stood at 79.14%, with the gap to full establishment being 269 HCAs. Work undertaken to project the net movement of joiners and leavers each month puts the dates for establishments to be at the 95% target as March 23 for RNs and February 23 for HCAs. Recruitment drives are continuing within each division, with a

continued emphasis on offering flexible working hours and contracts. Combined recruitment and retention efforts are required to achieve closure of the establishment gap. Reductions to the run rate levels of attrition would enable establishment targets to be met sooner. The associated plans have been shared with the People Committee.

6. **Right place & Right Time**

Action Card Usage Since March 2022

There have been five occasions since March 2022 where Clinical Action cards have been implemented, and all of these have been within the CAMHS division.

1/04/22 – CAMHS – Shortage of Staff
Implemented during a night shift due to the division being 14 below ward planned, and Seacole and Stowe feeling unmanageable. The escalation process was followed correctly and night site co-ordinators were unable to base themselves on wards. Clinical acuity was reviewed across all three wards and staff were redeployed to support the most clinically acute areas. This was felt to mitigate the risk for the shift.

2/04/22 – CAMHS – Shortage of Staff
This action card was implemented during a day shift due to being below planned numbers and the wards feeling clinically unmanageable with their current resource. The division, along with the SMoS for that day, correctly followed the escalation procedure. Staff were redistributed within CAMHS to support the most clinically acute wards. Enhanced support on Sitwell was reduced at times throughout the day, however no clinical harm was reported as a result of this. All surrounding wards and divisions were made aware of the challenges within CAMHS and advised to respond immediately for any urgent requests for support/group alerts/medical emergencies.

8/05/22 – CAMHS – No Qualified on shift & Shortage of Staff
Two clinical action cards were implemented; one due to insufficient qualified staff, and the other for shortage of staff. Overall staffing levels on the three CAMHS wards were below planned for this shift, and although initially clinically manageable, this was escalated to the SMoS at 00:00 when twilights left the division. Due to the clinical acuity on Stowe and Seacole, the NIC on Sitwell had to leave the ward on several occasions to support the rest of the division. The correct escalation process was followed and CAMHS first reviewed their own deployment options. Bleep holder (who was also the NIC on Sitwell) contacted the other divisional bleep holders, however no support was identified initially. This was then escalated to the SMoS and a site wide meeting scheduled at 01:15, where four staff from other divisions were redeployed to help close the action cards. No clinical harm was reported as a direct result of using this action card for this period of time.

This incident did however highlight the difficulty of the CAMHS qualified holding the bleep as well as being the accountable NIC for a ward. This has been escalated to the Clinical Ops Hubs and division for urgent review.

9/05/22 – CAMHS – Shortage of Staff
An action card was implemented for the day shift due to a shortage of staff across the division, with all three wards being below planned numbers and a 'feel' of the wards being unsafe for patients and staff. This action card resulted in some temporary restrictive practices being implemented, including temporary zonal nursing and suspension of all non essential patient care functions and non essential patient level. This was required to help mitigate the risk and help ensure a level of observation for all patients. The division was also unable to temporarily cover LTS enhanced observations for a patient that is over 18. This patient is usually nursed off ward

due to age, however had to be nursed on the ward with the other patients for a period of time. A safeguarding concern was raised due to this and this, along with the staffing concern, was escalated as per our escalation and action card process. MDT, enabling function, education and wider site support was requested to help close this action card.

7. Safety & Quality Indicators

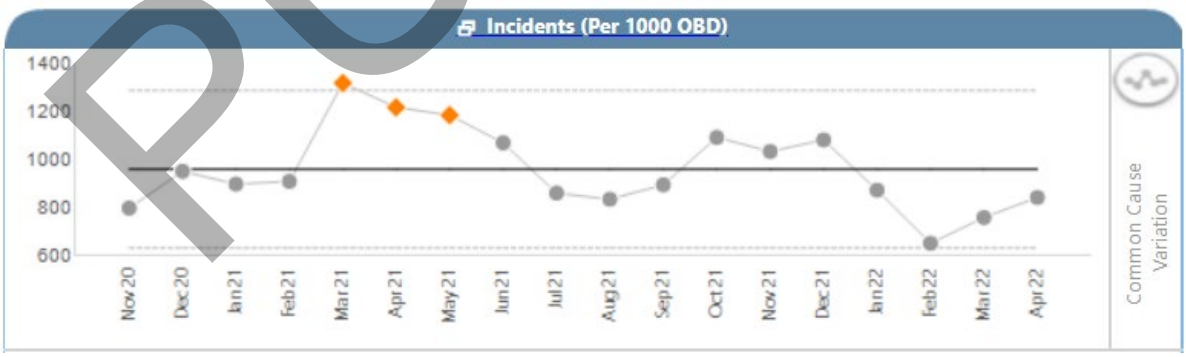
The indicators considered within this report reflect the approach taken in staffing reviews and reflect the current NHS England recommendations.

7.1 Incidents:

	Feb 22	Mar 22	Apr 22
St Andrews All (Rate per 1000 OPDs)	121.95	126.14	118.23
ASD/LD	133.1	121.51	110.34
Birmingham	15.44	16.57	20.77
CAMHS	650.7	757.95	841.81
Essex	79.91	58.82	49.43
LSSR	171.43	157.87	137.1
MSU	60.55	87.34	69.4
Neuro	149.3	156.12	136.35

As a Charity total, total incident levels from February to April have remained fairly static. ASD/LD have seen a total reduction in total incidents consistently month on month, which correlates with a consistent improvement in their staffing and fill rates position. In addition, Essex and Low secure have also seen consistent decreases in their level of total incidents.

CAMHS however have seen a consistent increase month on month of their total incidents within the last 2 months, which includes an increase in action card usage during this period.



Whilst it is important to note that CAMHS total incidents do still remain below their mean line, the division is currently experiencing increased incident levels compared to the low for February. It is this, combined with their rising enhanced support levels and some reduced fill rates that are challenging this division.

Our 3 newly appointed Quality Matrons are working closely, along with the Safer Staffing Matron, to provide some intensive quality support to the CAMHS division. An action plan made up of 6 key areas has been developed and work will begin to happen now, to put some immediate measures and support in place before the end of May. Some of this includes, focused supervision for our qualified nurses on the ward (provided by our experienced quality matrons); a focus on review of their current care plans and enhanced support; and out of hour's visits, with the first

one scheduled for 17/05/2022. This action plan and its progress will be regularly reviewed by the division, Quality Matrons and SSM, and the Chief Nurse.

7.2 Staffing Related Incidents:

	Feb 22	**March 22**	**April 22**
Total Count	63	105	76
Level 1 – No Harm	48	79	62
Level 2- Low	11	17	13
Level 3 – Moderate	4	9	1

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

The one moderate staffing incident that was reported via datix in April was for Sitwell in CAMHS and relates to the action card implementation that occurred on this date for the night shift. This incident did result in enhanced support temporarily being reduced for one of their patients, from 2:1 to 1:1. However, no clinical harm or injury was reported to either staff or patient as a result of this.

Out of the 13 low level staffing incidents reported in April; seven were within Neuropsychiatry; three for CAMHS; one for ASD/LD, one for MSU and one for Birmingham.

For Neuropsychiatry, five of these seven incidents were for temporary reductions of enhanced support levels. However, all of these were reported as clinically manageable at the time and no clinical harm was reported to staff or patients as a result of these. The other two reportable incidents were due to implementing divisional qualified contingency plans that resulted in two wards sharing a qualified nurse at night for a period of time. No clinical harm to either patient or staff was reported as a result of these contingency plans being implemented.

For CAMHS, two of the three incidents were reported due to having to temporarily reduce enhanced support levels. The third incident was due to insufficient response to group alerts called within CAMHS specifically on 9 and 10 April. To continue to mitigate this risk moving forward, the Northampton site has introduced three daily radio checks, in the morning, afternoon and night shift. These are co-ordinated and completed by the divisional bleep holders and responses/follow up action recorded on the daily site report. Bleep holders are also confirming radio allocation and response ability with each ward at the start of shift, highlighting any areas of response concern, and redeploying if necessary to help maintain adequate response levels within each building.

7.3 Complaints:

For March and April 2022 there were two concerns and one complaint relating to staff availability (reported via PALS/complaint team).

Complaint from ASD Meadow ward.
Patient complained that there was no qualified nurse on shift. The complaints team are currently awaiting information from the ward as to why this occurred on that occasion and to ascertain the likelihood of this happening in the future.

This complaint did not give a specific date or time as to when this occurred, however there have been no clinical action cards recorded for ASD/LD or Meadow during this time period.

Concern from MMH Danbury ward
Patient raised concerns that their MDT team is not available on day shift. Patient states MDT team fail to turn up to community meeting. This is currently with the service for investigating and we are awaiting their response.

Concern from ASD/LD Sunley Ward
Patient states that staff members have left the ward due to violence on the ward and the staff shortages make patient feel unsafe. Currently with the ward for investigations. Meeting arranged for 10 May between the complaints team and the ward to discuss the issues.

The ward responded in May and provided the following context and assurance:

1. Approximately four staff have left the ward in the previous six month period the reasons for which are varied, but are not attributed to assaults from patients.
2. Vacancies have been backfilled with staff from other clinical areas of the Division, e.g. Clinical Nurse Lead, and new starters who are making progress through their preceptorship period.
3. An additional three staff members have been off on Long Term Sick, these staff members are undergoing phased return to work.
4. There are five new starters in the pipeline that have been allocated to Sunley. The Division are running an ongoing recruitment cycle to fill Healthcare Assistant vacancies.
5. There are no Registered Nurse vacancies on the ward at present.

7.3.1 Freedom to Speak Up Concerns

As of 1 May, there have not been any concerns raised formally via the Freedom to Speak Up guardians in the last 3 months.

8 Moving Forward & Charity Developments

8.1 Allocate – E-Rostering Update

The project has been accelerated to reflect the importance of safe and fair rostering of all of our teams by 12 June, with the first live payroll on 30 June. Workforce Leads in each division are taking on the implementation and started with ward by ward data gathering, all of which was completed as planned by 29 April. Additional resources have been funded to support the overall programme, particularly in the HR/payroll domain.

Allocate helped us to train and build our first rosters at the beginning of May. After this our Workforce Leads, with support, will be setting up rosters and migrating the data from Kronos. On 23 May we will begin to train all Roster Managers on how to build their first roster and this will be followed up with authoriser training.

After 12 June, we will return to set the auto rosters up for each ward and build the SafeCare acuity into the system. This will be completed over July/August.

The Workchoice and agency staff module is ready to be built, with the data gathering exercise complete. It will go live at the same time as the rostering. There are significant opportunities to change the way we book and manage our temporary staff in this and we are focusing on including the Workforce leads in this work.

Kronos and the clocks system will not be used from the 12 June. We will be training Roster Managers to use 'Attendance Manager' within the Allocate software.

8.2 Establishment Reviews

Our first formal review of establishments will take place across June and July. These will be supported by a number of our senior ward leaders having now completed the MHOST acuity training, which provides additional assurance that this tool is being applied and used correctly. It has been recommended by our NHS workforce partner, that we complete these first full formal establishment reviews over a targeted area (e.g. one specific division) rather than the whole Charity. This will help us develop and confirm our formal establishment review process and template, and ensure a process that is consistently applied across all wards moving forward.

8.3 MHOST Acuity Training

As part of the Workforce Safeguards workstream, our NHS expert provided MHOST acuity training to our ward leaders in April, which included over 30 of our CNLs and NMs across the Northampton, Birmingham and Essex sites. As part of the Developing Workforce Safeguards guidance, it is a requirement that there are staff trained in the application of this tool and its descriptors, to ensure accurate data collection when rating our patients; and to provide assurance to the board that this tool is being used effectively and in line with its license. We have a further training date scheduled for the end of May to capture more of our senior ward leaders. Following this, our Safer Staffing Matron will be able to continue rolling out the training across divisions and it will include roll out to all levels of qualified nurses.

8.4 Clinical Ops Hub Developments

The introduction of the Clinical Ops Hub has over the last few months helped us maintain oversight of our staffing, including any challenges, both operationally and clinically. The Charity recently appointed a Clinical Ops Hub Manager who is managing the Hub and taking the lead in ensuring optimal performance of its day to day running and future improvements. We are also looking to recruit more 'Site Co-ordinators', who will pick up the day site co-ordination (similar to what we have now at night time) and will allow our CNLs and NMs to return to their patient facing and clinical roles. By recruiting a site team, we aim to improve consistently in the implementation of our new Safer Staffing Processes, and staffing model.

Risks for the Board to Consider

- Increased establishment gap across the Charity for both qualified and unqualified staff, as we move to increase our proportion of regular staff and reduce our reliance on WorkChoice and agency.
- There remains an increased reliance on WorkChoice and agency due to these vacancies, as well as the need to support temporary flex uplifts due to both increased acuity and demand, which is seeing wards needing to work above their planned number. This is a risk due to impact on continuity of patient care, patient experience and a potential impact on staff wellbeing due to the pressures of working alongside and supporting unfamiliar staff.
- Continued challenges in recruiting servery staff is seeing us unable to provide the allocated servery support agreed to all wards across the Charity. For wards without current servery support, they continue to receive a 0.3 uplift in their nursing number. However, with our current nursing establishment gap, this is only adding additional pressure to reach an increased nursing requirement.
- There are still some instances of refusals to redeploy, and CAMHS in particular are being most affected by this. Although our newly refined absence and refusal to redeploy management process is reducing the number of these instances, there are still occurring.

Proposal

- The Safer Staffing Matron (SSM) will continue to support the established Developing Workforce Safeguards work to provide assurance of safe staffing across the Charity.
- SSM will continue to work closely with the Heads of Division to complete the first set of formal establishment reviews and help support and implement changes where required.
- The SSM and Workchoice Leads will continue to work closely with the Senior Ward leaders of the Charity as we plan to roll out the first phase of Allocate in June. This will be key to changing and improving some of our scheduling behaviours and practices.

Paper for Board of Directors	
Topic	NHS Improvement Annual Solvency Commitment
Date of Meeting	Friday, 27 May 2022
Agenda Item	**11**
Author	Kevin Mulhearn
Responsible Executive	Kevin Mulhearn
Discussed at Previous Board Meeting	Yes – March 2022
Patient and Carer Involvement	Not suitable for patient/carer involvement.
Staff Involvement	Not suitable for staff involvement.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☐ Research & Innovation ☐ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	

Report Summary and Key Points to Note

The annual NHS Improvement Solvency Commitment Certificate was presented and approved by the Board in March 2022.

However, the annual declaration certificate for 2022/23 must be approved and signed after 1 April 2022 and therefore has been resubmitted to Board for approval and minutes.

Nothing has occurred since the March 2022 Board that compromises this annual declaration and therefore I ask the Board to approve the submission (due by 31 May 2022).

Summary of the Declaration

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

They require us to make the following statement:

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

In making this statement we have considered:

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

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

Appendices -

Paper for Board of Directors	
Topic	Board Assurance Framework
Date of Meeting	Friday, 27 May 2022
Agenda Item	**12**
Author	Duncan Long, Company Secretary
Responsible Executive	Jess Lievesley, Chief Executive (interim)
Discussed at Previous Board Meeting	November 2021 Board Strategy Day April 2022 Board Development Day
Patient and Carer Involvement	Not specifically for the update.
Staff Involvement	Not specifically for the update, however individual items relating to the process have been discussed with the appropriate personnel where required, with many involved in the actual development of the BAF.
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	Audit & Risk Committee meetings and Charity Executive meetings

Report Summary and Key Points to Note

The purpose of this paper is to provide the Board with further opportunity to review and comment on the revised and improved Board Assurance Framework (BAF).

The BAF will enable the Board to identify, capture and monitor the ongoing principal risks to the implementation and achievement of the Charity's strategic objectives. Effective use of the BAF should drive the agendas and focus of the Board and its sub-committees. The revised BAF will also ensure it meets the monitoring requirements of the Board as agreed at the March 2022 meeting, whereupon

strategic milestones will be transferred into the BAF process and progress against them monitored, with responsible executives held to account for delivery.

This revised version was reviewed and endorsed by the Charity Executive at its strategy meetings in April and May, as well as by the Audit and Risk Committee at their April meeting.

Following the endorsing of the new format and structure of the BAF, the Company Secretary and Internal Audit & Risk Manager arranged a series of meetings with the identified Executive Leads to finalise the Strategic Risks to be included within the BAF. The proposed eight Strategic Risks included in this paper were reviewed and endorsed by the Charity Executive at the Strategy Executive meeting on 11th May 2022.

The attached paper outlines the proposed process for introducing and maintaining the BAF, along with the proposed BAF Template, BAF process and procedures, proposed strategic risks and newly introduced Strategic Milestone Tracker process.

The Board is asked to review the proposed BAF format, process procedures, and:

1 – If in agreement approve the revised BAF template, process and reporting procedures

2 – If in agreement approve the initial proposed strategic risks to be maintained via the BAF

3 - If in agreement approve the initial proposed oversight allocation of risks for Board Committees

Appendices -

Appendix 1 – Proposed BAF Template example

Appendix 2 – BAF Process and maintaining the BAF

Appendix 3 – Strategic Milestone Tracker

Board of Directors - Board Assurance Framework

Introduction

The key role of the Board is to determine the strategic objectives that are critical to the continued success of the Charity, and ensure that they are delivered. The Board Assurance Framework (BAF) is used to record the principal strategic risks which could prevent the delivery of the strategic objectives, as well as the key controls and assurances which demonstrate that these risks are effectively managed. The BAF also records actions to address any gaps in controls and assurances so that implementation can be monitored by senior management.

The BAF provides the Board with a formal opportunity to oversee, discuss and challenge the current risks required in order to most likely achieve the strategic objectives of the Charity. The BAF facilitates a proactive approach to assessing the controls in place, assurances being provided, action being taken and the progress being made against the Charity's strategic objectives.

The proposed BAF Template (Appendix 01) and BAF Process (Appendix 2) were developed taking on board key attributes of BAFs currently seen in circulation throughout the NHS, as well as adopting areas of industry best practice. A number of these best practice improvements have been adapted to suit the StAH BAF, including the proposal to keep the number of Key/Strategic risks limited to no more than twelve, the separation of reported gaps in control and assurance (incorporating the source and level of assurance in line with ARC recommendations), and the importance of defined lines of governance and assurance alongside clear and consistent reporting within the Board and Committee Reports.

A revised format of the Charity's draft BAF was presented to the Executive at the Strategy Executive Meeting in April for review and comment, following on from which the BAF was discussed at the Audit and Risk Committee on 19th April, resulting in it being endorsed, subject to a number of minor revisions to the template.

Following the endorsing of the new format and structure of the BAF, the Company Secretary and Internal Audit & Risk Manager arranged a series of meetings with the identified Executive Leads to finalise the Strategic Risks to be included and managed within the BAF. The proposed eight Strategic Risks included in this paper were reviewed and endorsed by the Charity Executive at the Strategy Executive meeting on 11th May 2022.

Executive Summary

To ensure appropriate links to the existing Risk Management system, the Charity's Risk Management function has taken on the role of an "enabler and facilitator" in the development of the BAF and is providing oversight and challenge on the risks, controls and assurances that are to be included. The Strategic risks proposed in this paper have been selected taking into account the recently approved Charity Strategy 2022-27, the input and recommendations from members of the Executive, along with input taken from numerous BAFs in use within the Mental Healthcare sector, and recommendations from the IARM, using his experience and understanding of the Charity's risk cultural and risk maturity.

Our discussions with the Executives covered a wide range of topics including:

a) The degree of comfort they have with the new BAF template

b) Their historic experience outside of the Charity with BAFs (or similar) – its population, the number of risks managed, the administration of risks, the governance of risks, etc.

c) Detailed scrutiny of the existing set of Strategic risks (pre-populated within our original BAF) for their validity, completeness and clarity.

d) The Key risks they consider are of strategic significance in the context of the Charity and the approved strategy for 2022-27.

Key to including a specific risk was the answer to the following risk "litmus test" question:

"Will the exposure to a Strategic Risk (or failure to control the risk sufficiently that the full inherent impact is seen) result in derailing the Charity and see the likely failure of the Charity to deliver and achieve its immediate strategic objectives."

Using this litmus test approach has resulted in some areas that were initially considered as Strategic Risks being disregarded at this time, and may therefore be considered at a point in the future. These risks may therefore be best managed as Material Risks and incorporated into the existing Material Risk Register and process.

It is worthy of note that whilst the final Strategic Risks should be aligned to the Charity's seven Strategic Priority areas (and recorded on the BAF as such), a Strategic Priority Area will not necessarily be seen as a stand-alone Strategic Risk.

Furthermore to ensure the BAF is manageable and can be completed effectively we are planning to limit the number of Strategic Risks to no more than 12 at any one time.

Proposed Strategic Risks:

The following eight strategic risks are proposed for inclusion within the new BAF process. These eight broad risk areas have been suggested taking into account the consensus of opinion from the Executive meetings and how the risks link to the strategic priority areas within the new Strategy. Whilst the final risk descriptions, control activities and sources of assurance are yet to be documented there was full support for these risks being included.

Current proposed Strategic Risks:

1 – Strategy Delivery

2 – Quality of Services

3 – Financial Objectives

4 – Workforce

5 – Organisational Culture

6 – Partnership Working

7 – Strategic Assets and Estates Management

8 – Service Innovation

A number of other potential strategic risks were discussed for inclusion (or otherwise). These risks, including a number of Strategy Priority areas (Research and Education), were either seen as not meeting the aforementioned risk litmus test or the qualification criteria, (although it was agreed they may do in the future), or the risk areas were seen as enablers within the strategic risk process, or outcomes of the strategic risks. Such as in the case of Digital (an enabler) or Reputation (an outcome) and both these areas therefore would be documented accordingly within the final strategic risks included within the BAF.

The Strategic Risk Register and BAF are live documents, perhaps with less fluidity and ability for change as compared to the Material Risk Register and as such, should a Strategic Priority area (such as Research or Education) move into a high priority deployment phase, as in the case of Education and Training in the year 2025-26, and Research and Innovation in the year 2024-25; it may be appropriate to record an appropriate Strategic Risk for these areas within the BAF at that time. In the meantime, risks associated with the delivery of objectives and milestones in these areas will be managed within the Strategy Delivery Strategic Risk (in conjunction with the newly introduced Strategic Milestone Tracker process, Appendix 03).

Based on how the BAF template has been designed, it will be possible to readily see to which Strategic Priority area each risk aligns to, as well as how each Strategic Risk has links to others. Where controls are derived out of the enablers, they can be considered as key controls and therefore will be recorded within the BAF, under the Controls and Assurance section of the applicable Strategic Risks.

Strategic Milestone Tracker:

Whilst the Strategic Milestone Tracker process is overseen and collated by the Director of Strategy, it is the SRO for each Strategy Priority Area that will have responsibility for highlighting progress on objectives and providing the initial level of assurance and commentary. The Director of Strategy will produce a summary paper of the progress against the Strategy (including updates for each priority area) at each Executive Strategy meeting.

The summary will be based upon a standard question set / approach:

- Are relevant metrics in place and being tracked? What are they telling us?
- Notable activity / achievements in the period?
- Activity that is off track and the remedial plans?
- Critical activity planned for the next period and any risks to achievement?
- Are our current plans still relevant and sufficient? If not, why and what do we need to change / do differently?

Additionally there will be a schedule of priority area 'deep dives' established where the SRO will present their plans and progress etc. in more detail, including relevant metrics. The output from these Executive Strategy meetings will inform the progress updates for the Board alongside the BAF, specifically supporting the Strategy Delivery strategic risk.

Committee Oversight

As part of the BAF process it is recommended that Board Committees maintain a level of oversight of the agreed strategic risks. The table below details the suggested oversight responsibility for each risk, including the Executive Leads responsible. Committees should review the relevant strategic risks assigned to them at each of their meetings (this will entail those committees with strategic risks assigned, to potentially move to a bi-monthly frequency that is aligned with Board meetings), liaising with the Executive Lead if needed to provide an opinion on the levels of risk and assurance provided. These reviews will act as a further line of assurance over the BAF process and the achievement of strategic objectives.

Proposed Strategic Risk	Executive Lead	Proposed Board Committee	Links to Strategy Priority Areas
Strategy Delivery	Chief Executive Officer	Finance (& Performance) Committee	All seven areas
Quality of Services	Chief Nurse	Quality & Safety Committee	Quality / Service Innovation / Workforce Resilience & Agility
Financial Objectives	Chief Finance Officer	Finance (& Performance) Committee	Finance & Sustainability
Workforce	Executive HR Director	People Committee	Workforce Resilience & Agility / Finance & Sustainability
Organisational Culture	Chief Executive Officer	People Committee	Quality / Workforce Resilience & Agility
Partnership Working	Chief Executive Officer	Quality & Safety Committee	Research & Innovation / Education & Training / Partnership & Promotion / Finance & Sustainability
Strategic Assets and Estates Management	Director of Estates & Facilities	Finance (& Performance) Committee	Service Innovation / Education & Training / Partnership & Promotion / Finance & Sustainability
Service Innovation	Executive Medical Director	Quality & Safety Committee	Quality / Service Innovation / Partnership & Promotion

As part of the development and completion of the new BAF, meetings will be arranged with the Chairs of the appropriate Board Committees that will have oversight responsibility for the Strategic Risks assigned to them, to discuss the process, assurance levels and agree the frequency of review and reporting.

Conclusion:

Once the final Strategic Risk areas are agreed, the IARM and Company Secretary will, through further meetings with Executives and subject matter experts, detail the risk description, control activities, sources of assurance and any immediate actions required to finalise the first full draft version of the BAF for submission to the Audit and Risk Committee in July, ahead of presenting to the Board. Further updates on the development of the BAF will be provided to the Executive before the ARC and Board

The Board is asked to review and comment on the proposed format of the BAF, as approved by the Executive Team and Audit and Risk Committee, and if in agreement approve the format, the proposed process and reporting procedures.

The Board is also asked to approve the 8 proposed Strategic Risks for inclusion in to the new BAF and to state if they have any other risk areas for consideration within the BAF.

Finally, the Board is asked to review and comment on the proposed Board Committee oversight allocation, and if in agreement approve the allocations.

Duncan Long
Company Secretary

Mohammed Sajid Ali
Internal Audit & Risk Manager

Appendix 1 – Proposed BAF Template example
Appendix 2 – BAF Process and maintaining the BAF
Appendix 3 – Strategic Milestone Tracker

Risk Title	1 – Quality of Services			Strategic priority	Quality	Service Innovation	Research & Innovation	Education & Training	Partnerships & Promotion	Finance & Sustainability	Workforce Resilience & Agility
Description	Inconsistencies in the application, oversight and recording of clinical practice could undermine the quality and effectiveness of patient care, resulting in patient safety being compromised and an increased risk of reputational issues and intervention/action by external bodies.			Risk rating (impact x likelihood)		To be Determined					
				Initial score	4 x 4 = 16	Run Chart for Residual risk versus Risk Appetite					
Exec Lead	Chief Nurse	Oversight Committee	Quality & Safety Committee	Current score	4 x 3 = 12						
Datix material risk ref(s)	904, 906, 911, 986	Risk Appetite Category	Quality	Risk Appetite	Low (12)						

Assurance rating (Rolling by Board meeting)	May 2022	July 2022	September 2022	November 2022	January 2023	March 2023

Key controls in place	Assurance that controls are effective		Date
The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks	*Sources of assurance that demonstrate the controls are effective (both Internal & External) along with the level of assurance provided (where appropriate)*		*Date of last assurance*
P - Committee oversight of clinical activities and their safety and effectiveness (BENNS, LRP Advisory Group)	Committee minutes and action plans	I (L2)	
P - Embedded clinical governance framework (RP Monitoring Group, Clinical Governance Oversight Group)	Clinical audit, feedback from internal visits	I (L2)	
P - Safe Staffing levels, New Staffing model MHOST, Central Staffing Operational hub, Absence project work streams, etc.	Safe staffing report	I (L1)	
P - Delivery of evidence based and innovative therapeutic interventions	Dashboards and patient feedback	I&E	
C - Independent reviews and benchmarking programme (Clinical audit, CQI projects)	Audit and inspection reports	I&E	
P + C -Enhance knowledge and awareness through Online and off-line trainings, e-learning, real-time IQPR and Patient safety framework, fill rate reporting to the CEC and Board.	Dashboards, reports and staff eLearning data	I (L2)	

Gaps in control or assurance			
Gaps in controls		Gaps in assurance	
C1		A1	
C2		A2	

Actions (what can we do to fill these gaps?)				
Gap	Action description	Action owner	Status update	Deadline
C1		Chief Nurse		
C2				
A1				
A2				

Risk Scoring Matrix, Assurance Ratings and Risk Appetites

Likelihood	Impact: Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	05	10	15	20	25
Likely	04	08	12	16	20
Possible	03	06	09	12	15
Unlikely	02	04	06	08	10
Rare	01	02	03	04	05

Risk Domain / Category	Risk Appetite Level	Extent of Risk Appetite	Risk Tolerance	Risk Management Approach	Residual Risk for Escalation
Quality	1 – Minimal	Low Appetite	Low Tolerance	Cautious	12 or more
Safety	1 – Minimal	Low Appetite	Low Tolerance	Cautious	12 or more
Regulatory / Compliance	2 – Cautious	Moderate Appetite	Moderate tolerance	Conservative	12 or more
Research and Development	3 – Open	High Appetite	High Tolerance	Confident	15 or more
Reputation	2 – Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more
Performance and service sustainability	2 – Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more
Financial Sustainability	2 – Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more
Workforce	2 – Cautious	Moderate Appetite	Moderate Tolerance	Conservative	12 or more
Partnerships	3 – Open	High Appetite	High Tolerance	Confident	15 or more

Risk Rating	Action Required
Low (1-3)	Monitoring of risk, further risk reduction may not be feasible or cost effective, refer to risk appetite
Moderate (4-6)	Risk reduction required so far as is reasonably practicable, refer to risk Appetite
High (8-12)	Action required so far as is reasonably practicable, refer to risk Appetite
Major (12-25)	Immediate action required so far as is reasonably practicable, refer to risk appetite

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

APPENDIX 2 – BAF HIGH LEVEL PROCESS OVERVIEW

Each year, the Board determines the strategic objectives, which are critical to the success of St Andrew's Healthcare

1. The Charity's risk appetite in relation to each of the strategic priorities is agreed and documented, in line with the approved Risk Appetite process

2. The key (strategic) risks, which threaten the delivery of each strategic priority, are identified. Risks are scored using a 5 x 5 matrix

3. Each risk is assigned to an Executive Lead who is responsible for the systems and processes required to manage the risk. Each risk is also assigned to an appropriate Board Committee with responsibility for reviewing and challenging the risk and assurance levels

4. The key controls to manage each risk are determined and defined as either preventative or corrective. Sources of assurance (both internal and external) are also determined which demonstrate that the controls are operating effectively

5. The main areas of weakness which result in gaps in controls or assurances are identified, as well as the key actions necessary to close these gaps

6. The Executive Lead reviews and updates the BAF on a bi-monthly basis with the Company Secretary and Internal Audit & Risk Manager

7. Through discussion the Executive Lead determines the assurance rating for their risk ahead of each submission to the Board

8. Board committees review the relevant risks at each meeting, liaising with the Executive Lead if needed to provide an opinion on the levels of risk and assurance provided

9. The Board receives the updated BAF on a bi-monthly basis, the "current" risk score is formally updated and the overall assurance rating is determined based on the strength of the controls and assurances, and progress against improvement actions

The Board can easily see the key risks that threaten the achievement of the strategic objectives, and consider whether additional action is needed to address these risks and ensure the objectives are delivered

MAINTAINING THE BOARD ASSURANCE FRAMEWORK

The high-level process to maintain the BAF is documented in the diagram above. Additional and detailed elements of the process are as follows:

1. The BAF should be seen as a dynamic document that provides visibility over the risks associated with the achievement of the Charity's strategic objectives and priorities. The BAF is one of the main ways in which the Executive is held to account for the delivery of the Charity Strategy.

2. The BAF is the culmination of a number of risk and internal control processes, including the wider Risk Management System incorporating the Charity's Risk Appetite, Material Risk Register; the Strategy Milestone Tracker and individual Strategy Implementation Plans.

3. Although the BAF should be actively used and maintained by Executive Leads as part of day-to-day activities, it will be formally updated and reviewed as follows:
    - Executive Leads review their strategic risks, control activities, assurances and action plans on a bi-monthly basis in conjunction with the Company Secretary and Internal Audit & Risk Manager.
    - Risk and assurance ratings are proposed and updated by the Executive Lead, along with updates to controls, assurances and actions. Updates are collated by the Company Secretary ahead of submitting an Executive Summary of the BAF position at each Board meeting, supported by the complete and annotated BAF and selected supporting information.
    - Board committees review the relevant strategic risks assigned to them at each of their meetings (this will entail those committees with strategic risks assigned, to potentially move to a bi-monthly frequency that is aligned with Board meetings). Reviews will act as a further line of assurance over the BAF process and the achievement of strategic objectives.
    - The BAF Board Report will include:
        i. An up to date and complete BAF, that has clearly identified and annotated updates recorded, including changes to controls, assurances, actions and due dates.
        ii. Latest Strategy Milestone Tracker Executive Summary (as collated by the Director of Strategy and presented to the Executive Meeting immediately preceding the Board), to support the Strategic Risk relating to Strategy Delivery. Oversight of progress against the strategic milestones and objectives is maintained by the introduction of a Strategy Milestone Tracker (Appendix 03). The SMT pulls together all agreed milestones (154 were agreed at the March Board) and is completed on a monthly basis by the SROs for each Strategic Priority area. The summary will include narrative around:
            - The outcome of any scheduled deep dives into strategic priorities
            - Whether relevant metrics are in place and being tracked. What are they telling us?
            - Any notable activity / achievements in the period
            - Activity that is off track and the remedial plans
            - Critical activity planned for the next period and any risks to achievement
            - Whether current plans remain relevant and sufficient. If not, why and what is needed to change, or be done differently.
        iii. Relevant supporting appendices, such as Risk Scoring Matrix; Risk Appetite Levels, Risk Appetite Statement and Lines of Assurance.
        iv. An Executive Summary of key issues and developments relating to the strategic risks since the last Board meeting, including changes to risk ratings, new or closed risks, deviation from risk appetite; status of actions; items escalated for Board attention and any other issues or changes of note.

- The Board will receive and review the full BAF at each meeting. The Board will 'confirm and challenge' the BAF and consider:
    i. Have the correct and appropriate risks been identified and recorded?
    ii. Are the reported risk scores accurate and in line with their understanding?
    iii. Are the identified controls and sources of assurance appropriate?
    iv. Whether gaps in controls or assurance have been correctly identified.
    v. Whether any further action is deemed necessary in relation to any of the risks or strategic priority areas.
- The Audit and Risk Committee (ARC) will review whether the format of the BAF and the way it is drawn up and used (in particular its maintenance and updating) are 'fit for purpose'. The ARC may achieve this by commissioning an annual review of the BAF from internal audit. Note: It is proposed that once the completed BAF is finalised and formally approved (likely to be following July's ARC and July Board) that an initial review is scheduled for January 2023, at which point any major changes can be completed.

4. Strategic risks will be scored using the methodology described in the Risk Management Policy and Risk Management Procedure, and follows the current 5 x 5 scoring and rating process.
5. The assessment of the overall assurance level for each strategic risk will be rated using the Charity's existing assurance terminology.
6. The Board will oversee the remediation of gaps in controls / assurance that threaten the delivery of the strategic objectives (i.e. by strengthening internal controls, or commissioning internal audits to provide assurance over the internal controls / functions that are critical to the achievement of individual strategic objectives).
7. The Charity's Strategy will be reviewed and updated on an annual basis to ensure that it remains appropriate, with the BAF updated to reflect any changes.

GLOSSARY OF TERMS

Board Assurance Framework - The key source of evidence that links the organisation's 'mission critical' strategic objectives to risks, controls and assurances, and is the main tool the Board uses in discharging its overall responsibility for internal control. The BAF follows the structure of the organisation's strategic objectives and is supported by the Charity's Risk Management System.

Internal Controls - The systems and processes the Charity has in place to give the Board reasonable assurance that things are running, as they should and that the organisation is achieving its objectives and meeting its legal and other obligations. For BAF purposes, controls are classified as either Preventative or Corrective. Examples of internal controls likely to be seen within the BAF include:

- Strategies (e.g. Estates, Health & Safety, Quality, IT, People)
- Policies and Procedures
- Targets, standards and Key Performance Indicators
- Staff Appraisals and management supervision
- Staff training programmes and eLearning
- Local audits

Strategic Risk – An inherent risk to the delivery of the organisation's strategic objectives that should not change significantly over time. These risks have the highest potential for external impact, for example does the organisation meet patients' expectations in relation to the overall quality and safety of care.

Sources of Assurance – Evidence that controls are working as intended (positive assurance) or not working as intended (negative assurance). For BAF purposes, sources of assurance are classified as either internal or external.

Example sources of assurance	
Internal sources of assurance	**External sources of assurance**
Internal audit	External audit
Key performance indicators	Care Quality Commission
Board reports	NHS England / Improvement
CEC / Sub-committee reports	OFSTED
Reports from specialist leads (e.g. business continuity, health and safety, risk management)	Accreditation schemes (e.g. ISO27001)
Clinical audit	Patient feedback
Staff surveys	Healthwatch
Staff appraisals	
Training records	
Results of internal investigations (including Serious Incidents)	
Complaints records	
Data Security and Protection Toolkit self-assessment	
Whistleblowing reports	

Gaps in Control / Assurance – The main areas of weakness, which result in ineffective, or absent controls / assurance. Gaps are to have a clearly defined (and SMART) action attributed and recorded on the BAF.

Strategy Milestone Tracker – The SMT is used to pull together progress on all agreed milestones and is supported by a monthly deep dive into selected strategic priority areas, and a summary report that provides an ongoing narrative into the delivery of the strategic objectives and milestones.

St Andrew's Healthcare Strategy 2022-2027

Our charitable purpose: "A charity that promotes wellbeing, gives hope and enables recovery"

STRATEGIC PRIORITY	AIM	MILESTONE OBJECTIVES		INDIVIDUAL OBJECTIVE		Scheduled completion	Assessed by	Assessed on	Commentary / Update
Quality	Deliver high quality care and recovery outcomes through our quality first ethos	Quality Care that is fit for the future		To be delivering improved patient outcomes in a consisten manner across all service					
				All services to be rated GOOD or to have improved as a minimum at the next CQC inspection					
				To implement innovative models of practice and technology to support and improve the experience and outcomes for our service users					
				We will have an agreed physical health stratgey to improve the physical health of our patients					
				Physical health strategy plan implemented					
		Minimising patient harm and delivering safe care		We will have an agreed patient safety strategy ensuring that safe care is central to all we do, and aligned to the NHS practices					
				Patient safety strategy deleivery training plan implemented					
				Funded Clinical Equipment budget with policy and processes to support Charity's ongoing need					
				To have timely and accurate information about quality, compliance and safety indicators accessible to all ward staff to support and to be routinely used in the clinical governance structure					
				Implementation of an agreed Quality Team structure to sup[illegible] line staff to achieve the overall improvements identified in the safety strategy					
		Delivering a great patient experience		We will have greater patient engagement and i[illegible]vment [illegible]ns agreed and implemented					
				We will increase the quality, type and [illegible]ailability of inte[illegible]ation about the services provided, treatments, models of care accessible [illegible]ts and ca[illegible] to support collaborative decisi[illegible] making					
				We will have improvement[illegible]ient eng[illegible]ment and satisfaction of services					

Progress Level	[illegible]ption
Substantial Progress	Substantial progress is being made on achieving strategic objectives and me[illegible]res. Objectiv[illegible]nd me[illegible]res may already have been achieved [illegible]re either on track or ahead of plan for achieving them.
Adequate Progress	Although there are some recognised control gaps, they are not sufficiently critical to compromise the achievement of the strategic objectives or measures. Manage[illegible]nt are general[illegible]on track in terms of agreed timelines and milestones [illegible]or the relevant objectives/measures. Where progress is slightly behind plan, management have confirmed and realistic plans in place to ad[illegible]ss the slippage.
Partial Progress	The control gaps, or lack of progress in completing agreed actions, taken together or individually may indicate the strategic objective or measure will not be achieved in t[illegible]eed timescale or as initially int[illegible]ed. Manag[illegible]ent and objective owners may need to complete additional actions to remain on track in terms of agreed timelines and milestones, however they remain at an early stage.
Limited Progress	Targets and milestones have been missed, or management have not commenced the necessary actions required in order to achieve the strategi[illegible]objective [illegible]easure. Significant actions and activities are required by management to address the shortfall in progress.
Not planned to have commenced	Work to deliver on this objective not p[illegible]d to [illegible] com[illegible]ced at present time

Paper for Board of Directors	
Topic	Integrated Quality Performance Report
Date of Meeting	Friday, 27 May 2022
Agenda Item	**13**
Author	Anna Williams (Workforce supported by Lara Conway and IT security provided by Adam Griffiths)
Responsible Executive	Jess Lievesely
Discussed at Previous Board Meeting	Routine paper
Patient and Carer Involvement	As the My Voice work provides insights, these will be used to tailor the focus of the IQPR to ensure patient voice
Staff Involvement	As the Your Voice and Lead the Change programmes provide insights, these will be used to tailor the focus of the IQPR to ensure staff voice.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☐ Assurance ☒
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐
Strategic Priority Area	Education and Training ☐ Finance & Sustainability ☒ Service Innovation ☐ Quality ☒ Research & Innovation ☐ Workforce, Resilience & Agility ☒ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Quality metrics are considered via QSC. Workforce is considered via the People Committee. Finance is considered via Finance Comm.

Report Summary and Key Points to Note

Review of the period ending April 22

Quality – at a Charity level, six of the quality KPIs (included in quality scorecard) are showing a special cause improvement (sustained improvements for: incidents of violence, restraints, long term segregation, enhanced support episode and staffing levels required for enhanced support and a new improvement for Level 2 incidents). The remaining metrics show common cause variation. Assurance is provided for Division level concerns. At ward level 92% of the quality scorecard KPIs are either in control, have little or no data or show a statistically insignificant trend. The quality scorecards for each division and ward are routinely shared with QSC. Leading indicators continue to be a focus. My Voice response rates show a small improvement yet remain low – additional promotion is underway. Updates are provided on the setting of Clinical targets and the approach for Clinical benchmarking (with ratification via QSC planned for June).

People – training and agency spend are favourable to target at Charity level. Registered Nurse and HCA establishment ratios are projected to be at target by March 23 for RNs and February 23 for HCAs. There is a joint focus on recruitment and retention to secure these projections. Monthly voluntary turnover is adverse to target – with divisions higher then enabling functions. Sickness % has shown a positive reduction, yet remains adverse to target. In common with other healthcare providers, both locally and nationally, the Charity is working tirelessly to mitigate potential impacts to patient care arising from the combination of a challenging recruitment market and above target absences levels. Remedial actions are shared in the report.

Finance – April 2022 Actual Performance v Budget, Net deficit £1m - £0.1m lower than budget, with 98% achievement of budgeted income offset by positive movement in costs of £0.4m (£0.3m Operational & £0.1m Overheads)

Integrated Quality & Performance reporting improvements update

This paper includes the proposed Clinical targets approach and the Charity's plan for benchmarking.

The requested waterfall chart showing the net impact of starters and leavers from opening to closing headcount is included. This is currently at Charity level – work is on-going to enable role level reporting. Transfers to WorkChoice are to be included in voluntary turnover moving forward.

Pending improvements – these are progressing but are not yet presentable

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

Appendices -

St Andrew's Healthcare Integrated Quality Performance Report

reviewing the period ending April 2022

1) Quality Scorecard

Quality Scorecard at a Charity level there are special cause improvements across six quality indicators with no special cause concerns. Clinical targets have been underdevelopment – a headline proposal is shared in the coming slides and will be presented to the next QSC for consideration.

Charity Position

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

Divisions

Measure	Incident		Violence		Incident L1		Incident L2		Incident L3		SI		Restraint		Seclusion		LTS		LTS Days		ES Episodes		ES WTE	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
ASD & LD																								
Birmingham																								
CAMHS																								
Community																								
Community Partnerships																								
Essex																								
Low Secure & Specialist Rehab																								
Medium Secure																								
Neuro																								

ASDLD – recurring LTS concern is due to two inappropriately placed patients and two patients whose exit plans require external placements. Every effort is being made to secure an appropriate setting for the inappropriately placed patients.

Community – all concerns relate to the deterioration of one service user who is beginning to respond well to their amended care plan.

Delayed transfers of care remain a challenge – with 65 at mid May, of particular note, the Charity is currently supporting three >18 year olds in CAMHS, due to a lack of availability of onward care. Placements within STAH are being considered in the interim.

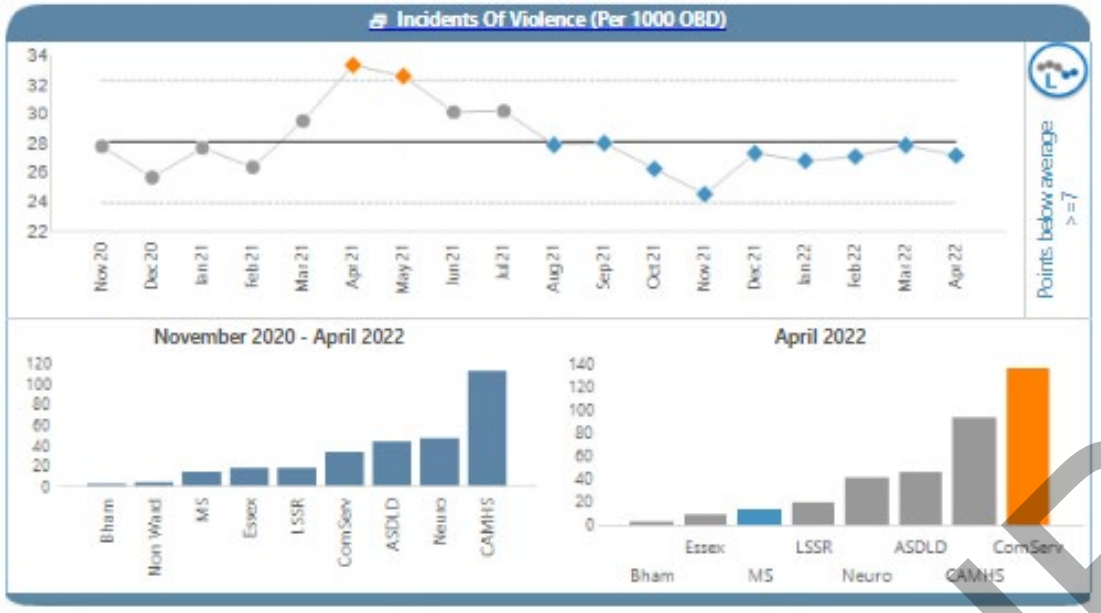
Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

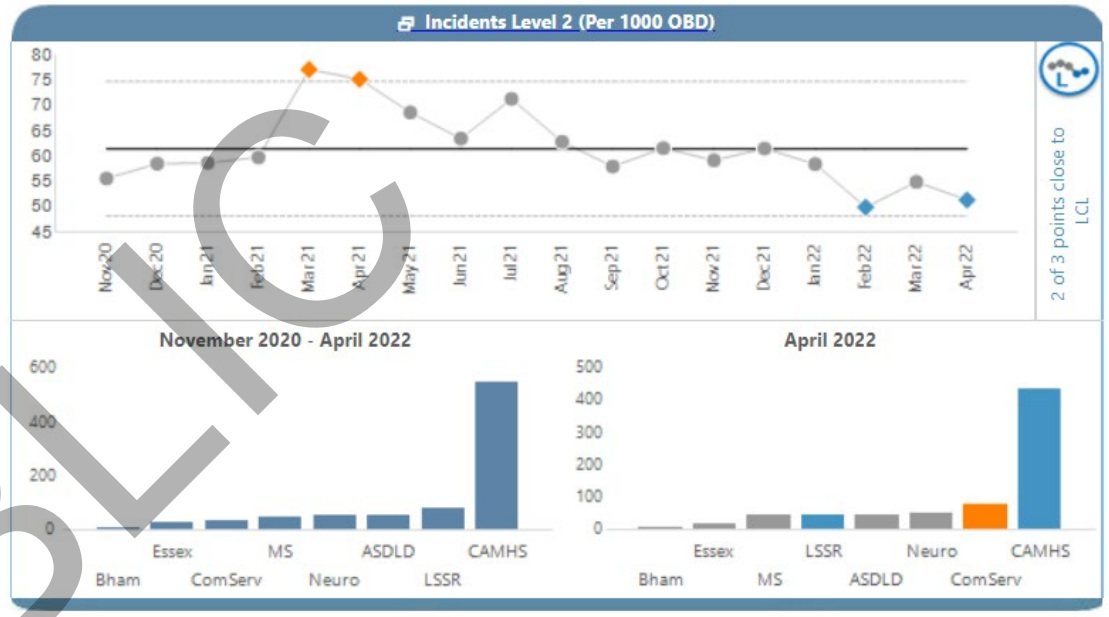
Concerns Improvements In Control

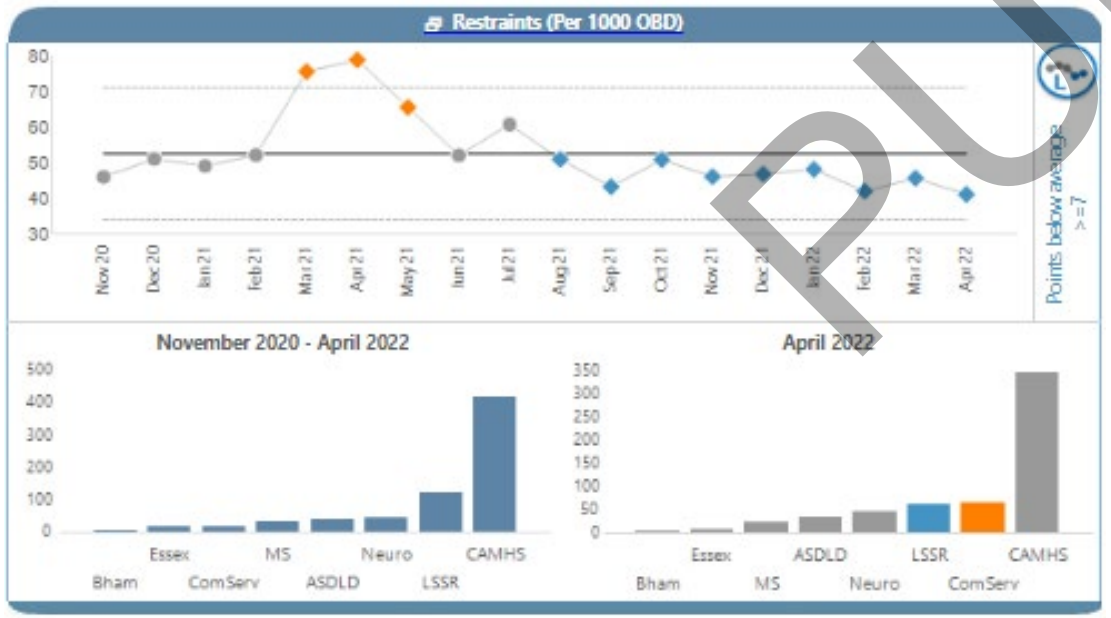
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

Exception reporting – Violence, Incident Level 2 & Restraint

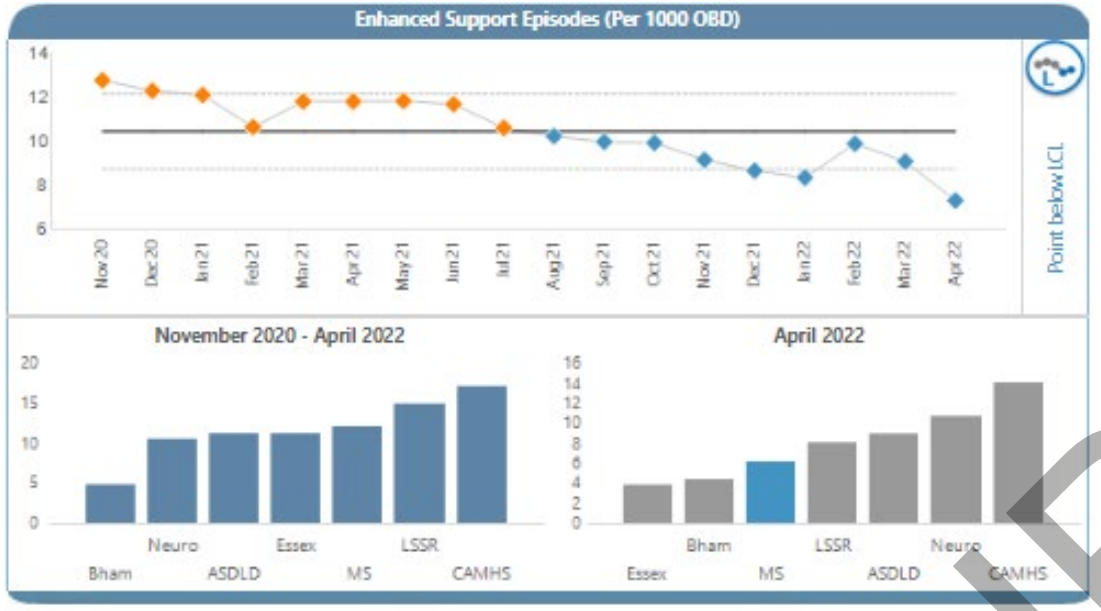


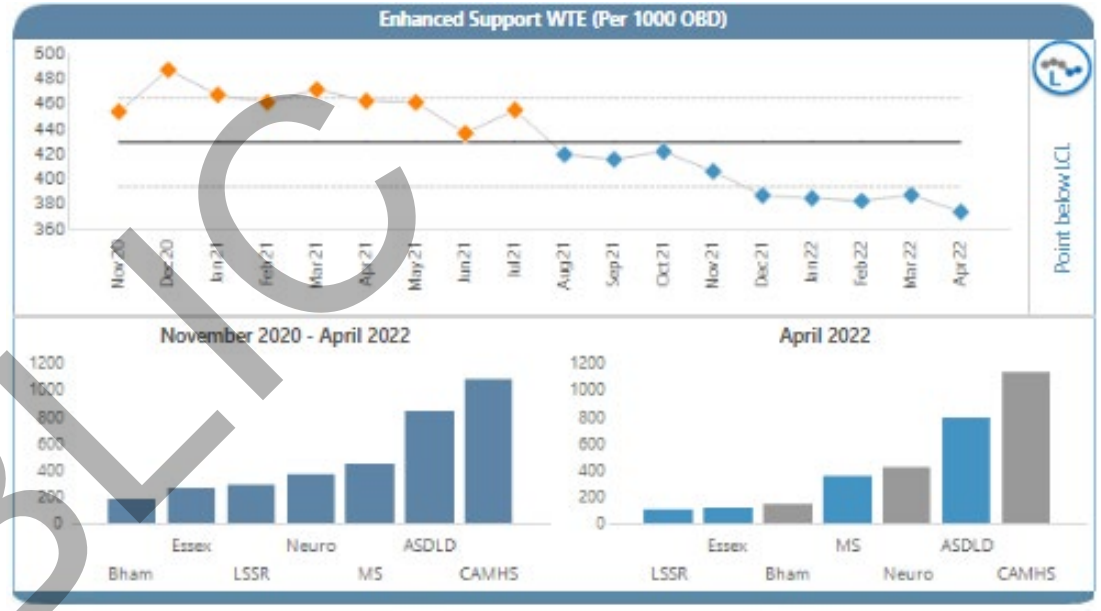


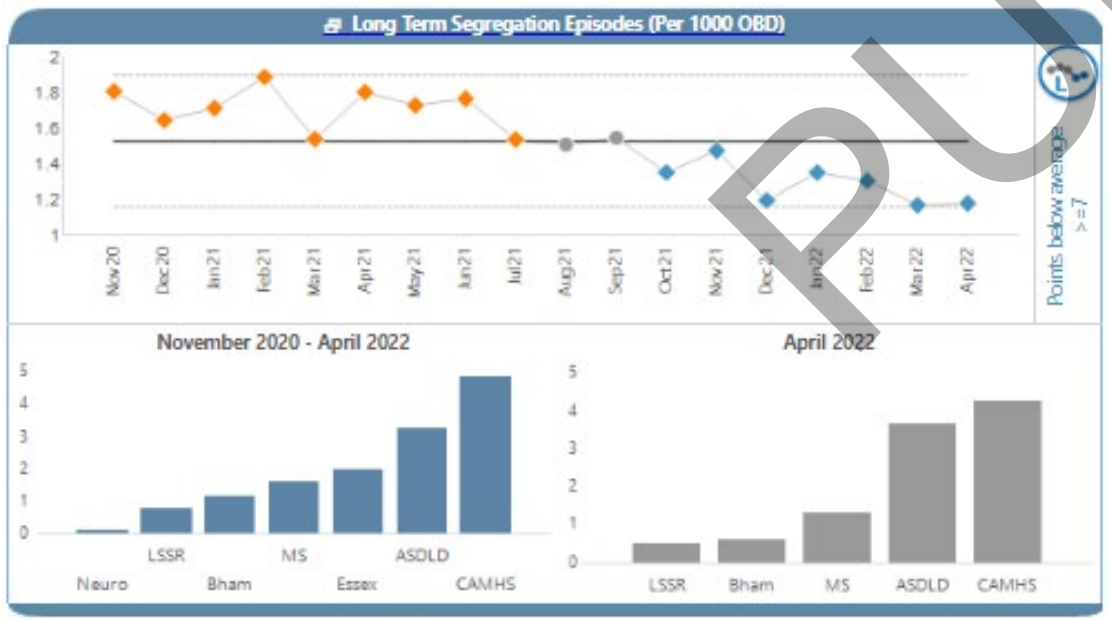


Sustained special cause improvements for incidents of violence and restraint. This reduction correlates with the REDUCE programme that has been in place since September 2019. Level 2 incidents present a special cause improvement for the first time – with levels currently close to the lower control limit. The improvement is driven by CAMHS and LSSR. Overall incident levels and incident levels 1 & 3 are within control limits.

Exception reporting – Enhanced Support & Long Term Segregation







Sustained improvement - fewer new episodes of enhanced support, correlating with a reduction in the level of resource required. Special cause improvements for ES and LTS, initially reported to the Board in January, have been sustained. This reduction correlates with the REDUCE programme, alongside the sustained scrutiny of enhanced support.

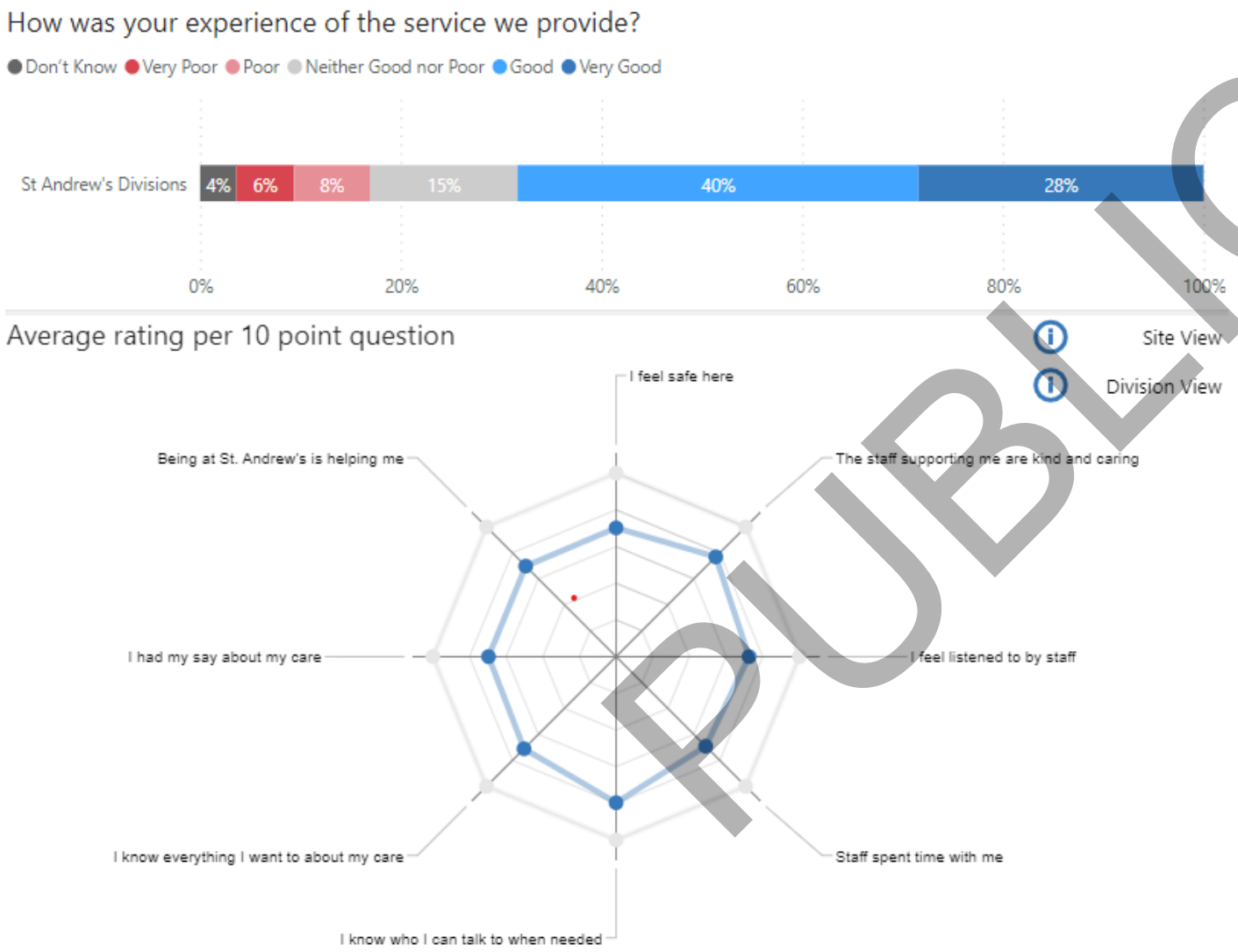
Ward level assurance

The quality scorecard presented in this report provides a Charity position alongside a disaggregated divisional view. The Quality & Safety Committee is provided with a further level of granularity in the form of the ward level quality scorecards, associated causal analysis and remedial actions. The below table represents a hybrid – providing an overview of the status, at ward level, of the 12 current quality KPIs. In summary 92% of the ward level quality KPIs are in control, have little or no data, or show a statistically insignificant trend, 5% show statistically significant improvements and less than 3% show statistically significant concerns (this is consistent with March 22).

Division	Wards	SPC Concern	SPC Improvement	SPC Common Cause	Trend Concern	Trend Improvement	Little or No Data
ASD & LD	14	6 %	5 %	21 %	8 %	21 %	39 %
Birmingham	8	1 %	3 %	14 %	7 %	19 %	56 %
CAMHS	4	0 %	4 %	40 %	19 %	8 %	29 %
Community	2	21 %	0 %	0 %	0 %	8 %	71 %
Essex	6	0 %	4 %	21 %	7 %	14 %	54 %
Low Secure & Specialist Rehab	9	0 %	8 %	17 %	7 %	6 %	62 %
Medium Secure	11	0 %	5 %	27 %	14 %	5 %	50 %
Neuro	12	5 %	7 %	28 %	7 %	7 %	47 %
Totals	**66**	**3 %**	**5 %**	**22 %**	**9 %**	**11 %**	**49 %**

Through the Integrated Quality and Performance reporting approach the Charity considers both SPC and trend concern themes at a metric level and reviews the distribution of concerns at ward level. Clinical plans are subject to check and challenge. This information is shared with the QSC for consideration. Leading indicators continue to be reviewed, there remains an open action for these to be incorporated into the IQPR matrix. The Charity's internal Quality Assurance approach is currently being redeveloped – learnings are being taken from our NHS buddy organisations and digital tools are being considered.

My Voice



The collated responses show 68% of respondents rate their experience as good or very good (63% March 2022). Response rates remain a concern, with inconsistent and insufficient completion levels. Increased promotional activity is underway. Access to devices is a reported blocker that is being removed. Actions and learnings from My Voice will be included in ward, division and Charity wide QIPs. With lesson learnt being addressed via the dedicated Embedding lessons learnt into practice work stream (one of the nine work streams in the Improvement Programme).

*As at 10th May 2022

Clinical Targets

The Charity is setting clinical targets within the spirt of the collective desire to continually improve the experience and outcomes of those we support. With this in mind, targets will be bold and aspirational, aligned with our strategic ambition to **facilitate high quality person centred outcomes and experiences.**

The approach to developing these targets has been benchmarked with our NHS buddy organisation and draws on national targets as agreed in the Mental Health Safety Improvement Programme (MHSIP - for which St Andrew's chair the East Midlands Alliance). Aligned with these methodologies, a percentage reduction from baseline approach is being proposed. The baseline being the mean achieved for the preceding 18 months. Clinical colleagues from across the Charity have been engaged in the Restrictive Practices Monitoring Group (RPMG) and through this have been party to the agreements within the MHSIP. In line with other providers a target for total incidents will not be set. There will be a focus on reducing the proportion of incidents that result in harm. For key restrictive practices the MHSIP has set a 25% reduction target over 24months. The Charity is proposing to adopt this target, segmenting the achievement across six month periods. In June the QSC will be asked to ratify the approach. The Charity REDUCE programme has been established since 2019 and has implemented a wide range of initiatives, which is reports to QSG and QSC. This programme can be reviewed such that additional focus, effort and resources can be directed to meet the improvement targets.

Metric	Incidents L3+	Restraint	Seclusion episodes	Seclusion hrs	LTS episodes	LTS days	Rapid Tranq
Target	25% reduction over 24 months						
Improvement plans	Patient safety strategy	REDUCE Programme, e.g. full Safewards implementation	REDUCE Programme	REDUCE Programme	REDUCE Programme, HOPE(s) training for LTS management	REDUCE Programme, HOPE(s)	Clinical Supervision, Medicines Management - rapid tranq action plan

Clinical Benchmarking

The Charity remains committed to benchmarking clinical performance against comparable services. It remains challenging to achieve this commitment, chiefly due to a lack of specificity within the available benchmarking data. The data available via the NHS Benchmarking Service and Model Hospital is at best at security level, with very little diagnostic or gender classification. This in turn impedes the validity of the comparisons and renders the existing benchmarking options insufficient in their present form. Data at Trust level is not useful, not only as we do not necessarily know the services each Trust has, but even if we did, we may not know which services are included in any data set.

There are two medium term solutions to this problem. Firstly, for our secure services, in either Q1 or Q2 22/23, providers will be asked to report specialised quality data by service type. This data will go to the national Quality Surveillance Information System (QSIS) and soon into the Model Hospital system as QSIS is being discontinued. We will have access to the Model Hospital and as such, we can benchmark against meaningful granular data e.g. comparing our male, mental health, medium secure wards with all other male, mental health medium secure wards.

The second solution, which has been discussed with one of the NEDs, is that we hold a series of workshops where we test assumptions, using our own data, on the key statistical drivers of different outcomes e.g. violence, restraints, seclusions etc. Once we establish the key drivers, we can try and control for those when comparing benchmark data e.g. if diagnosis is a driver, and we do not have benchmarked data for outcomes by diagnosis, we then remove that as a variable from our own data and then compare to the benchmarked data.

We intend to set up a series of these workshops, as they will also help inform quality improvement efforts.

2) People Scorecard

People Scorecard at a Charity level, training and agency spend are favourable to target. The remaining metrics are adverse to target.

Charity Position

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

Divisions

Measure	Vol Turnover Month		RN Ratio		HCA Ratio		Training		Agency Spend		Sickness %	
-	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target	SPC	Target
ASD & LD												
Birmingham												
CAMHS												
Essex												
Low Secure & Specialist Rehab												
Medium Secure												
Neuro												

As a key enabler for quality, a driver for employee experience and financial results, there is a considerable focus on improving the performance of workforce metrics.

Data and insight improvements, integral enabling informed decisions, are in flight.

22/23 people targets have been agreed at a headline level and are included as the comparators for this report. Work is on going to disaggregate and individualise the targets for divisions and functions.

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

*Please note as CAMHS are a smaller division they may be disproportionately impacted by a small number of staff members

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

Trend lines used for KPIs with data volume too low for statistical significance
Concerns Improvements Stable

Target icons show if KPIs are passing or failing
Passing Failing

No icon shown if the KPI has little or no data in the last 6 months

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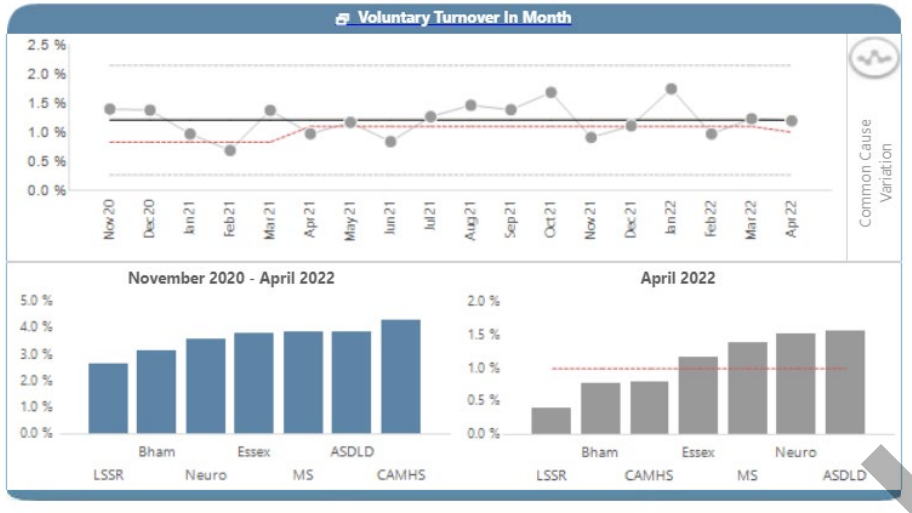
Exception reporting –Voluntary Turnover in month



At a Charity level the April voluntary turnover was marginally adverse to target at 1.08% (in patient divisions returned 1.19%* with enabling functions at 0.85%).

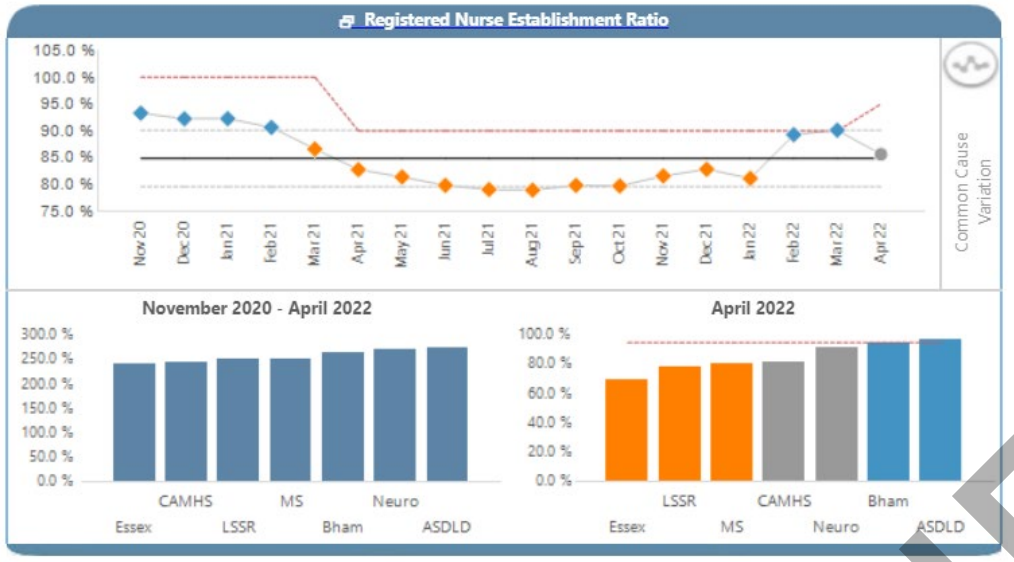
The average tenure of voluntary leavers was 4.5 years, 8 individuals left in the first 12 months. The top reason for leaving in April was work life balance. There remains a trend of people leaving for a 'better package'.

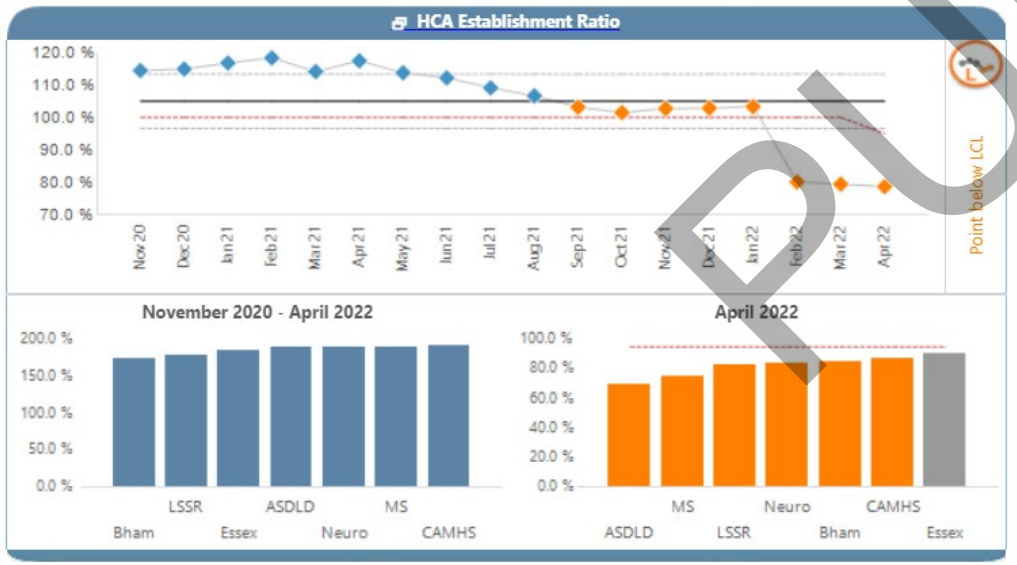
The newly developed waterfall chart demonstrates the impact of the current attrition levels.

Retention Initiatives - There are a number of initiatives in place that will aid retention including the Lead the Change culture programme, local your voice action plans, the roll out of Allocate (e-rostering) and offering more flexible shifts, the recent increase to pay the Real Living Wage (and next steps of pay progression for critical roles), talent management, career development support and further support on wellbeing

*excluding transfers to WorkChoice. BI development work pending to include these as turnover.

Exception reporting – establishment ratio (permanent staff) adverse to target





Establishment targets have been harmonised at 95% for registered nurses and HCAs. As at the end of April the RN establishment stood at 86% and HCAs at 79%.

Recruitment projection analysis has been developed – the net impact of increasing requirement (due to increased occupancy forecasts), planned starter volumes and the offsetting impact of role specific turnover results in a projected March 23 date for registered nursing establishment to meet target and February 23 for HCAs.

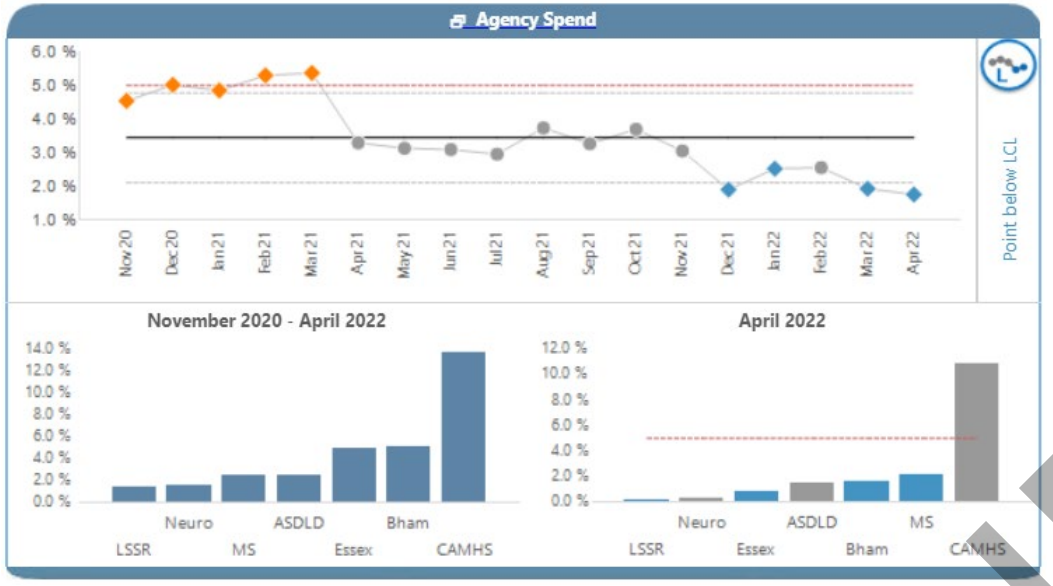
Actions to achieve the projection:

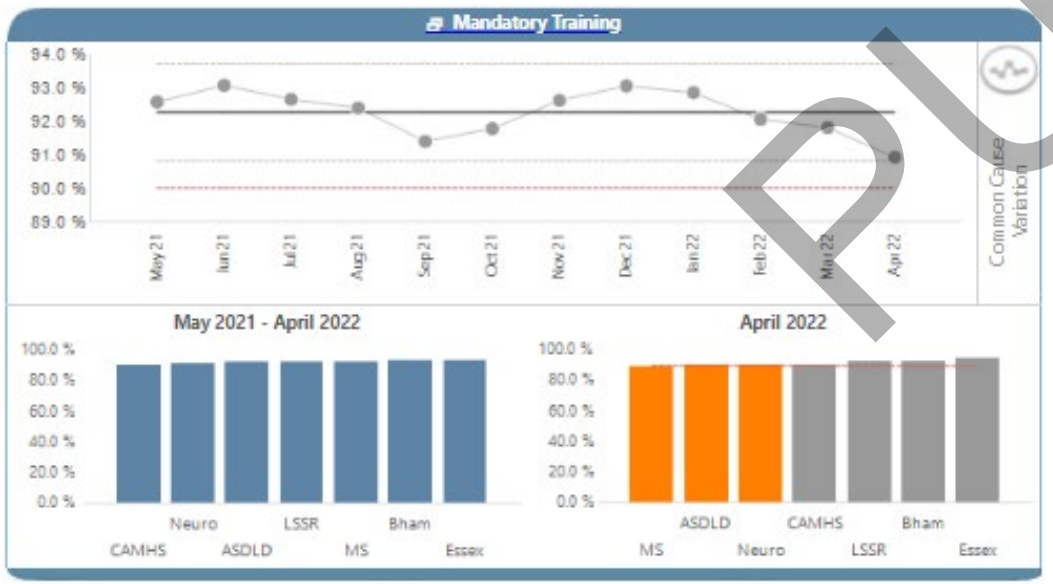
- Significant recruitment activity is underway, including international recruitment
- Pipeline and assessment capacity increased
- Regular WorkChoice Nurses and HCAs being converted to substantive flexible contracts
- Advertising all posts as part time / flexible to increase potential candidate pools (early indications are that this approach is having an impact - WTE of existing HCAs averages 0.95, WTE of incoming pipeline averages 0.86)

Securing the retention initiatives will bring forward the trajectory for target establishment achievement

*the SPC for HCAs is pending rebasing due to the change in establishment methodology

Exception reporting – agency spend & training favourable to target





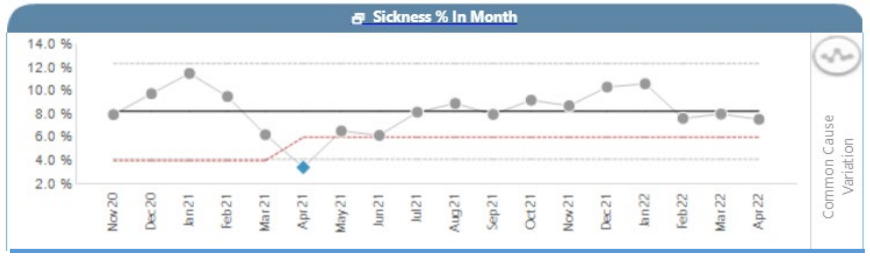
Charity wide agency spend is 1.75% and remains low with a cost in April of £94k. All divisions are below the tolerance except CAMHS at 10.8% (this reflects planned and consistent agency utilisation in order to mitigate a period of under establishment).

The current levels reflect a lack of availability of agency staff and a highly competitive market place. The Charity continue to work closely with agencies with the intention of increasing supply for specific wards to support staffing.

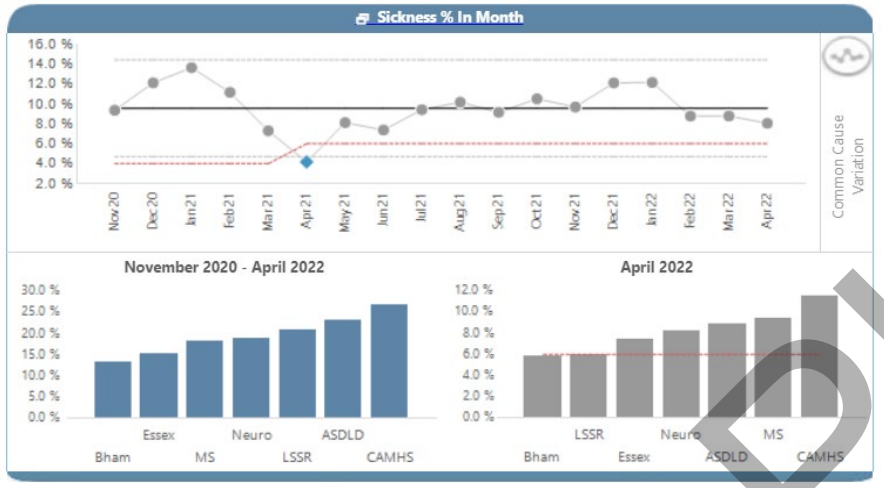
Training remains favourable to target at a Charity level. Medium Secure, Neuro and ASDLD are marginally below the threshold, all at 89-90%. The Charity is currently focused on increasing the volume of staff trained in BLS (79%) and SIT, replacement for MAPA, (84%). Ward staffing levels has restricted the number of staff available to be released for training. The Charity's training levels continue to benchmark favourably.

Exception reporting – sickness adverse to target

Charity wide



Inpatient divisions



At a Charity level sickness has remained largely static since February, standing at 7.25%* for April (7.8% for divisions & 5.9% for enabling functions) equating to 28,430 hours of working time, at a cost of £450k (£256k for wards). Sickness absence remains in excess of the charity wide target and continues to have a significant impact on ward staffing and productivity.

Short term absence levels remain higher than budgeted for and there are 69 long term absence cases (78 in February). For divisions, in addition to commitments to reduce sickness absence the Charity is focused on reducing all forms of non-patient facing shift.

Remedial actions:

- A project group has been set up with a priority focus on reducing sickness absence and non-patient facing shifts – the impact of each strand of the project is being assessed in order to prioritise resources. A key strand is supporting managers to support employees back to work – with improved MI an enabler
- The employee relations team are providing central management for long term sickness cases
- A continued focus on wellbeing supporting colleagues to stay well

*final figure likely to be higher due to lag in RTW forms

Finance Overview

Financial Year 2021/22

March 2022 Full Year Performance v FYF

- **Net deficit £12.3m - £2.2m lower than FYF**
- Operating Deficit £3.7m lower than FYF, mainly due to :
  1. Lower staffing costs and ward costs
  2. Income £0.8m ahead of FYF, mainly due to Qtr3 and Qtr4 COVID cost recovery claim (not forecasted)
  3. Occupancy slightly below FYF but different patient mix has mitigated any income variance
  4. Enabling function costs were in line with forecast and all cost challenges were achieved
- Non Operating Costs were £1.5m higher than forecast, impacted by one off events, including RCF extension, Workbridge restructure and Investment Portfolio valuation decline (linked to stock market movement in Qtr4)
- **At March 2022 cash held was £6m - £2m better than forecast** (relational to better operating position)
- **No covenant breach risk has occurred during 2021/22**

	March 22 Full Year			Full Year		
Financial Performance - £m	Actual	Forecast	Variance	Forecast	Budget	Variance
Income	159.2	158.4	0.8	158.4	171.4	(12.9)
Direct & Indirect Costs	(124.0)	(126.6)	2.6	(126.6)	(128.7)	2.1
Net Contribution	**35.2**	**31.8**	**3.4**	**31.8**	**42.7**	**(10.8)**
Enabling Services	(30.1)	(30.1)	0.1	(30.1)	(30.3)	0.2
Depreciation	(13.4)	(13.6)	0.2	(13.6)	(13.7)	0.1
Operating Surplus/(Deficit)	**(8.2)**	**(11.9)**	**3.7**	**(11.9)**	**(1.3)**	**(10.6)**
Non Operating Costs	(1.1)	(1.0)	(0.2)	(1.0)	(1.5)	0.6
Exceptional Costs	(1.8)	(0.9)	(0.9)	(0.9)	(0.6)	(0.3)
Disposal of Fixed Assets & Impairment	(0.3)	(0.4)	0.1	(0.4)	0.0	(0.4)
Project Costs - OPEX	(1.5)	(2.0)	0.5	(2.0)	(4.0)	2.0
Investment Gains/Losses	0.7	1.6	(0.9)	1.6	0.0	1.6
Net Surplus/(Deficit)	**(12.3)**	**(14.5)**	**2.2**	**(14.5)**	**(7.4)**	**(7.1)**
	March 22 Full Year			Full Year		
Occupancy	Actual	Forecast	Variance	Forecast	Budget	Variance
Available Beds	691.5	692.2	(0.7)	700.1	700.5	(0.4)
Avg Occupied Beds	575.6	579.1	(3.5)	579.1	621.8	(42.8)
Occupancy %	83%	84%	(0%)	83%	89%	(6%)

Financial Year 2022/23

April 2022 Actual Performance v Budget

- **Net deficit £1m - £0.1m lower than budget**
- In April 2022 we saw our largest increase in occupancy for several years
- However, occupancy was slightly behind plan (mainly due to external factors and delays from commissioning authorities) **with 98% achievement of budgeted income**.
- **Offset by positive movement in costs of £0.4m** (£0.3m Operational & £0.1m Overheads)
- At March 2022 cash held was £5.3m and no covenant risk existed

Qt1 Outlook Performance v Budget

- For the next quarter we expect similar trend to continue. **Shortfall in income but offset by costs and budgeted net deficit achieved.**
- Occupancy growth is critical to achieving the financial budget and growth continues - notwithstanding factors outside of our control.
- CQC have recently reduced the approval criteria for Wards under S31 restrictions (allowing one admission per ward per week without CQC approval) and this will assist the continued occupancy growth.
- Cash and covenants are expected to track inline with budget.

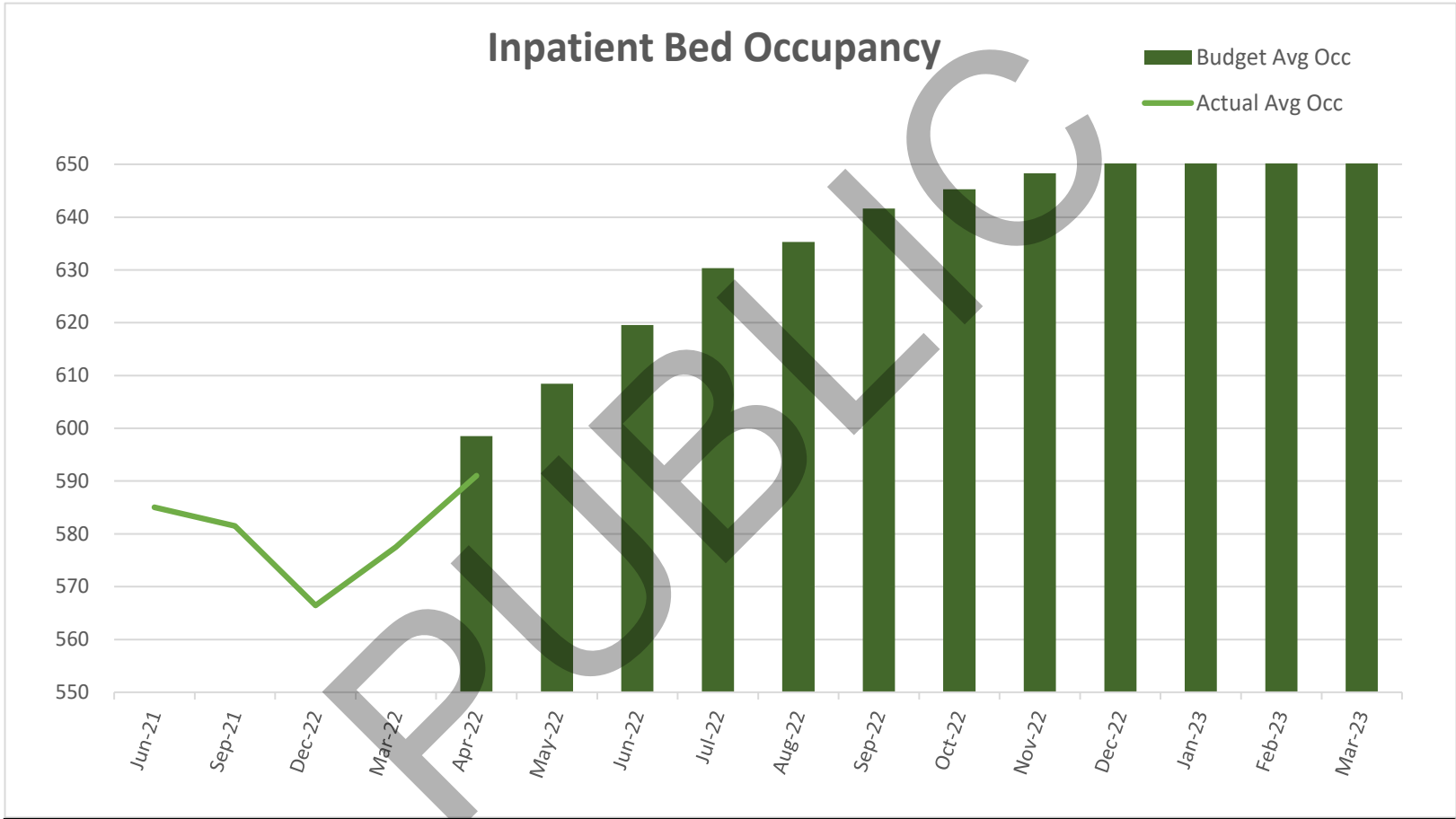
	Apr-22			Full Year
Financial Performance - £m	Actual	Forecast	Variance	Budget
Income	13.40	13.68	(0.28)	176.08
Direct & Indirect Costs	(10.47)	(10.73)	0.26	(130.41)
Net Contribution	**2.93**	**2.95**	**(0.02)**	**45.67**
Enabling Services	(2.72)	(2.79)	0.07	(31.88)
Depreciation	(0.94)	(0.98)	0.04	(11.26)
Operating Surplus/(Deficit)	**(0.73)**	**(0.82)**	**0.09**	**2.53**
Non Operating Costs	(0.05)	(0.05)	0.01	(0.37)
Exceptional Costs	(0.11)	(0.11)	0.00	(1.00)
Disposal of Fixed Assets & Impairment	0.00	0.00	0.00	(0.25)
Project Costs - OPEX	(0.16)	(0.18)	0.02	(3.33)
Investment Gains/Losses	0.00	0.00	0.00	0.00
Net Surplus/(Deficit)	**(1.04)**	**(1.16)**	**0.12**	**(2.42)**

Balance Sheet & Cashflow

St Andrew's Consolidated Balance Sheet	Mar-21 Audited	Jun-21 Actual	Sep-21 Actual	Dec-21 Actual	Mar-22 Actual	Apr-22 Actual
	£M	£M	£M	£M	£M	£M
Intangible and tangible fixed assets	209.0	205.9	203.3	198.2	196.6	195.6
Investments						
Stock Market Investments	15.7	15.8	15.9	17.6	11.6	11.6
Investment Properties	5.7	5.7	5.7	5.7	5.7	5.7
Current Assets						
Stock	0.6	0.5	0.4	0.5	0.4	0.4
Trade debtors	7.3	10.4	9.0	9.6	8.2	9.6
Other Debtors & Accrued Income	5.2	5.6	6.1	4.4	4.1	4.3
Prepayments	1.7	1.3	1.6	2.0	1.8	1.6
Cash	5.8	4.1	4.5	5.8	6.0	5.3
	20.6	**21.9**	**21.6**	**22.3**	**20.5**	**21.2**
Current Liabilities						
Trade Creditors	(7.6)	(4.9)	(3.8)	(2.8)	(3.3)	(3.6)
Taxation and Social Security	(3.1)	(3.4)	(3.6)	(2.8)	(2.8)	(2.9)
Other Creditors & Accruals	(8.5)	(8.6)	(9.0)	(8.6)	(8.3)	(8.3)
Staff Accruals	(4.0)	(3.3)	(3.6)	(4.4)	(4.4)	(4.6)
Deferred Income	(2.5)	(2.7)	(3.5)	(4.3)	(2.5)	(2.7)
	(25.7)	**(22.9)**	**(23.5)**	**(22.9)**	**(21.4)**	**(22.1)**
Net Current Assets/(Liabilities)	**(5.2)**	**(1.0)**	**(2.0)**	**(0.5)**	**(0.8)**	**(0.9)**
Total Assets Less Current Liabilities	**225.2**	**226.4**	**223.0**	**221.0**	**213.1**	**212.1**
Bank Loans (between 1 and 5 years)	(19.8)	(24.8)	(24.9)	(24.9)	(20.0)	(20.0)
Pension Scheme Liability	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)
Total Assets Employed	**204.7**	**200.9**	**197.4**	**195.4**	**192.4**	**191.4**
Reserves	**204.7**	**200.9**	**197.4**	**195.4**	**192.4**	**191.4**

Cashflow Summary - £m	Full Yr 2021/22 Actual	April 2022 YTD
Net Surplus/(Deficit)	(12.31)	(1.04)
Add Back Non Cash Items		
Depreciation	13.39	0.94
Fixed Asset Impairment/(Profit on Disposal)	0.28	0.00
Investment Portfolio Valuation Movement	(0.94)	(0.01)
Net inflow/(outflow) from Operations	**0.42**	**(0.12)**
Total inflow/(outflow) - Working Capital	(4.00)	(0.59)
Total inflow/(outflow) - Capital Expenditure	(3.00)	0.00
Total inflow/(outflow) - Asset Disposal	1.75	0.00
Total inflow/(outflow) - Investment Portfolio	5.00	0.00
Total inflow/(outflow) - Loan Facility	0.00	0.00
Net Cash (Outflows) / Inflow	**0.18**	**(0.71)**
Cash at the beginning of the period	**5.82**	**6.00**
Total Cashflow Movement	0.18	(0.71)
Cash at the end of the period	**6.00**	**5.29**

Occupancy



	Jun-21	Sep-21	Dec-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Budget Avg Occupancy					599	608	620	630	635	642	645	648	651	658	658	658
Actual Avg Occupancy	585	582	566	577	591											
Actual % Achievement					98.7%											

IT Security overview

IT Security Metrics (Jan – Mar 2022)

Legend	No Change	Trending Down	Trending Up

	JAN	FEB	MAR	RAG Rating	March – *Causal*	March – Remediation
Vulnerabilities not fixed within SLA Highlights the amount of infrastructure vulnerabilities that haven't been fixed within the agreed timescales	0	0	0		**Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix.	**Remedial Actions:** IT Security and Advanced will continue to monitor and track SLA breaches and raise any Non-Conformances if required.
Overdue Penetration Test Remediation The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue.	0	0	0		**Causal Analysis**: No overdue actions again this month. Network Segregation Penetration Test currently in scope, to be conducted by Bulletproof in April.	**Remedial Actions:** None
Security Incidents Trend of Priority 1, Priority 2 and Priority 3 incidents	P1 0 P2 0 P3 1	P1 0 P2 1 P3 4	P1 0 P2 0 P3 5		**Causal Analysis**: All incidents in March related to phishing attacks. There was no clickers and for 3 of the phishing emails the landing page URL was already blocked by Forcepoint.	**Remedial Actions:** IT Security are reviewing the current phishing awareness methods as a multi-pronged approach is required. 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well.
Blocked Network Attacks These are blocked network attacks directed at our external network edge	46,699	59,214	48,669		**Causal Analysis**: We are constantly being port scanned and probed by external threat actors. Our firewall is configured to block this traffic. Russian IPs are automatically dropped and blocked at the firewall.	**Remedial Actions:** Enhanced monitoring owing to the ongoing war in Ukraine and the increased cyber risk to the west.
Overdue IT Sec Audit Actions Number audit actions and their rating from scheduled internal and external audits.	0	0	0		**Causal Analysis**: There has been positive engagement from action owners. Updates have been provided with some actions closed.	**Remedial Actions:** Regular catch ups are conducted with audit action owners. Next steps will be automation from 4action and ensuring action owners have visibility of 4action. (External Audit OBS)
Outstanding Operating System Patches % of devices patched across the infrastructure. Separated into server and endpoint estate	Servers = 93% Client = 92%	Servers = 93% Client = 96%	Servers = 92.8% Client = 95.6%		**Causal Analysis**: An average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). Client devices are all built to a government secure industry standard, have anti-malware installed, are protected by the web filter even off the network and have firewalls enabled	**Remedial Actions:** The patching process for client devices is due to be reviewed with more staff working remotely or not being based in an office which causes some delays e.g. Community Partnerships.
Anti-Malware Installation Compliance % of machines on the network that have anti-malware protection installed and enabled	100%	100%	100%		**Causal Analysis**: None	**Remedial Actions:** None
Blocked Attacks on Staff Accounts Attempted logins from malicious actors to staff accounts. These aren't successful and are flagged by our SIEM tool	14	21	22		**Causal Analysis**: Attackers perform password attacks against accounts they find on LinkedIn or through other means. They will use 1000s of common passwords through automated tools. Finance is the most targeted department per ratio of 100 staff	**Remedial Actions:** IT Security monitor these on a daily basis and will investigate to ensure they are not successful. High risk departments have Multi-Factor Authentication enabled e.g. Finance, HR, IT, Estates.
Security Awareness % of applicable staff who have completed their e-learning module on cyber security & information governance	91%	88%	89%	135	**Causal Analysis:** L&D are seeing challenges in staff booking and being released to attend training with the current staffing challenges. Not at the required level of 95% for the Data Security & Protection Toolkit.	**Remedial Actions:** IT Sec & Info Gov have revised the training and are looking to have different training courses for different job roles to ensure staff are getting the right information at the right level. Currently with L&D to implement.

Navigating St Andrew's SPC charts

Target line

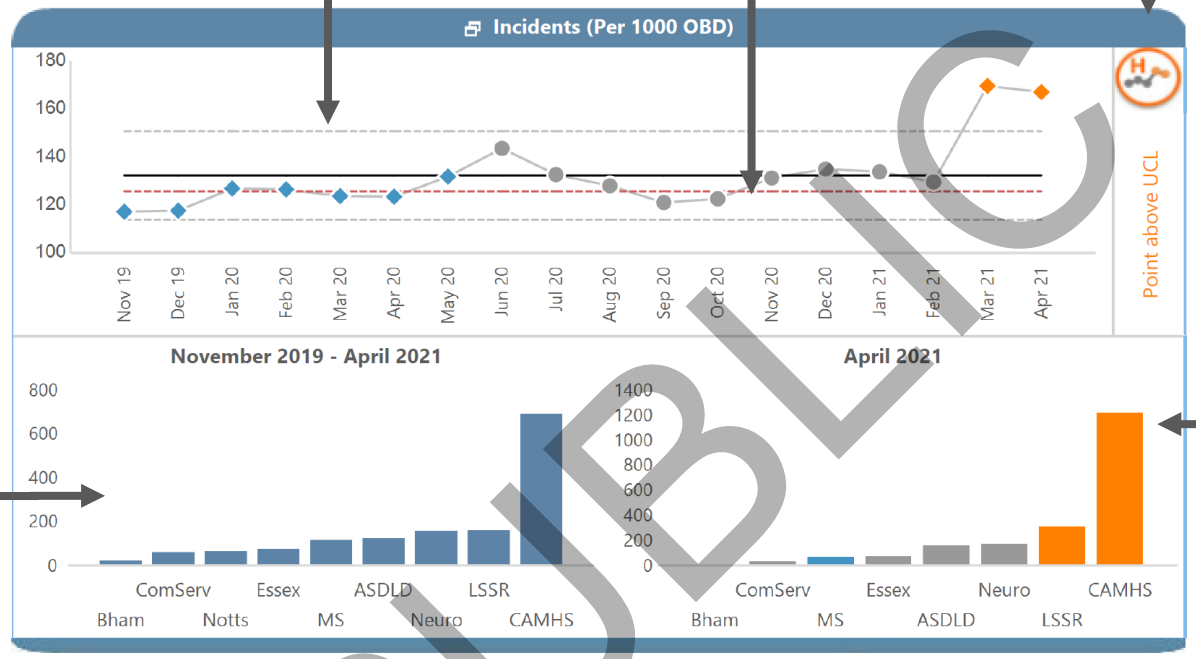
Proposed target for the KPI

SPC icon for the latest month

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

Charity level SPC chart

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



Division average for the last 18 months

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

Latest month by Division

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

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

Example Narrative

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

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

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

Divisional Presentation (including Patient Voice)

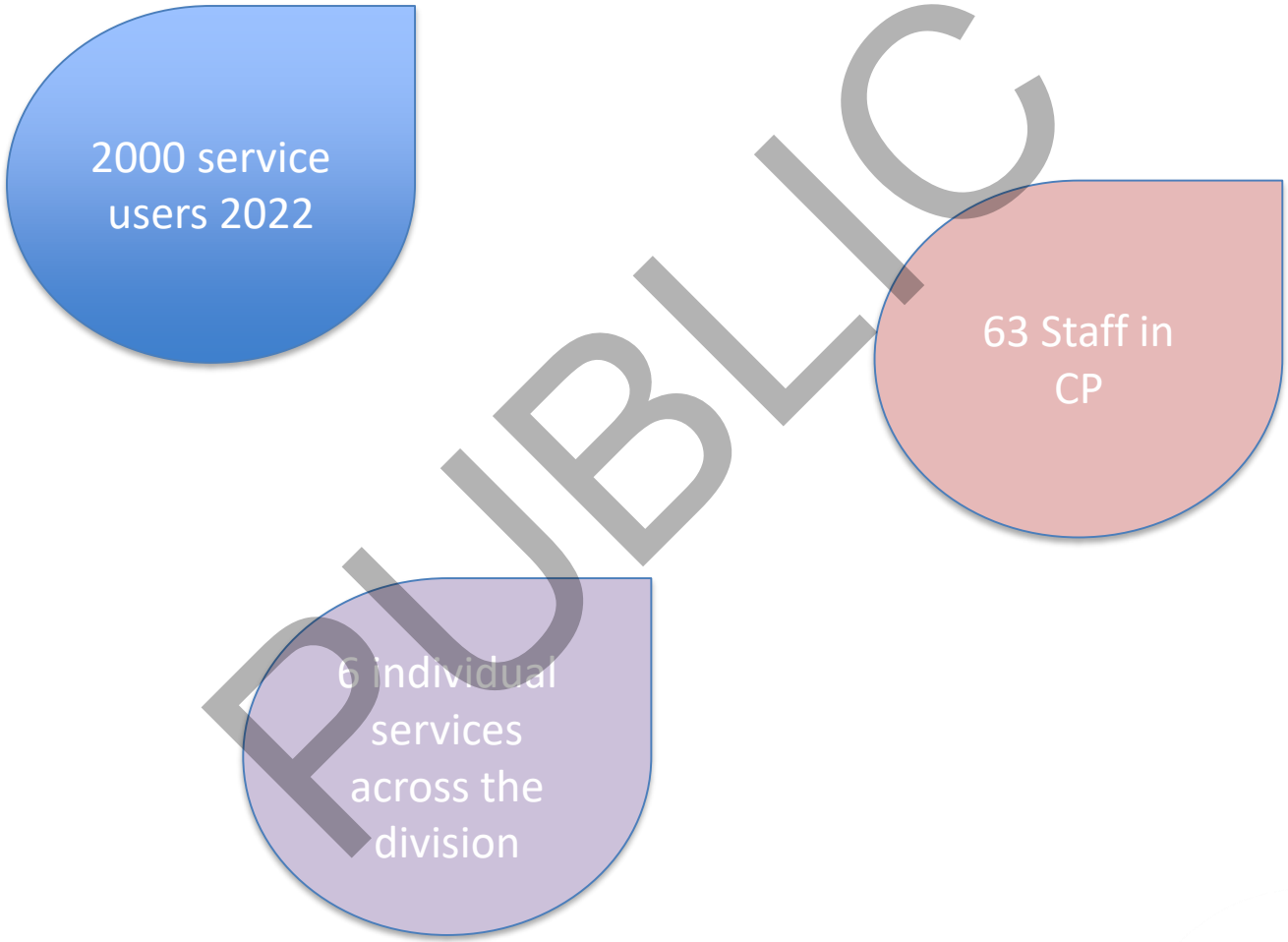
Community Partnerships

Dr Sanjith Kamath
Cat Vichare

Community Partnerships Divisional Presentation

Catherine Vichare – Clinical Director

Community Partnerships Overview
Where are we now?



St Andrew's HEALTHCARE

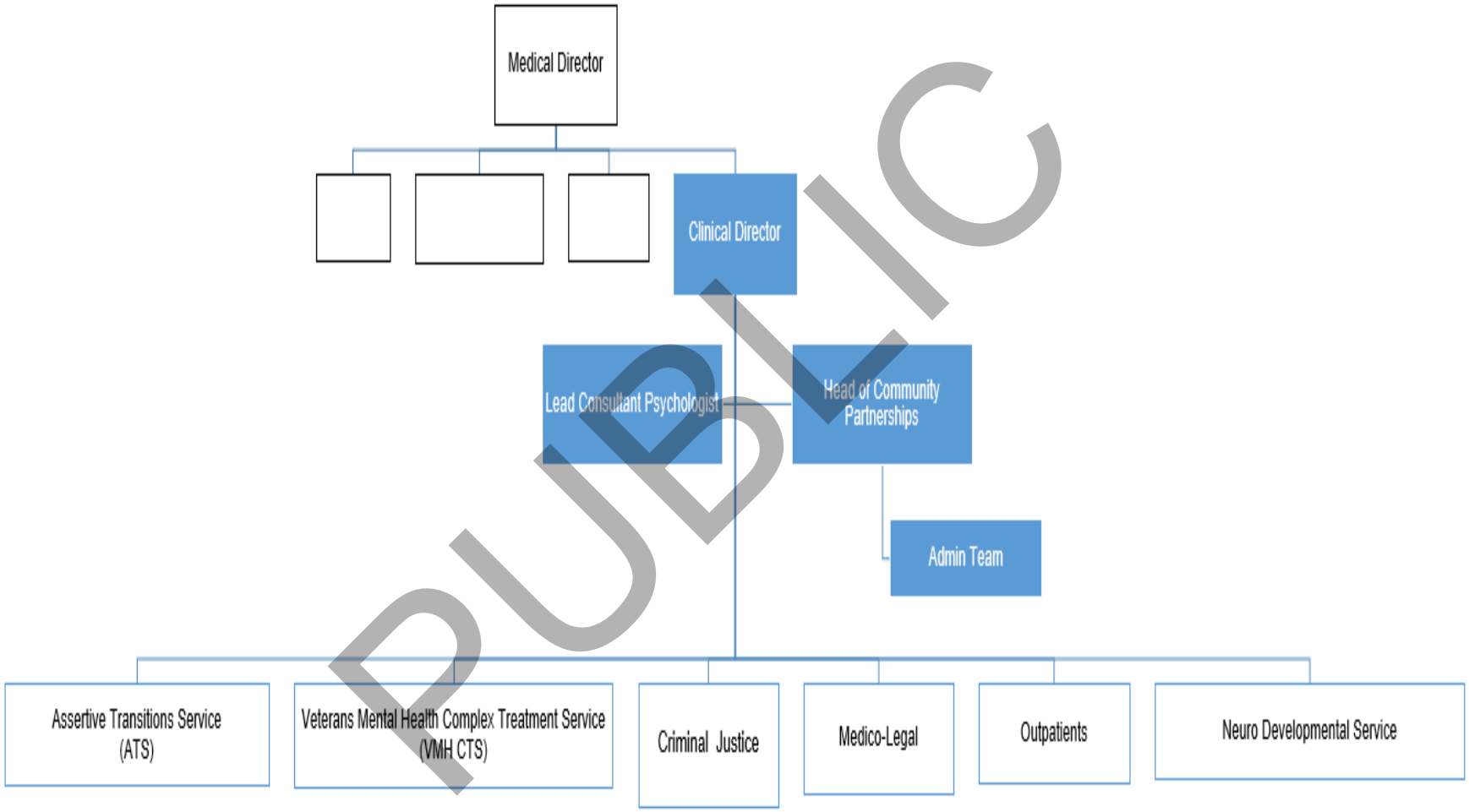
Community Partnerships Overview
4 year growth plan

CSTR – 1 additional tender per year – aim for 8 services by 2024/25

Plan to grow Neurodevelopmental Services to complete 2000 assessments per year by 2025/26

Aim to grow existing outpatients income by 5% year on year

St Andrew's HEALTHCARE


Medical Director
Clinical Director
Lead Consultant Psychologist
Head of Community Partnerships
Admin Team
Assertive Transitions Service (ATS)
Veterans Mental Health Complex Treatment Service (VMH CTS)
Criminal Justice
Medico-Legal
Outpatients
Neuro Developmental Service

Criminal Justice
Clinical Lead Dr James Fowler

- In June 2021 our contract with the National Probation Service ended. Rather than this being a challenge, we moved our resources into our existing (limited) CSTR Services
- The Community Sentence Treatment Requirements (CSTR) Programme is a sentence ordered by the courts as a possible alternative to a custodial sentence.
- As of May 2022, we are actively providing CSTR services in Essex, London, Reading and Oxford, mobilising Maidstone.
- Our services in Essex and London have received 284 referrals since they were established in June 2021
- Awaiting confirmation from NHSE for Norfolk and Suffolk CSTR Services.

St Andrew's HEALTHCARE

Veterans CSTR
Clinical Lead Dr Melanie Coxall
Team Lead Adele Barrett

- Veterans accessing the CTS are requiring mental health support, as a consequence of trauma related to their military service.
- Between 1 April 2021 and 31 March 2022 the Veterans' Complex Treatment Service supported 232 veterans.
- St Andrews signed the Armed Forces Covenant in November 2021, and we are delighted to have now been awarded Bronze in the Defence Employer Recognition Scheme.
- During 2021, the CTS team supported the Royal College of Psychiatrists in developing and launching the Quality Network for Veterans Mental health Services QNVMHS). We were delighted to be ranked top following our own peer review
- Service Retender is commencing in June 2022, and we are working closely with partners in the East of England and East Midlands to continue to provide this service.

St Andrew's HEALTHCARE

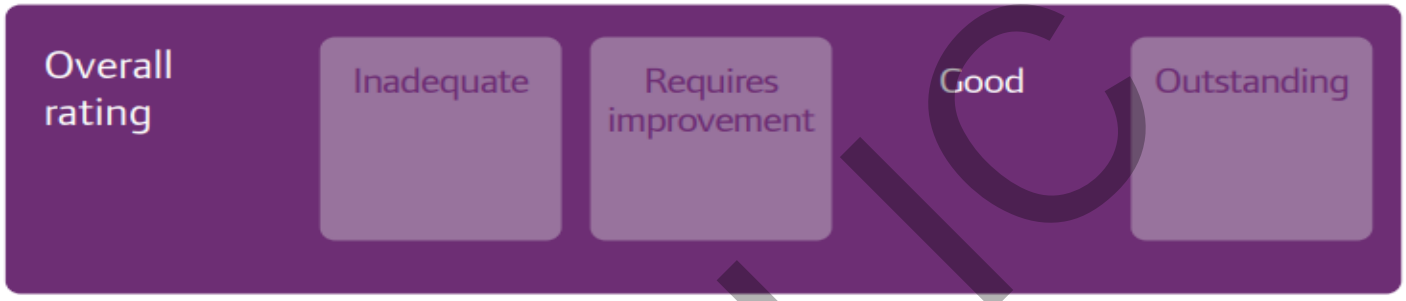
Assertive Transition Service
Clinical Lead Dr Carly Wilson
Team Lead Tawanda Pendeke

- Commissioned by IMPACT (the Provider Collaborative across the East Midlands) the ATS is a partnership between Nottinghamshire NHS FT and St Andrew's.
- The ATS employs peer support workers who bring their lived experience to the team and service users.
- Additionally Framework and Rethink staff are embedded within each team bringing carer support, employment support, substance misuse expertise and community based support workers.
- The teams will work with service users for up to a year supporting them in their transition from a secure in-patient settings to a sustainable community placement.
- Between 1 April 2021 and 31 March 2022, the ATS supported 34 individuals in their journey out of secure care.
- IMPACT have recently recommissioned STAH and Nottinghamshire NHS FT to continue to provide ATS for a further 2 years.

Out-Patients and Community Services Clinical Lead Dr Sophie Littler

- Out patients is primarily private therapy but it is often where we pilot services.
- Between 1 April 2021 and 31 March 2022 our clinicians offered 1039 sessions and undertook 439 assessments for adults and young people.
- In 2018 we set up a service supporting NHS Trusts in addressing the backlog of child and adolescent and adult ADHD and ASD assessments. Working closely with NHS clinicians our staff, who in most case hold honouree contracts with the Trust, undertake assessments on behalf of the Trust. By working collaboratively with the Trust existing ND team we are ensuring that if a positive diagnosis is made there is minimal delay in the child and their family accessing the appropriate support pathway within the NHS Trust.
- We currently are working with 4 local NHS Trusts, assisting them in their waiting list reduction schemes.

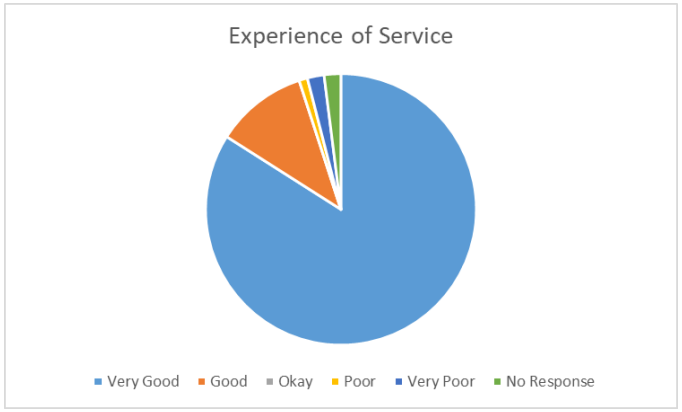
Community Partnerships

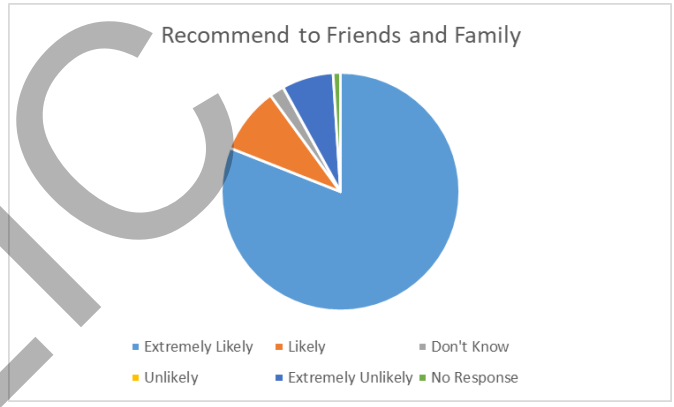


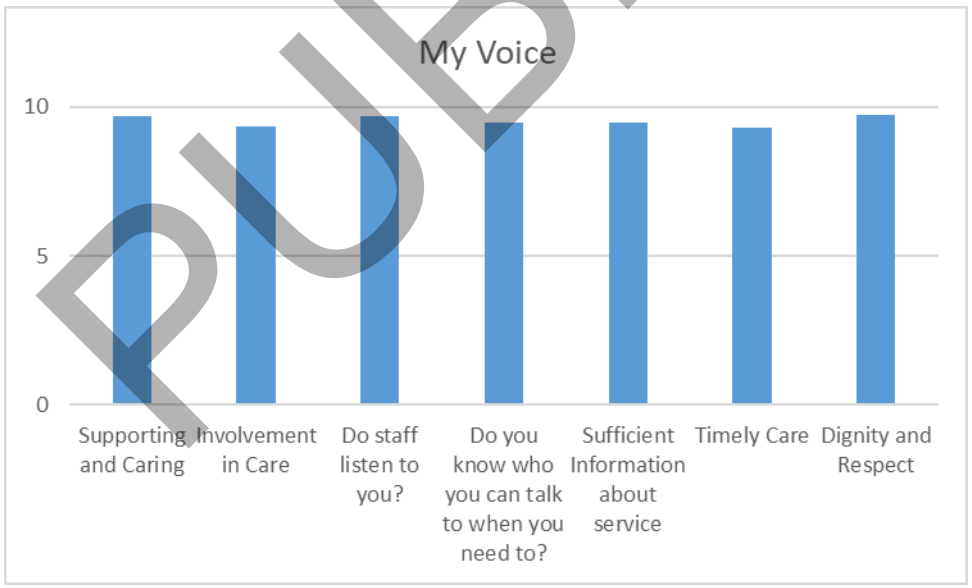
Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well-led?	Good

My Voice (PREMS)







Service User Experience

- St Andrew’s to host Northampton veteran Hubs » St Andrew's Healthcare (stah.org)
- Essex mental health reoffending prog gives woman New Year hope » St Andrew's Healthcare (stah.org)
- ‘Desperate’ Headfest attendee says Northampton festival experts have given him ‘hope’ | Northampton Chronicle and Echo
- St Andrew’s Healthcare mental health community service rated 'good' in first watchdog inspection | Northampton Chronicle and Echo
- Luton army vet on the mental health charity that helped save his life | Luton Today

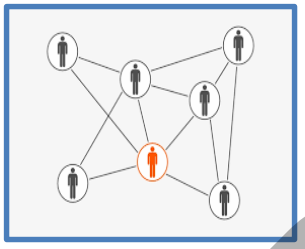
Community Partnerships Strategy

Our vision

"Go to" provider of high quality, partnership delivered, accessible to all, specialist mental health community services.

Strategic Priorities

Cement our positon in the provision of our existing flagship services



Create a national network of accessible out patient mental health services

Design agile services that are able to mobile rapidly to changing demands

Develop a nationally recognised assessment centre for neurodevelopmental disorders

To be a financially sustainable business unit, with income exceeding costs allowing reinvestment in future service innovations

Enablers

Charitable Status

inclusive, accessible and compassionate

Quality of Care

Governance Approach aligned to NHS framework, positive regulatory body feedback

Operational Foundations

strong finance management, new business tender experience, agility to mobilise positive partnerships

St Andrew's HEALTHCARE

2022 Focus

- Successful re-tender for Veterans CTS
- Addition of at least 1 CSTR Service
- Expansion of Outpatients including mobilisation of Birmingham Consultancy Service
- Development of Supervision Hub with East Midlands Alliance
- Extending Business to Business Opportunities
- currently exploring work with local and national Financial Services to develop Mental Health Wellbeing in the workplace packages

St Andrew's HEALTHCARE

Summary

- **Risks**
- Recruitment
- Agility in establishing new services

- **Positive Messages**
- Demand for Neurodevelopmental Assessments is a growing.
- Community Partnerships Strategy Completed, and aligned with Charity Service Innovation Objective.
- CQC Report
- Feedback from Service Users via Care Opinion and PREMS is incredibly complimentary.

Paper for Board of Directors	
Topic	R&I Strategy and Implementation Plan
Date of Meeting	Friday, 27 May 2022
Agenda Item	**15**
Author	Stanton Newman, Paul Wallang and Kieran Breen
Responsible Executive	Stanton Newman
Discussed at Previous Board Meeting	Not previously discussed by the Board
Patient and Carer Involvement	Meetings with PALS (N Lintott and R Amena). Bryan Green is Carer representative on the Research Committee and has been involved in the document discussions from the start.
Staff Involvement	Widespread stakeholder engagement, including Exec, Divisional Leads, Academic Centre, Psychiatrists, Psychologists and MDT
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒
Strategic Focus Area	Education and Training ☐ Finance & Sustainability ☐ Service Innovation ☐ Quality ☐ Research & Innovation ☒ Workforce, Resilience & Agility ☐ Partnerships & Promotion ☐
Committee meetings where this item has been considered	Research Committee

Report Summary and Key Points to Note

Please see the attached R&I Strategy document and accompanying Implementation Plan.

Appendices

Research and Innovation Strategy

Contents

Introduction

This strategy sets out an ambitious vision for a step change in the way research and innovation is delivered at St Andrew's Healthcare. It is aimed to support a significant transition from an organisation where research is not prioritised to one with a research and innovation capability and performance that has both a national and international standing. The strategy is intended to be purposefully ambitious in recognition of the fact that St Andrew's Healthcare is striving for excellence through the development of a strong culture of research and innovation in every part of the organisation, in order to ensure that all staff engage in, support, or consume research and innovation activities or products. It is widely accepted that high quality research carried out within a healthcare organisation is translated into improved patient care (Jonker and Fisher 2018). The achievement of this vision will have beneficial and mutually reinforcing effects on multiple areas of the charity and is designed to clearly identify St Andrew's as a leading force in mental health practice and policy, both in the UK and wider arena.

Aim

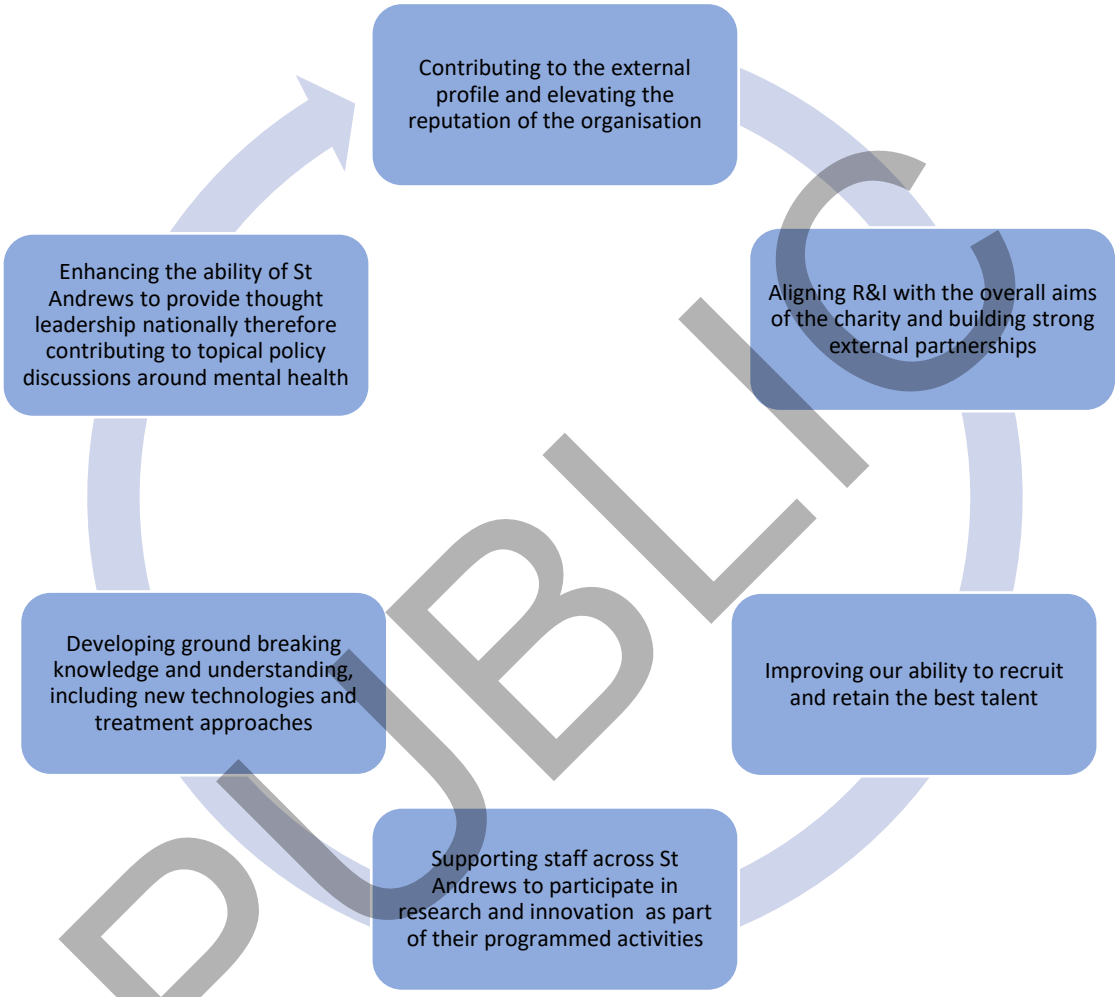
The goal of this research strategy is to move St Andrew's into a position where the charity's name is synonymous with outstanding innovative translational research within the mental health field, so that external audiences automatically associate the charity with being at the forefront of mental health thought leadership, treatment practices and policy.

Why is research and innovation important to St Andrew's Healthcare - why should the Charity invest in research and innovation?

The development and introduction of the best technology and systems for the treatment of patients with complex mental health disorders requires a solid evidence-based approach. This can only be achieved where there is a strong and cutting-edge research-based culture. The best outcomes for patients are achieved in centres of excellence, where evidence-based care is developed by combining scientific and technological advances. World-class research supports innovation and the development of state-of-the-art mental health therapies through the mechanism of clinical research that will impact positively on patient experiences and outcomes. It also supports the development of an interdisciplinary research approach which can impact on all aspects of a patient's journey while at St Andrew's and the subsequent stages of their healthcare journey. The development of research collaborations with additional experts in the field will facilitate the development of a research culture at St Andrew's; for example through the establishment of joint MSc and PhD studentships that will strengthen specific research themes.

The unique nature of St Andrew's which includes the treatment of patients in care as well as those in the community, means that it is critical for us to be at forefront of the development and introduction of ground-breaking research that will have a direct and tangible evidence-based impact at all stages of a patients care and transition. It is also important to acknowledge that St Andrew's cannot achieve this alone. By developing a reputation for high quality innovative and translational research, the charity can develop partnerships with other key stakeholder organisations, in the clinical, social, and academic sectors. The longer-term aim is for the charity to be considered as a "go to" mental health facility with whom partnerships can be formed to develop state of the art clinical research programmes. Furthermore, the development of a solid research reputation will attract research-active clinical staff to take up clinical posts, potentially with an academic partner, to expand the research-

based reputation of the organisation. The current global socio-economic situation is changing rapidly and unpredictably. The last year has seen major challenges in the form of a pandemic and rapidly widening inequalities. Considering the current challenges and those that lie ahead, this document argues that building a strong research and innovation capability will have beneficial effects on multiple areas of the Charity and act as a 'virtuous circle' for the organisation, helping to improve its overall effectiveness and corporate resilience as depicted in Fig 1 (Below):



Transforming the culture

Although research and innovation is present within the charity, is not consistent and significant attention will need to be given to building a research-based culture at all levels of the organisation. This approach also needs to be integrated into other aspects of the organisation, particularly teaching and education. It is envisaged that there will need to be a programme of cultural transformation over an initial five-year period to embed the desired changes. This will require high level support and robust coordination through regular seminars, workshops, conferences, and other forums to improve understanding and engender enthusiasm for and a commitment to, a research and innovation culture. An initial coalition of interested and enthusiastic individuals could start this work with a view to gradually expanding the opportunities and nurture an understanding around the importance of research and innovation throughout the wider organisation. Ultimately R&I must become an integral and valued part of all staff IPDR performance reviews.

Research and innovation for all

It is vital that research and the uptake of new innovations is not observed as being carried out by a small number of specialist professionals within the organisation but rather as an underpinning principle of everything that we do with an opportunity for all to be involved, either in contributing to the R+I effort or consuming its products. It is critical to nurture curiosity in the charity so that all clinical professionals become consumers of research. Helping everyone to believe that they can participate in research that will translate into benefits for patients and staff will take careful planning. This is a fundamental change in culture and, as such, will require a sufficiently resourced change management plan. Such a plan will be developed at the implementation stage and will include milestones and a solid communication strategy.

History of research and innovation at St Andrew's

St Andrew's has an extraordinary history. During its first 150 years, the Charity established a formidable reputation for innovative clinical practice and the ethical and humane treatment of patients. Notable examples include: the abolition of mechanical restraint in 1839, treatment advances including the introduction of electrical convulsive therapy in 1941, and more recently, being one of the first hospitals in the UK to offer Dialectical Behaviour Therapy (DBT) in the 1990s. These ground-breaking treatment approaches provided the Charity with a national reputation and a sustainable competitive advantage. St Andrew's has also been at the forefront of the development and validation of numerous clinical rating scales that are now in routine use nationally and internationally. These include HoNOS, START and SASBA and they are frequently used as outcome and risk assessment measures in the evaluation of new therapeutic approaches. More recently the charity has been engaged in the ground-breaking use of virtual reality technology with dementia patients, a multicentre study looking at the use of antipsychotics in personality disorder and a large inequalities project commissioned by NHSE.

How will we focus on innovation?

Considerable research and literature has accumulated concerning which conditions lead to organisations developing a deep and consistent capability around innovation. It is now generally understood that there are four fundamental facets that need to be in place to nurture innovation (Dyer et al 2011):

- Strong leadership that supports and participates in innovation
- A deep culture of experimentation where everyone in the organisation has a questioning attitude and understands what innovation means and its benefits
- Organisational support that allows staff to have dedicated time to develop innovative ideas
- An infrastructure that allows ideas to feed through and coordinates the available resources to enable the ideas to develop.

Given that these four ingredients articulated by Dyer et al (2011) are generally considered to be the fundamental components of innovation, the question is about how St Andrews can establish these principles to develop a strong capacity around innovation, and will be the subject of separate implementation plan.

Where do we want to be in in 2026?

- Research and innovation will be considered as underpinning all functions of the organisation and all staff will have a clear understanding of the organisational benefits.
- There will be a clearly enhanced research reputation with St Andrew's viewed by external partners (NHSE, academia, industry etc.) as an innovative organisation that facilitates world-leading research and innovation including the testing of new therapies
- The Charity will be carrying out high-quality research as evidenced in peer-reviewed publications and presentations at national and international meetings
- We will have multiple partnerships in the development of joint posts, thus expanding our research portfolio as well as developing our reputation as an academic research institution
- We will have achieved successful applications for research funding directly from St Andrews and also in collaboration with academic partners
- Our academics in joint posts will participate in NIHR-funded clinical studies in collaboration with key players in the mental health research field
- Self-funding researchers (e.g. NIHR fellowships) will choose to be located at St Andrew's
- Staff throughout the Charity will be provided with an opportunity to carry out research projects, aligned with the charity's research priorities and as part of their programmed activities. There will also be a diverse range of workshops, conferences and other opportunities to learn and become involved in (or consume) research and innovation.
- A robust financial model will be developed including the identification of long-term income streams to ultimately allow the core research activities to become self-financing and sustainable.
- We will be able to clearly evidence the impact of R&I activities on our clinical care and patient recovery.
- The charity will also be regarded as an exemplar institution for co-production practices and patient participation in its R&I activities.

The relationship between research and education

There is an integral relationship between research and education with the two disciplines have a synergistic connection. A vibrant research and innovation culture within St Andrew's will contribute to, and strengthen, the teaching capacity within the charity. Research will inform undergraduate teaching as well as developing opportunities for postgraduate research opportunities. These will cement research relationships with specific universities, and we already have examples of the successful placement of MSc students from the University of Buckingham enrolled in the Health Psychology course, and four joint PhD students with Loughborough University focusing on physical health and exercise. It is proposed that the research and teaching facilities be combined into a single Academic Centre, nurturing greater strength and overall capability. It would ensure that all students have an opportunity to participate in research and innovation projects as an integral part of their teaching programme and that they can support the programmes that are being developed within the charity. This approach is in line with other similar clinical institutions where there is an active cross-fertilisation between research and teaching. This set up, would also support the mixing of ideas between the two areas and the charity's research reputation would be highlighted through the hosting of joint workshops/conferences with professional bodies. Furthermore, as teaching is a source of income for the charity the integration with research and innovation will provide a key opportunity for research to ultimately become self-financing and sustainable.

The relationship between research and recruitment and retention

The development of a research and innovation culture at St Andrew's will ensure that all staff are provided with an opportunity to engage in research programmes or support the infrastructure that underpins the research. Protected programmed activities for clinicians who are interested in research will also help to attract and retain high calibre research-active individuals who are keen to pursue research careers alongside their clinical duties but currently cannot do so due to the unavailability of options with the charity. This will contribute to the 'virtuous cycle' as depicted above in Fig 1.

Research and Innovation supporting the wider charity strategy

A new Charity strategy (2021 – 2026) has been produced following a comprehensive board level strategic review. The renewed purpose of the charity is to 'promote wellbeing, give hope and enable recovery'. Research and innovation is one of the seven 'strategic priorities' and as such forms an important driver for strategic success. As with the other six strategic priorities, research and innovation will contribute directly to delivering the Charity's purpose through two of the stated enablers of 'building a diversified portfolio' and 'inventing the future':

- Helping to build a diversified portfolio - expanding research and innovation activities, building R&I capability and creating new and exciting academic, industry and state partnerships will contribute substantially to a renewed and modern charitable portfolio in keeping with the charity's vison.

- Supporting the Charity to invent the future – a stronger research and innovation capability will provide substantial support to the Charity's vision to 'invent the future' by engaging in innovation, championing improved understanding, contributing to ground breaking research leading to treatment advances and providing high-level thought leadership in the areas of mental health, developmental disabilities and neuropsychiatry.

Capabilities and resources assessment

- The charity has an existing IT capability that will support the intended research and innovation vision, although there may be a requirement for additional capacity
- We have a diverse range of clinical expertise that can be drawn upon for specialist research projects
- St Andrew's has one of the largest cohorts of patients suffering with severe mental health problems in the country which represents a considerable research asset.
- The charity has a dedicated research and innovation team with knowledge and experience.

Resources required

- A combined academic centre and research and innovation function to maximise the synergetic opportunities of research and education and ensure a unified approach throughout the charity.
- Joint academic posts, with clinical roles where appropriate, to support the priority research areas. It is envisaged that the joint clinical-academic research posts should be recruited on a staggered basis over an initial three-year period however, this will be subject to an implementation plan.

- A number of clinical secondment positions will be available on a rolling basis for staff members who have a particular interest in research that aligns with the charity's research strategy. This will be highlighted as part of the recruitment process for future clinical posts.

How we will choose the areas of focus for research

To ensure that the research at St Andrew's is focused, yet sufficiently adaptable to embrace innovative areas, the following cross-cutting areas have been proposed based upon:

- Areas in which St Andrew's has a specific research history or has developed strong research collaborations
- Areas that are likely to have the greatest benefit for St Andrew's patients
- An analysis of existing St Andrew's research strengths (SWOT)
- Discussion with key stakeholders about the areas that are most likely to provide a return on investment for St Andrew's
- An analysis of both national and international drivers for research and innovation (PESTLE)
- Areas of innovation in which St Andrew's can develop as a leader in innovative applied clinical research

These will be discussed as part of a future internal and external consultation process in order to finalise the key research focus areas. These areas should also align with the charity's overall strategic objectives including an increase in the provision of community services. Five potential research areas are considered below, although they may change following consultation with key stakeholders. It must also be considered that there should be a flexibility to allow adaptation to changes in the external landscape and the charity's clinical strategy.

Cross cutting area 1 (Physical healthcare and physical activity)

The problem…	**Why St Andrew's…**	**Our approach…**
The importance of physical health in mental health has been highlighted as an urgent national priority. We know from numerous studies that those people with a severe mental illness (SMI) are at much greater risk of poor overall healthcare outcomes and premature death (dying on average 15-20 years before those without SMI). There is an urgent need to research and address this major health inequality.	St Andrew's treats one of the largest cohorts of patient with SMI in the UK. Our patient group is particularly complex, and it is only through a multi-faceted approach that we can optimise their treatment to minimise their time with us and ensure that they are best prepared for the next stage of their recovery journey. Understanding, and therefore improving, the physical health outcomes of our patients would have a major impact on our patients' wellbeing and longevity and contribute to the national debate in this area. The charity already has developed strong research collaborations in this area and it has been identified as a priority area.	We want to see sustained improvements in our patients' health outcomes. To this end, we will prioritise 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 pathways designed for patients with SMI.

Cross cutting area 2 (Trauma focused care)

The problem…	Why St Andrew's…	Our approach…
Traumatic events can occur at any age and cause lasting harm. There is a huge unmet need for trauma-informed care in the UK and more research is desperately needed to develop effective therapies and interventions to alleviate the mental health consequences of traumatic experiences. Moreover, the recent pandemic has left large swathes of the population with enduring emotional distress which will require innovative treatment pathways.	The charity cares for many patients with a history of the most severe trauma ranging from adverse childhood experiences, PTSD, complex PTSD, and survivors of abuse. St Andrew's has a record of accomplishment in the production of high-quality studies on trauma and expertise in its management and treatment. It also has a particular strengths and competitive advantage in DBT skills and therapy where the charity is considered as a leader in the field.	We want to provide innovative trauma therapy and trauma informed services to our patients and contribute to the wider literature on this subject. Prioritisation will be given to researching the impact of early trauma, the intersectionality of trauma and other important determinants (ethnicity, diagnosis, gender). Exploring the outcomes of different therapeutic approaches and partnering with multiple national and international groups will be pivotal in developing this area.

Cross cutting area 3 (Community Mental Health)

The problem…	Why St Andrew's…	Our approach…
There is a strong socio-political shift towards providing care closer to home and away from hospitals. Community mental health services are therefore playing an increasingly important role in delivering mental health care across the UK. The NHS Long Term Plan and NHS Mental Health implementation plan 2019/20 – 2023/24 both set out a wide-ranging vison to transform the provision of community mental health care for adults with severe mental illness to enable faster and more equitable care to be delivered closer to home.	St Andrews already provides community care services (outpatients, veterans, ATS etc.) and has a large number of patients who are discharged into the community each year from the group's hospitals. Focusing on research which provides innovative and ground-breaking care solutions for those receiving mental health care in the community would align with the Charity's core purpose. Moreover, focusing on research which seeks to understand how we can reduce the length of stay for our patients whilst attaining the same outcomes and improving the efficiency and experience of discharge will would have a substantial benefit. St Andrews could also investigate novel community treatment solutions (e.g. telemedicine or semi/fully automated therapies such as computerised CBT) which have the potential to generate new	We will build on our existing strengths in this area and align with the national impetus to develop and expand community mental health care solutions. St Andrews already has several community services in operation (veteran's service, outpatients, ATS etc.) these will provide a firm foundation for further research and innovation. We will continue to encourage and develop projects which seek to understand the barriers to discharge and length of stay such as the current collaboration with Prof Jon Glasby's team at the University of Birmingham seeking to understand barriers to discharge for our ASD/LD patient.

revenue streams with corollary societal benefits.

Cross cutting area 4 (Technology-assisted therapies)

The problem…	Why St Andrew's…	Our approach…
The development of technology-based therapies is evolving rapidly. These are innovative and can be targeted at groups of, or individual, patients. The challenge is that many of the people who are involved in the development do not have a clinical background and are interested in developing collaborative partnerships.	St Andrew's has already been involved in the development of virtual reality-based therapies through the provision of expert clinical input into research partnerships. These have included treatments for people with dementia, in addition to those with social avoidance problems. The charity has developed collaborations with the University of Kent and Oxford (including the spin-off company Oxford VR). We are working with them to optimise the therapies, including the use of the therapy to treat some of our out-patient groups. These could be used externally in other patient groups. Other researchers have approached us to consider future collaborations, based upon our research reputation in this area.	The aim is to further develop this research area, as it is a rapidly developing area where we have demonstrated that it can have a real clinical benefit for some of our patients. Partnering with researchers who have expertise in the development of emerging technologies, such as virtual reality, will ensure that they are developed with a clear clinical focus and identify St Andrew's as a leader in this field.

Cross cutting area 5 (Precision medicine)

The problem…	Why St Andrew's…	Our approach…
Precision medicine is a pivotal area of clinical research which ensures that patients receive the optimal therapy for their condition. The patients at St Andrew's have complex mental health conditions which need to be treated on a case-by-case basis. This requires a detailed understanding of their individual conditions. This can be achieved at both genetic and epigenetic levels. The use of data has been identified as a key mechanism of understanding complex conditions. Genetics is another tool to identify disease subtypes which, in combination with	The charity has access to a large internal clinical dataset which has enormous potential to be used to understand mental health. There is the potential for a more coordinated use, especially with external researchers. Previous collaborations with UCL have demonstrated that large, anonymised datasets can be generated to carry out mathematical modelling of patient groups. Furthermore, St Andrew's have built up collaborations with Meomics (University of Cardiff), Genomics England and Psychiatric Genetic Testing (Maudsley Hospital), all of	We will build upon our existing collaborations, focussing on data-driven approaches and genomics as these are strengths in which the charity has an opportunity to enhance our reputation. By understanding our patient population, we have the best opportunity to focus specific therapeutic approaches to minimise their time with us and ensure that they are best prepared for the next stage of their recovery journey.

symptomatic data, will provide a powerful tool to understand specific conditions and develop an approach to provide a more targeted, individualised therapy.	which demonstrate the viability of using a genomic approach for the development of precision medicine. The charity is a member of the AKRIVIA collaborative which provides access to healthcare records from over 10 Trusts which allows large-scale data analysis.

Implementation

Well planned and methodical implementation of the strategy is a key component of its success. Once this strategy has been agreed, a full and detailed implementation plan will be delivered including costing, required roles, governance arrangements and KPI's. As noted above a cultural change plan will also be required.

Conclusion

This strategy sets out a substantial category change for research and innovation at St Andrews Healthcare. Its aim is to place St Andrews at the forefront of research and innovation both nationally and internationally within five years. The strategy is ambitious in its scope however, it does not underestimate the challenges ahead. With robust planning and adequate resource the vision contained within these pages can become a reality with all of the attendant benefits.

Appendix

SWOT

Strengths	Weaknesses
• CEC & Board recognise that research can support other areas of the charity, e.g. funded clinical secondments. • Governance procedures (R&I Policy & Research Wiki) • Expertise of AMD, Research and Committee Chair/NED for Research • Unique clinical population and setting • Clinical data • Academic expertise (PhD student supervision) • Communicative research team • Long history of research and innovation in the Charity (with national reputation) • Knowledgeable staff motivated to engage in research. • External service evaluations • Technology	• Current research budget • Small number of dedicated research posts (1 x research associate and 0 x research assistants) and recruitment difficulty • Lack of dedicated time for staff to do research and capacity for translation into practice. • Little current in-house "research": lack of clinician-led projects • No R&I staff with joint university posts, limiting access to certain funding streams. • Inability to attract charity funding due to reputation and external perception of STAH wealth. • Recruitment difficulties: 2 x unrecruited secondments and repeated rounds of research associate recruitment • No appetite for strategic alignment with other departments (CQI, Academic Centre, trauma etc.) • Financial uncertainty for longer-term research • Uncertainty about the role of research within the charity • PPI often ineffective; staffing levels on wards does not support additional research activity. • IT support for research • Research not a recruitment criterion • Data quality/missing data • Inability to get free ethics approval (IRAS)
Opportunities	**Threats**

• Rewarding place to work providing research time and projects has ability to improve clinician wellbeing and decrease risk of burnout, while also improving opportunities to translate into practice.
  ○ Make research a recruitment criterion.
  ○ Include in IPDR
• Unrecruited clinical secondment posts allows strategy-specific recruitment.
• Collaborations:
  ○ Alignment with others, e.g., CQI & Academic Centre to complete translation into practice circle
  ○ Industry
  ○ Jointly funded clinical/academic posts – become a "University Medical School"
  ○ Community partnerships
  ○ NHFT collaboration
• Potential for well-defined priority areas – opportunity to develop reputation; selection of topics that lend themselves to translation.
• New IT strategy has more focus on research.
• Akrivia Platform – maximise use of data; wider charity usefulness (BI, Clinical Audit)
• Innovation (Genomics, VR etc.)
• Staff training in research
• USP – patients
• MH & COVID
  ○ Interest in mental health research
  ○ Acceptance of working from home
	• Interdependent areas are not achieving their aims/running effectively
	• Financial position of charity – funding withdrawn or not guaranteed for long enough to get established.
	  ○ Decreasing patient numbers and income levels – prioritisation of research?
	• CQC ratings and reputation – reputational effect on ability to engage collaborators, funding.
	• Ability to recruit 'star' academics/joint posts – supporting structures required
	• Geographical location of hospital
	• Capacity to obtain research funding (only as part of university collaborations)
	• Clinical secondees cannot deliver in 2 days a week.
	• STAH bureaucracy prevents technology projects from developing.
	• Conflicting organisational interests/messages
	• Difficulties in evidencing impact
	• External research environment (e.g., COVID)

PESTLE

POLITICAL	• The Secretary of State for Health has recently announced a major investment in Research and Innovation as a basis for sustainable healthcare across the UK (NHSE 2021) • The Academy of Medical Royal Colleges and a consortium of healthcare organizations across the UK are encouraging the development of *'Research for all'* in organisations; this report heavily promotes research and innovation as a catalyst for quality improvement (Academy of Medical Royal Colleges 2019) • New Care Models and provider collaboratives means there is a political direction to provide care closer to home; collaboration also means access to wider patient group and focus on partnerships not competition (joint posts)
ECONOMIC	• Multiple reports have indicated the growing importance of Research and Innovation as a driver for revenue generation and providing a basis for sustained competitive advantage (Mckinsey 2021) • Trend to reduce grant giving due to impact of COVID on fundraising in the charitable sector.
SOCIAL	• The growing concept of 'Shared Value' is gaining traction meaning that an organisation's strategy is increasingly being aligned with complementary social activities and partnerships in the wider community (Porter 2016) • Importance of PPI in research engagement, and outcome identification and evaluation
TECHNOLOGICAL	• There is enormous technological change occurring in society with the acceleration of interconnectivity, the dawn of artificial intelligence and global automation; the recent pandemic has accelerated such uptake. • Recognition of the importance of clinical data analytics • National Data Opt-Out could impact on data available.
ENVIRONMENTAL	• Society increasingly recognises that organisations need to provide leadership in creating 'environmentally sustainable workplaces' (Bratton 2020:378) • There is a growing trend towards the promotion of pro-environmental behaviours and encouraging employee voice around sustainable practices, such as '*Low Carbon Work Systems*' (Bratton 2020)
LEGAL	• The healthcare regulator (Care Quality Commission) has recently introduced '*well led inspections*' – part of the Inspection Framework specifically focuses on Research and Innovation, meaning that such activity will be increasingly scrutinised from the regulatory perspective (CQC 2020)

Current Resources

Staffing	Associate Medical Director (0.5 WT), Head of Research & Innovation (1.0 WTE) Senior Research Project Manager (1.0 WTE), Research Administrator (0.8 WTE), Research Associate (1.0 WTE – currently vacant), Research Assistant (1.0 WTE – fixed term until March 2022)
Tangible assets	Access to the MRI scanner at Three Shires (fees apply), large unused space in the Main Building, computer hardware and software, telecommunications equipment.
Intangible assets	None currently (no patents etc.)

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Research and Innovation Implementation plan

2022 - 2027

Version	Author	Date
1.1	Dr Paul Wallang Dr Kieran Breen	December 2021

Contents

Introduction

This document sets out a clear five year implementation/execution plan for the corresponding research and innovation strategy which was approved by the St Andrews Board in September 2021. This implementation plan emphasises a simplicity of approach and pragmatism. It also places an importance on value creation, building strong external partnerships and long term operational and financial sustainability. The following pages set out the overarching goals for research and innovation over the five year period, detailed workforce plan, cost structure, key performance indicators and an analysis of potential barriers and mitigating actions. The plan has used high quality, evidence based guidance around successful strategy implementation throughout (Nielson et al 2008).

Alignment with other priority areas in St Andrews strategy

The new Strategic direction for the Charity (2021 – 2026) has been developed following a comprehensive board level strategic review. The renewed purpose of the charity is to '*promote wellbeing, give hope and enable recovery'*. Research and innovation comprises one of the seven strategic priorities and as such forms an important driver for strategic success. As with the other six strategic priorities, research and innovation will contribute directly to delivering the Charity's purpose through two of the stated enablers of *'building a diversified portfolio'* and *'inventing the future':*

- **Helping to build a diversified portfolio -** expanding research and innovation capability and creating new and exciting academic, industry and state partnerships will contribute substantially to a renewed and modern charitable portfolio in keeping with the charity's vison.

- **Supporting the Charity to invent the future –** a stronger research and innovation capability will provide support to the Charity's vision to *'invent the future'* by engaging in innovation, championing improved understanding, contributing to ground breaking research leading to treatment advances, providing an evidence base for improved therapies and providing high-level thought leadership across multiple areas of mental health practice.

Research and innovation will also play a key overarching role in helping to transform the organisational culture of the charity so that it develops as a learning organisation, using the most innovative technology and evidence based practice. There is evidence that the development of a research culture in an organisation leads to better clinical outcomes and this follows the NIHR recommendations (See https://www.nihr.ac.uk/health-and-care-professionals/engagement-and-participation-in research/embedding-a-research-culture.htm)

Summary of our core ambitions

The core ambitions for research and innovation can be encapsulated in three broad areas:

1. Impact on our patients
2. Impact on the organisation
3. Impact on the wider community.

The diagram below (fig1) indicates how each ambition will support the wider Charity through the two strategic enablers of *'building a diversified portfolio'* and *'inventing the future'*.

Fig 1

CORE AMBITIONS			Alignment to STA strategy (enablers)
Impacting on patient care	1	We will be able to evidence clearly the impact of R&I activities on our clinical care and patient recovery.	Building our portfolio
	2	The charity will be regarded as an exemplar institution for co-production practices and patient participation in its R&I activities.	Inventing the future
	3	We will focus on 5 key research areas to bring maximum benefit and value	Inventing the future
Impacting on the wider organisation	4	A robust financial model will be developed including the identification of long-term income streams to ensure a significant sum of money flows into the R&I function.	Building our portfolio
	5	All employees (Clinical and non-clinical) throughout the Charity will be provided with an opportunity to participate in research, aligned with the charity's research priorities and as part of their programmed activities. There will also be a diverse range of workshops, conferences and other opportunities to learn and become involved in (or consume) research and innovation.	Building our portfolio
	6	We will nurture multiple partnerships with academia, industry and the third sector with an emphasis on the development of joint posts; thus expanding our research portfolio, as well as developing our reputation as an academic research institution.	Building our portfolio
	7	There will be a clearly enhanced research reputation with St Andrew's viewed by external partners (NHSE, academia, industry etc.) as an innovative organisation that facilitates world-leading research and innovation; including	Inventing the future

Impacting externally		the testing of new therapies and clinical processes to improve patient outcomes and making St Andrews attractive to prospective employees.	
	8	We will have achieved successful applications for research funding directly from St Andrews and also in collaboration with academic partners.	Building our portfolio
	9	The Charity will be carrying out high-quality research as evidenced in peer-reviewed publications and presentations at national and international meetings	Inventing the future

Planning and delivery requirements

The table below (Table 1) sets of the practical activities that will be required to enable the strategy to be implemented within the Charity. The main areas of operational focus will be:

1. Building contractual relationships with suitable and strategically aligned academic institutions
2. Recruiting qualified and skilled research staff through joint posts with universities
3. Nurturing a culture of research and innovation through conferences, workshop, symposia and other charity wide events so staff become contributors of consumers of research and innovation.
4. Creating a pipeline of funding by developing experience and skill in the ability to win large grants and access other funding streams.
5. Coordinating and organising links with Universities to have their postgraduate students (MSc and PhD) students doing research with St Andrews and being jointly supervised.
6. Having St Andrews recognised as a partner equivalent to NHS trusts such that all patients recruited for research result in a payment to St Andrews.

Table 1

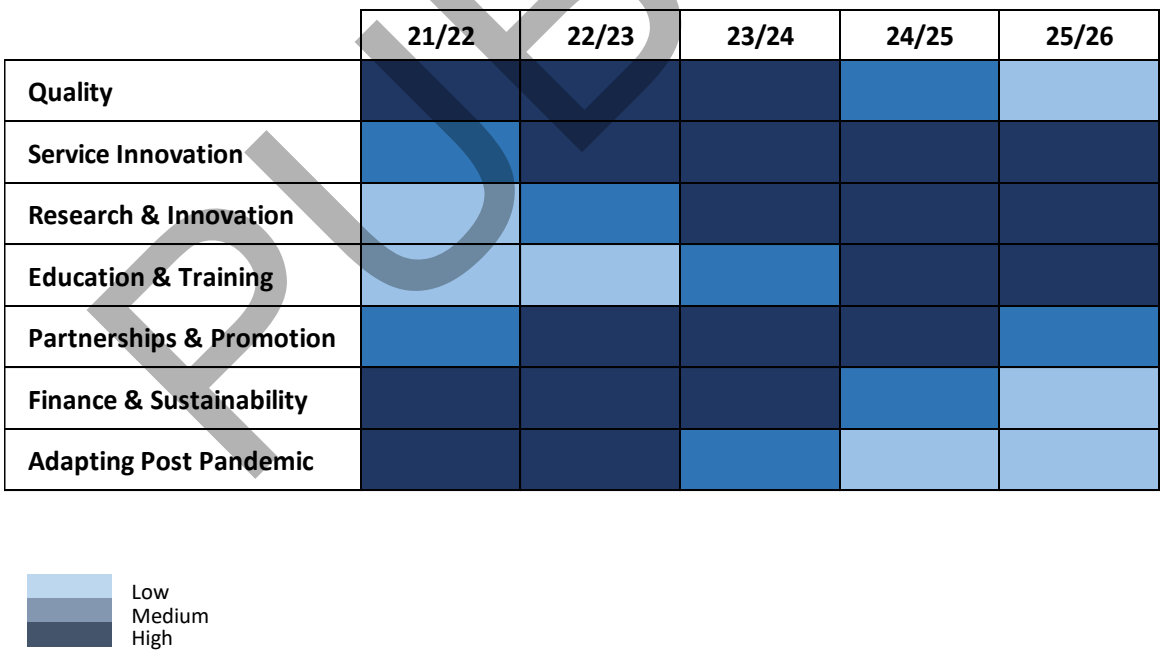
Ambition	Year 1	Year 2	Year 3	Year 4	Year 5
	2022/23	2023/24	2024/25	2026/27	2027/28
Nurturing strong relationships with suitable and strategically aligned academic institutions	Build a relationship with our first key academic institution, Including contractual arrangements.	Build a relationship with our second key academic institution Establish an enlarged and combined 'research and education Hub' in the historic Northampton hospital building with input from our academic and	Build a relationship with our third key academic institution	Grow the number of PhD students and M.Sc. student across the three partner universities.	Establish the St Andrews 'research triumvirate' by further integrating the three academic institutions within the burgeoning St Andrews Research Hub.

		industry partnerships.			
Developing a research capability with appropriate staffing, skills and seniority	Recruit to one joint post (Professor level) and one full time Lecturer/research assistant to support the new partnership with our first academic institution.	Recruit to a second joint post (Professor level) and first senior lecturer (joint post) with a lecturer/research assistant to support our second academic institution and research themes.	Recruit a second senior lecturer (joint post) and third lecturer/research assistant with final partner academic institution.	Continue to develop a strong research collaboration across the triumvirate organisations	Develop strong research partnerships nationally and internationally in collaboration with the academic triumvirate.
	Continue research secondments for one or two qualified and motivated staff on a two yearly basis				
Building a strong research culture across St Andrews	Hold one high quality conference with a partner academic institution and engage research champions in each division Develop an 'outreach' and training capability with dedicated time from our research team for St Andrews staff.	Hold two high quality conferences with two partner academic institutions. Begin Quarterly research symposia. Provide regular updates to staff on new developments in Mental Health through meetings and podcasts, as well as providing ongoing 'outreach' and training	Hold three high quality conferences with all partner academic institutions Continue research symposia Provide regular updates to staff on new developments in Mental Health through meetings and podcasts, as well as providing ongoing 'outreach' and training	Hold three high quality conferences with all partner academic institutions Continue research symposia Provide regular updates to staff on new developments in Mental Health through meetings and podcasts, as well as providing ongoing 'outreach' and training	Hold three high quality conferences with all partner academic institutions Continue research symposia Provide regular updates to staff on new developments in Mental Health through meetings and podcasts, as well as providing ongoing 'outreach' and training
	Establish a regular diet of nationally renowned speakers on a diverse range of research and innovation topics				
	Establish prestigious bursaries and scholarships for training at our partner Universities through fundraising with the support of our trustees and governors				

Create a sustainable funding stream	Pump prime research capability with targeted Charity funding	Generate and support applications for research grants and other income streams from the research through NIHR/MRC etc. Obtain recognition from NIHR and NHS to receive patient research funding.	Win first large grant application with the help of our professorial input.	Start to win regular national grant applications with sizable awards	The Research and innovation team would be bringing a significant sum of money supported by regular successful joint grant applications to NIHR/MRC/Wellcome etc.

The plan (above) has been designed to fit with the overall charity implementation plan (fig 2 below) with Research and innovation being a lower strategic priority in the first year then increasing in prioritisation toward the final years of the charity strategic implementation timeframe

Fig 2 – Charity strategic prioritisation schedule



Workforce planning

In order to fully realise the research and innovation strategy the Charity will need to make key appointments. It is envisaged that there will be a gradual introduction of research expertise over the five year implementation period and an emphasis on joint appointments with academic institutions sharing a strategic interest in the five research areas. The proposed build up of staff as shown in Table

2 (below) implies a 50:50 partnership on the funding of these appointments. This will be subject to negotiations and discussions with our Academic Partners. The bulk of appointments will be spread over the first three years, allowing a gradual development of the research capability. This gradual approach will allow the charity to control the development of the function and maintain some degree of flexibility. Joint posts would also allow the Charity to maintain a clear research agenda. The plan is to deliver the strategy with smaller numbers of very highly skilled research staff (Professors and senior lecturers) and higher numbers of supporting research staff (research assistants, PhD students, M.Sc. students, secondments). Research assistants would support the academic teams as well as contributing to important cross charity projects which can add value. It is anticipated that all appointments will carry designations with a clear link to the charity (e.g. St Andrews Professor and St Andrews Senior Lecturer). The Charity would also be intimately involved in all aspects of the recruitment of candidates, appointments, job planning and regular appraisals. There will also be clinical secondments provided on a rolling 24 month basis.

Academic posts contributing to St Andrews

Each academic post would be expected to make a significant and sustained contribution to St Andrews research culture as well as building a research programme around a designated theme. Each post would be subject to an annual St Andrews appraisal. The job description for each appointment would include (amongst other elements):

- Engaging in high quality research which has a demonstrable academic and clinical impact
- Contributing/coordinating a programme of internal research activities such as training events, seminars, CPD events.
- Providing 'outreach' guidance and support for members of staff with an interest in research.
- Attending and participating in external national and international events to network, promote St Andrews work, and provide a conduit for new and exciting research insights to flow into the Charity.

The workforce plan across the five years is shown below with the proportion of the appointment funded by St Andrews (Table 2):

Table 2

Additional staff resource	Year 1	Year 2	Year 3	Year 4	Year 5
	2022/23	2023/24	2024/25	2026/27	2027/28
Professors (joint appointment)	One FT (0.5 funded by St Andrews)	One FT (0.5 funded by St Andrews)			
Senior Lectureship (joint appointment)		One FT (0.5 funded by St Andrews)	One FT (0.5 funded by St Andrews)		
Lecturer/Research assistants	One FT (0.5 funded by St Andrews)	One FT (0.5 funded by St Andrews)	One FT (0.5 funded by St Andrews)		

Post graduate Research PhD		Joint PhD appointment (though grant funding)	Joint PhD appointment (though grant funding)		
Research secondments		Rolling 0.5 secondment (24 months duration) (clinical or non clinical)		Rolling 0.5 secondment (24months duration) (clinical or non clinical)	
Scholarships and bursaries	One substantial bursary/scholarship per year (cost to be derived from benevolent sources, trustees, governors, industry etc.)				
Cumulative staffing resource *(All jointly funded (50% st Andrews/50% academic institution - apart from secondments)*	1 WTE professor 1 WTE lecturer	2 WTE professor 1 WTE senior Lecturer 2 WTE lecturer 0.5 secondment 1 joint PhD appointment (through grant funding)	2 WTE Professor 2 WTE senior Lecturer 3 WTE lecturer 0.5 secondment 2 Joint PhD appointment (through grant funding)	2 WTE Professor 2 WTE senior Lecturer 3 WTE lecturer 0.5 secondment 2 Joint PhD appointment (through grant funding)	2 WTE Professor 2 WTE senior Lecturer 3 WTE lecturer 0.5 secondment 2 Joint PhD appointment (through grant funding)

Current Capability

The Charity already has an established research team who will continue to provide ongoing support for the implementation of the strategy. It is envisaged that this 'core' team will always be required to provide the necessary fundamental infrastructure; direction, operational management, governance, project management skills, administration etc. to provide sustainability of the function. The 'core' team will continue to receive funding from charity revenue as is currently the case. Due to the complexity and high level negotiations needed to develop strong academic partnerships with universities, the Charity will need to appoint a senior academic in the first year with substantial experience in order to provide the necessary skill to lead on the academic developments; it is therefore necessary that we would appoint a member of staff at a very senior level in the first year (Professor) with one of our academic partners.

Funding Profile

Each pound of Charity income must be spent wisely and translate into maximum value. Furthermore, investment in research and innovation should demonstrate measurable improvements in outcomes

and deliverables. The additional funding required for the workforce plan, over the next five years (over and above the 'core' R&I team) is shown below. Average and competitive salary estimates have been used below. It is anticipated that by the final year the department will be generating a significant amount of money through joint university funding, grants and research awards, supported by regular successful applications to NIHR/MRC/Wellcome etc. The five year funding required by St Andrews to implement the strategy is shown in Table 3 (below). Again it is assumed that the Universities would fund 50% of salaries.

Table 3

Year		Staffing (WTE)	Individual cost (£)	Total Cost per year (£)
Year 1	**2022/23**	• 0.5 WTE professor • 0.5 WTE Lecturer/Researcher	57,456 27,972	**85,428**
Year 2	**2023/24**	• 1 WTE professor • 0.5 WTE senior lecturer • 1 WTE lecturer/researcher • 0.5 secondment • 1 Joint PhD	114,912 31,626 55,944 36,000 13,500	**251,982**
Year 3	**2024/25**	• 1 WTE Professor • 1 WTE senior Lecturer • 1.5 WTE lecturer/researcher • 0.5 secondment • 2 Joint PhD	114,912 63,252 91.224 36,000 27,000	**332,388**
Year 4	**2025/26**	• 1 WTE Professor • 1.5 WTE senior Lecturer • 1.5 WTE lecturer/researcher • 0.5 secondment • 2 Joint PhD	114,912 94,878 91,224 36,000 27,000	**364,014**
Year 5	**2026/27**	• 1 WTE Professor • 1.5 WTE senior Lecturer • 1.5 WTE lecturer/researcher • 0.5 secondment • 2 Joint PhD	114,912 94,878 91,224 36,000 27,000	**364,014**
Total over five years for additional staffing costs				**1,397,826**

Average salary without 26% pension and NI

Professor: £91,200, Senior lecturer: £50,200, lecturer/research Fellow £44,400, PhD candidate stipend: 27,000

Average salary including 26% pension and NI (PhD stipend is non pensionable)

Professor £114,912, Senior lecturer: £63,252, Lecturer/research fellow: £55,944, PhD candidate stipend: 27,000.

Culture change

The principle governing the culture of the charity will be that all clinicians are consumers of research in order to remain up to date with the latest developments particularly around treatments and some colleagues will also be producers of research. As noted above a fundamental element of the implementation plan will be changing the culture of the organisation so that we nurture greater understanding, curiosity and skill around research and innovation across the organisation. To this end, multiple activities will be planned across the implementation timeframe including, research days, seminars, CPD events, conferences and invited guest lectures and speakers etc. A rich and varied schedule of high quality research opportunities would also support St Andrews in increasing its attractiveness to future potential employees. We would also actively promote multiple bursaries and scholarships, with an emphasis on prestige, engaging our governors, trustees and other benevolent friends of the Charity. Such academic prizes would be awarded through competition and seek to elevate the reputation of the Charity.

Key performance indicators

Implementation of the strategy will be the responsibility of the first Senior Joint appointment along with the existing Research team on behalf of the charity executive. The board will have oversight of activities including an annual report highlighting the progress towards the key performance indicators. Each key performance indicator is listed below in Table 4, and constitutes a measurable target aligned to the core ambitions in the research and innovation strategy:

Table 4

CORE AMBITIONS	KPI
R&I having impact on charity care and processes	We will establish an 'impact assessment' for all projects to ensure they add maximum value. • Target: 75% of projects attaining a good/excellent impact assessment.
Being an exemplar institution for co-production practices in Research and innovation	Feedback from external and internal stakeholders. • Target: Above 90% positive feedback.
We will focus on 5 key research areas to bring maximum benefit and value	We will complete regular audits indicating whether the gating procedure aligns all new projects to the five priority areas. • Target: 100% of projects aligned after April 2023.
Long-term income streams will be developed	We will have a year on year growth in grant funding (NIHR, Wellcome etc.). • Target: year on year grant funding growth
Provision of research opportunities	Number of workshops, conference and symposia

	• Target: increasing number of conferences, workshops and symposia over the 5 year period.
Nurturing partnerships	Number of joint projects with academia, industry and the third sector. • Target: increasing number of joint projects with academia, industry and the third sector.
Improved reputation	We will conduct a stakeholder review to understand how R&I is contributing to the overall reputation of St Andrews • Target: Stakeholder feedback will be overwhelmingly positive (over 90%).
Successful applications for research funding	We will increase our capability to win grant funding from large national bodies (NIHR, Wellcome etc.). • Target: increasing number of successful grant applications
Peer-reviewed publications and presentations at national and international meetings	There will see a year on year increase in the number of peer reviewed articles and presentations at high quality conferences. • Target: increasing number of peer reviewed articles and presentation at conferences.

Barriers to implementation

Table 5 (below) indicates the main anticipated barriers to the implementation of the research and innovation strategy over the five year period. It also highlights corresponding mitigating actions to reduce the risk:

	Potential barrier	Mitigation
1	The Identification of suitable Universities with whom to partner.	We already have an established and strong relationships with several universities who could potentially align with our research strategy.
2	Ability to recruit suitable research staff with the right skills and seniority to carry out independent research in line with the strategic priority areas.	We may need to pay above market level salaries to entice suitable candidates.

3	Capacity to promote and support the development of the research capability among the existing St Andrew's staff	The charity will need to prioritise research and Innovation as an important strategic activity. There will need to be ring fenced time for workshops etc. and staff being involved in research and innovation activities.
4	Development of an appropriate research infrastructure within St Andrew's to facilitate and support the new joint academic posts and increased research portfolio.	There is an existing research team with experience and skill who can help to develop the appropriate infrastructure for expansion.
5	Inability to obtain funding through NIHR/MRC/Wellcome etc.	Joint posts will allow the charity to access the expertise of established academics (Professors) who have track records in successful funding applications.
6	Ability to effectively change the culture of the organisation to one in which it is research focused.	A cultural change plan using established and evidence based methods (e.g. Kotter's 8 steps of change) will be used over the first several years to maximise success.
7	Achieving satisfactory partnership arrangements with target Universities	The charity will have professorial input, high level guidance (Board input) and legal expertise to negotiate favourably.
8	Succeeding in making appointments in line with the timetable	The posts will be attractive to potential candidates through designated research team support. The core team has an in-house project manager to ensure advertising, recruitment and on-boarding are completed to time.
9	Negotiating the Charity having similar per patients funding for patients taking part in research	The incorporation of senior researchers in the team (Professor/Senior lecturer) will bring substantial experience and skills around costing and access to NIHR funding per patient.
10	Satisfactory support and success in Fundraising	The Charity has established contacts with notable and benevolent friends/supporters who can help to raise or donate capital.

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Neilson, G. Martin, K. Powers, E. (2008). The secrets to successful strategy execution. Harvard Business Review.

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Paper for Board of Directors	
Topic	Information Governance Data Protection and Security Toolkit (DPST) - Annual Submission
Date of Meeting	Click or tap to enter a date.
Agenda Item	**16**
Author	Lucy Neville
Responsible Executive	John Clarke
Discussed at Previous Board Meeting	Standard annual submission
Patient and Carer Involvement	No patient involvement required for this submission
Staff Involvement	The Information Governance Group (IGG) has led the review of the requirements.
Report Purpose	Review and comment ☐ Information ☐ Decision or Approval ☒ Assurance ☐
Key Lines Of Enquiry:	**S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒
Strategic Focus Area	Quality ☐ People ☐ Delivering Value ☐ New Partnerships ☐ Buildings and Information ☒ Innovation and Research ☐
Committee meetings where this item has been considered	The internal audit on the DSPT 2021/22 concluded with adequate assurance and was presented to ARC in April 2022

Report Summary and Key Points to Note

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

As a result of the detailed due diligence undertaken, internal audit assurance and the re-accreditation of ISO27001, we are confident that the DSPT requirements will be met.

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

Appendices

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

Executive Summary

St Andrew's must undertake an annual assessment, called the Data Security and Protection Toolkit (DSPT) to identify and evidence its current compliance against a set of recognised data protection and data security standards, which is then assessed by NHS Digital. The Data Protection Officer has been co-ordinating this work over the last year through the Information Governance Group (IGG) with support from key staff including, the Senior Information Risk Owner (SIRO) (Sanjith Kamath), Caldicott Guardian (Andy Brogan) CIO (John Clarke), Head of Audit and the IT Security Team.

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

The assessment criteria have been ratified by Information Governance Group (IGG) during the period November 2021 to March 2022.

The DSPT requires CEC and the Board to be informed on Information Governances risks and to approve the annual submission.

Background

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

Completing the toolkit is a contractual requirement in the NHS England standard conditions contract (section 21.2) that relevant providers undertake DSP Toolkit assessments on an annual basis: "The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Information Governance Toolkit (or any successor framework), as applicable to the Services and the Provider's organisation type."

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

Summary of Work Undertaken

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

- We have introduced a layered approach to how we advise people how their personal information will be used. An easy read version of the Patients and Service Users Privacy Notice has been created and we have also created a patient leaflet which has been distributed by the Wards.

- We have developed a Privacy by Design and Default Procedure and framework enforces that ensure that privacy and data protection are embedded throughout the entire life cycle of technologies, from the early design stage through deployment, use and disposal.
- We have surveyed all of our IT software to ensure we that we documented where we have not been able to keep software up to date. This has involved carrying out data security risk assessments and working with our main IT Supplier to ensure we are capturing any risks and where required ensuring we have mitigation plans in place,
- The Information Governance risk register has undergone significant development and is much improved to ensure that we are capturing our risks consistently and that where required, they are escalated to the right people at the right time.
- A review of our training and education requirements has taken place, and we have completely re-designed the E learning modules on Information Security and Information Governance. We have developed three levels of training for staff depending on their role and what data they access and what they do with it- we expect the new modules will go live by the end of June 2022. This new approach to training helps us consider the differing needs of staff groups rather than providing a single training resource.
- The Information Security Team now provide regular metrics to the board to aid the understanding of the information security landscape. The update includes the following items- vulnerability management, audits undertaken, security incidents, outstanding security updates, and blocked network attacks.
- We have worked with procurement colleagues to develop a centralised list of all suppliers that process personal data on the Charity's behalf. Previously, this information was held by a number of teams and there was no standardised process in collating and holding the data processing agreement. Now, the IG are keeping all data processing agreements and evidence items in one place which helps us in demonstrating our accountability requirements.

Data Security and Toolkit Position

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

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

	security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management	

One of the standards of the DSPT is ensuring that organisations meet a 95% completion rate of staff who work with personal data, undertaking their mandatory Information Governance training. Our highest completion rate so far has been 91%. We are working with the senior management team to try to reach the 95% target by the 30th June 2022.

However, it should be noted that we require all staff to complete the training, regardless of whether they work with personal data. The IGG have received assurance that 95% of staff who have access to personal and confidential data have completed the training.

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

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

Requirement of the Group
As a result of the detailed due diligence undertaken and the re-accredited ISO27001, we are confident that the DSPT requirement will be met before we are required to submit the assessment to NHS Digital.

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

Lucy Neville (Data Protection Officer)

Questions from the Public for the Board

(Paul Burstow - Verbal)

Any Other Urgent Business

(Paul Burstow - Verbal)

Date of Next Board Meeting in Public -

Tuesday 26 July 2022 9.00am

(Paul Burstow - Verbal)