St Andrew's HEALTHCARE

Quality Accounts

2025-26

Transforming lives together

Contents

SECTION 1

Quality Statements

A welcome from Trevor Torrington, our Chief Executive Officer

The past year has been one of intense scrutiny and important learning for St Andrew's, particularly in Northampton.

The concerns raised by the Care Quality Commission (CQC) have had a significant impact on the people we care for, their carers, our staff, and our partners. As CEO of the Charity, I want to be clear that the standards identified were not acceptable, and we are determined to put this right.

I joined St Andrew's at a time when the Charity was already addressing these issues with honesty and urgency. What I have seen since arriving is an organisation that understands the scale of change required and is committed to delivering it.

While patients at our Northampton hospital might not be cared for by St Andrew's in the future, for the time they are in our care, we are determined to continue to improve standards.

We now have a new leadership structure, strengthened governance, and a clearer focus on quality and safety. St Andrew's will look different going forward - more accountable, more consistent, and more aligned to our mission.

Amid these challenges, we must also recognise there has also been positive progress. Our Essex hospital achieved a Good CQC rating during this reporting period and our Outpatients services continue to be rated Good.

A total of 75% of our Adult Care Services (ACS) are rated Good, demonstrating consistent quality of care and one domain was improved from Requires Improvement to Good in Well Led.

Additionally, we have also seen improvements in the quality of care in Birmingham. These successes show what is possible when teams are supported and expectations are clear.

We have also seen powerful examples of patient recovery across our services; stories of people regaining independence, reconnecting with family, and moving forward with hope for their futures. These outcomes remind us why our work matters.

I want to recognise the commitment of our staff, many of whom have continued to deliver compassionate care during a period of intense scrutiny and change. Their dedication provides a strong foundation for the improvements we are making.

The year ahead will be one of continued transformation. We will strengthen our culture, listen more closely to patients and families, and ensure colleagues feel valued and able to speak up.

We will continue to work openly with regulators and partners, and we will hold ourselves to the highest standards of safety, compassion, and professionalism.

St Andrew's has a long history of caring for people with complex mental health needs. Our responsibility now is to build a future in which that care is consistently safe, effective, and of the highest quality. With the right leadership, structure, and culture, I am confident we can achieve this.

A statement from David Foord, Executive Director of Nursing and Quality

This year's Quality Account is presented at a time of significant challenge and reflection for our organisation. As Director of Nursing and Quality, I am committed to providing a clear, honest, and transparent account of the care we deliver, the concerns that have rightly been raised, and the actions we are continuing to take to address them.

Over the past reporting period, our Northampton Hospital has been received three inspection reports from the Care Quality Commission (CQC), each of which resulted in an overall rating of Inadequate. In addition, we have received two formal Notices of Decision from the CQC, requiring us to make urgent and sustained improvements. These findings are deeply concerning. They highlight serious shortcomings in the quality and safety of services provided to people who are often among the most vulnerable in society. This has included shortfalls in how we manage infection prevention and control. I want to acknowledge the impact this has had on our patients, their families, our staff, and our partners. It is not the standard of care we strive to provide, and it falls short of our values and responsibilities.

We fully accept the CQC's findings. Since the inspections, we have worked closely with regulators and commissioners to understand the root causes of the issues identified. These include weaknesses in leadership, governance, staffing, and the delivery of safe, effective, and person-centred care. While some improvements had been initiated prior to the inspections, it is clear that they were neither sufficiently robust nor embedded to achieve the consistency and reliability required.

Despite this, I want to recognise the dedication and compassion shown by many of our staff during an exceptionally difficult period. Delivering safe care in a secure mental health setting is complex, and many teams have continued to show professionalism and commitment in the face of scrutiny and uncertainty. However, good intentions alone are not enough; we must ensure that every patient receives safe, high-quality care every day.

In response to the CQC findings, we have implemented a comprehensive and organisation-wide improvement programme. This includes strengthening our leadership capacity, enhancing clinical governance and assurance frameworks, improving staffing levels and skill mix, and embedding a culture that prioritises safety, openness, and continuous learning. We have established clear improvement plans with measurable outcomes, rigorous oversight at Board level, and external support and challenge where needed. Part 3 of this Quality Account highlights some of the quality improvements we have made this year specific to the objectives set for 2025/26. We are also delivering a detailed plan of improvements in estates, facilities and clinical practise to address infection prevention and control concerns.

Importantly, we are placing the voices of patients and their families at the centre of this work. We are listening more closely, responding more effectively to concerns, and ensuring that people are treated with dignity, respect, and compassion always. We are also committed to creating an environment in which staff feel supported to raise concerns, contribute to improvement, and deliver the high standards of care that they can provide.

On 9 March 2026 NHS England instructed commissioners to expedite safe discharge or transfer of all inpatients from our Northampton Hospital. We are working with NHS England, in their support role, as a regulator and a commissioner, alongside ICBs, other commissioners and system partners to ensure effective systems and processes are in place to involve patients and their families in decisions made. Whatever their future holds, our clinical teams are striving to ensure any decisions about a patient's discharge or transfer are safe, involve them, and in their best interests.

Since 9 March we have been working to understand the implications of the changes at the Northampton Hospital on the wider Charity, specifically ensuring a maintained focus on safety and quality, which will continue into 2026/27.

During the period that this report accounts for we have also received a Good rating for our hospital in Essex following a CQC inspection. At time of writing, we are still awaiting the outcome of the CQC inspection of our Birmingham Hospital. Our Adult Care and Outpatients services remain rated Good.

This Quality Account sets out in more detail the issues identified, the actions we have taken so far, and our priorities for the coming year. While there is still much work to do, we are determined to demonstrate sustained and meaningful improvement. Our focus is unequivocal: to ensure that our services are safe, effective, caring, responsive, and well-led.

Statement of Directors' responsibilities

The Department of Health has issued guidance on the form and content of the annual Quality Account. In preparing the Quality Account, Directors should take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Charity's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is:
  a. Robust and reliable
  b. Conforms to specified data quality standards and prescribed definitions
  c. Subject to appropriate scrutiny and review
  d. Has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account for 2025/26.

SECTION 2

Reflections

Priorities for improvement 2026-2027

2026/27 Quality Priorities

For 2026/27 financial year, the quality priorities for the charity are focussed on ensuring that we can assure ourselves of continued quality improvement in key areas of challenge for the charity. These reflect feedback received externally from partner and regulators, including the CQC and NHS England. This feedback included a need for us to improve our culture of openness and make our quality governance more robust. This is reflected in the detailed quality improvement plans that sit behind these headline priority areas for improvement:

- Assurance of staffing, skill mix, environment, and governance across all our services
  - We are embedding the new Quality Assurance Governance Framework to provide robust assurance and highlight areas of risk, ensuring these have adequate plans for mitigation.
  - We are continuing the implementation of improvement plans associated with Infection Prevention and Control, including the physical environmental challenges for the charity following significant issues with this over the past 12 months.
  - We are continuing our programme of safe staffing improvement alongside our programme of routine establishment reviews.
- Assurance of safe inpatient capacity and patient flow
  - We are working with commissioners and regulators on the significant challenge to ensure that we can evidence safe systems and processes for assessment, admission and discharge/transfer of patients.
  - We are ensuring that as inpatient numbers change, moving up or down, we apply evidence-based approaches to ensuring safety and effectiveness of services, including staffing levels and skill-mix.
  - We are ensuring effective mechanisms for clinical engagement throughout the process of monitoring inpatient capacity and patient flow.
- Embedding sustainable regulatory compliance through strengthened clinical governance, quality and open cultures
  - We are delivering a range of improvements seeking to open cultures and ensure psychological safety for colleagues.
  - We are working with regulators to meet universal regulatory requirements and additional restrictions applied to our registration, including continued improvements to our approach to restrictive practise.
  - We are embedding governance mechanisms to ensure effective oversight and assurance of meeting all regulatory requirements.

Statement of Assurance from the Board

Review of Services

During 1st April 2025 and 31st March 2026, St Andrew's Healthcare provided services in the field of mental health, learning disability and brain injury to 754 patients. Of these around 95% (713) were funded by NHS services or organisations. Non-UK organisations, private funders or individuals fund the remaining 5% (41) of patients.

Involvement in Clinical Audit and Research

Throughout the year the Charity has continued to use Clinical Audit as an assurance and improvement Tool and actively involved in Research. Details of our participation in National Clinical Audits, use of Local Clinical Audits, and Research activities can be found in Appendix 1. The Charity Quality Committee has overseen the progress and outcomes of Clinical Audits throughout the year.

Goals agreed with commissioners - CQUIN

The national NHS contractual requirement for commissioners and providers to agree CQUINs was paused again for 25-26. There were a number of national and local requirements for service development (service development improvement plans) on which St Andrew's worked with commissioners including implementation of implementation of the Professional Nurse Advocate (PNA) role, Oliver McGowan training, and (in Birmingham) reduction in health inequalities with a focus on physical health monitoring, reduced length of stay and implementation of Dundrum assessment tool.

What others say about St Andrew's

Statements from the CQC

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. All providers of regulated activities must be registered with the CQC under the Health and Social Care Act 2008. As from 1st April 2015, all providers are expected to meet the fundamental standards as laid down by the CQC.

We are registered to carry out the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983;
- Treatment of disease, disorder or injury;
- Accommodation for persons who require nursing or personal care.

Conditions of registration require that all regulated activities are managed by a Registered Manager in respect of that activity, and that each activity must be carried out at the locations detailed within the Certificate of Registration. The Charity is in the process of having one Registered Manager per site and where a registration application is pending there is interim registration in place.

St Andrew's services have been subject to CQC inspections within the past year. The changes are as follows:

Northampton Hospital

The Northampton site has seen a decline in ratings across Safe, Caring, Responsive and Well Led, with an overall rating of Inadequate. Action plans have been in place prior to the release of this report and continue take place, with reporting to the CQC in line with a Notice of Decision issued in the past year.

The impact of the quality of services on our rating has been acknowledged by the Charity's leadership and has been a key driver for our improvement plans. We are working collaboratively with regulators, including the CQC to address our quality challenges. We continue to provide four-weekly assurance reports to the CQC on improvement progress associated with our regulatory compliance, having commenced this approach in 2025/26.

The St Andrews Healthcare leadership team meet regularly with CQC colleagues to update on recent changes, developments and improvement activities. This also provides an opportunity to discuss assurance approaches and how we can work together to improve patient safety and outcomes.

Birmingham Hospital

The Birmingham site continues to implement and measure the effectiveness of action plan initiated in January 2024 and awaits feedback from the inspection in November 2025. The Birmingham site retains its overall RI rating (all domains RI except good for Effective and Caring).

Essex Hospital and Outpatients

The Essex and Outpatients services have retained their ratings of Good following inspections respectively in October and March of 2025.

17 and 23/23a The Avenue (Adult Care Services)

17 The Avenue and 23/23A The Avenue have also received CQC ratings in the past year with 17 the Avenue having an overall rating of Good and the Avenue of RI.

	Inspection Date	Safe	Effective	Caring	Responsive	Well Led	Overall
St Andrew's Healthcare (Northampton)	October 2025	**Inadequate**	**Requires Improvement**	**Inadequate**	**Requires Improvement**	**Inadequate**	**Inadequate**
Birmingham	November 2024	**Requires Improvement**	**Good**	**Good**	**Requires Improvement**	**Requires Improvement**	**Requires Improvement**
Essex	October 2025	**Requires Improvement**	**Good**	**Good**	**Good**	**Good**	**Good**
Winslow	March 2025	**Requires Improvement**	**Good**	**Good**	**Good**	**Good**	**Requires Improvement**
Outpatients (formerly Community Partnerships)	March 2025	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**
17 The Avenue	September 2025	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**
23/23a The Avenue	March 2025	**Requires Improvement**	**Good**	**Good**	**Good**	**Good**	**Requires Improvement**

Data Quality

Actions Taken During 2025/26

During 2025/26, St Andrew's Healthcare continued to strengthen its approach to data quality as part of the organisation's wider Data Strategy and commitment to delivering safe, effective and evidence-based care.

Key actions undertaken during the year included:

- Collaboration between clinical services, operational teams, IT and the Data & Performance team to improve understanding of data requirements and address inconsistencies in data capture processes.
- Continuous review of clinical and operational systems to ensure they support accurate, complete and timely data capture, decreased reliance of paper processes and isolated spreadsheet reporting.
- Implementation of an Enterprise Resource Planning System (ERP), bringing together disparate data and IT systems to provide a single platform.
- Continued effort to update source systems data capturing processes to reduce human error and therefore improve data quality
- Continued review and enhancement of reporting processes to improve consistency and transparency of information provided to internal and external stakeholders.
- Ongoing compliance with national data standards, including the Data Security and Protection Toolkit (DSPT), ensuring that data is managed securely and responsibly across the organisation.
- Commencement of work to define data standards, data ownership arrangements and governance controls required to support data quality improvement work.

Impact and Outcomes

The actions undertaken during 2025/26 have resulted in a stronger organisational focus on data quality and accountability. Positive outcomes achieved include:

- Increased collaboration between operational, clinical and data teams to resolve data quality issues at source rather than through retrospective correction.
- Improved confidence in the accuracy and consistency of information used to support operational decision-making and performance management.
- Enhanced foundations for the delivery of the organisation's wider Data Strategy and future analytical capabilities.
- These efforts will also positively affect future use of advanced analytics and artificial intelligence technologies.
- ERP implementation was not without its challenges, with periods of difficulty in accessing management information systems. Overall, this change has been positive for the Charity with the new single platform now in place.

Whilst progress has been made, the organisation recognises that data quality maturity varies across systems and services, and further work is required to achieve consistent standards across all areas.

Priorities for 2026/27

During 2026/27, St Andrew's Healthcare will continue to strengthen its data quality arrangements through the following priorities:

- Development of a formal Data Governance framework to establish clearer accountability for data quality across services and corporate functions.
- Identification and engagement of Information Asset Owners (IAOs) to strengthen ownership and accountability for all datasets and information assets.
- Introduction of a structured review of critical reporting datasets used for commissioner, contractual and regulatory reporting, enabling data quality issues to be identified and addressed more systematically.
- Further review of key clinical and operational systems to ensure they support accurate, complete and timely data capture.
- Delivery of targeted training and guidance to improve understanding of data quality responsibilities across the organisation.
- Continued compliance with national information governance, cyber security and data protection requirements.

These actions will support the organisation's ambition to create a trusted, reliable and well-governed data environment that improves decision-making, service delivery and patient outcomes.

Information Governance

Compliance with the Data Protection Act, UK GDPR and ISO 27001.

The organisation processes large amounts of personal and sensitive data about patients, their carers and families, staff, volunteers, and other third parties. This means that we are obliged to ensure that we uphold the privacy rights of individuals, and that we make sure we collect, handle and store personal data in accordance with Data Protection requirements. To ensure we follow best practice we have reviewed our policies and procedures to ensure they are up to date and fit for purpose.

The Information Governance Team is continuing the process of having all the required reports (Information Asset Register (IAR), Record of Processing Activity (RoPA) and External Information Sharing) updated and ready for the Cyber Assurance Framework - Data Security and Protection Toolkit (CAF - DSPT) submission on 30 June 2026. This will help the Charity ensure its compliance with the Data Protection legislation and the IT certifications we hold.

The Charity continues to deal with a large number of Subject Access Requests (SAR) and information requests from patients, staff, and their representatives. Due to the current Charity's circumstances, we are noticing and increase on staff members DSARs. We anticipate that this trend is likely to increase as the Charity undergoes further restructuring and transformation activity. This increase will not be limited to staff members but also patients requesting their clinical records.

In 2025 Q4 we had no reported incidents to the DSPT. However, we received a letter of advice from the ICO related to a complaint made by a former outpatient. All this activity ensures that the Charity is maintaining robust Information Governance arrangements and complies with the UK General Data Protection Regulation, the Data Protection Act 2018, the Common Law Duty of Confidentiality, and relevant NHS information standards.

NHS Number and General Medical Practice Code Validity

Aligned to other Mental Health service providers, St Andrew's does not provide Hospital Episode Statistics (HES) as it is not required to. The Charity does however submit the Mental Health Services Data Set (MHSDS) in line with national requirements. The codes are checked and validated on a regular basis against national lists.

Data Security and Protection Toolkit

Cyber Assurance Framework - Data Security and Protection Toolkit Compliance

All independent providers to the NHS need to provide information security and protection assurances to the NHS on an annual basis. These assurances are provided through completion of an online assessment tool, the NHS Cyber Assurance Framework - Data Security and Protection Toolkit (CAF - DSPT). In order to provide services to NHS England, the Charity must meet a contractual requirement to meet the 'Standards Met' compliance status. The Charity exceeded this requirement in June 2025 and achieved a 'standards exceeded' status. The toolkit work is being overseen by the Information Governance Group, which is chaired by the Charity's Senior Information Risk Owner (SIRO).

The CAF-DSPT requires a mandatory external audit. This audit will focus on eight mandatory outcomes and four discretionary. The auditor suggested we select the discretionary from Objective B as they are more experienced on that objective and can provide better insight and improvement suggestions.

The answers to these 12 outcomes are being finalised (quality of the answer and evidence to justify our profile) and we are expecting to have the mandatory external audit on the 3rd week of April 2026.

Clinical coding error rate

St Andrew's Healthcare was not subject to the Payment by Results clinical coding audit during 1st April 2025 and 31st March 2026 by the Audit Commission.

Never Events

St Andrew's is pleased to confirm that; there have been no Never Events during the reporting period. Never Events are serious, largely preventable, safety incidents that should not occur if the available preventative measures are implemented.

There are limited Never Events in the NHS National Framework that apply to St Andrew's services. However, throughout 2025/26 we continued our implementation of PSIRF (Patient Safety Incident Response Framework) across the Charity, ensuring an appropriate level of investigation into all incidents reported.

National Core Indicators of Quality

Indicator	Measure	2024/25	2025/26
The percentage of patients aged: (i) 0-15 and (ii) 16 or over Readmitted to a hospital, which forms part of the Charity within 28 days of being discharged from a hospital, which forms part of the Charity during the reporting period.	Percentage	0% 1.31%	0% 1.13%
Patient safety incidents (Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare)	Number	22,349 (total number of patients in hospital during period 1,114)	25,339 (total number of patients in hospital during period 754)
Patient safety incidents that resulted in severe harm or death*	Number (Percentage)	29 (0.13%)	16 (0.06%)

* This includes expected deaths

All patient safety incidents are reported on our Datix incident reporting system. Data quality checks are routinely undertaken. Data from this system is used to provide the Charity and key external stakeholders with detailed analysis of reported incidents.

The Charity Executive Team has oversight of all Patient Safety Incidents that require Patient Safety Incident Investigations (PSIIs), under PSIRF (Patient Safety Incident Response Framework).

The Charity utilises a Patient Safety Action Notice system, through which, any learning from incidents can be cascaded Charity-wide with immediate effect. On a monthly basis the quality forum meets with standing agenda items including Safety and Quality.

Patient Safety

The Charity remains committed to improving the systems and process to ensure learning from patient safety incidents. The Charity went live with PSIRF in March 2024 following board approval and with support of our ICB.

The central Patient Safety Team support our PSIRF trained Engagement Leads and Response Leads to embed PSIRF responses across the charity. The responses now include Duty of Candour prompts to ensure compliance.

Our triage systems embrace PSIRF and we have moved to a governance structure to support internal and external reporting under LFPSE (Learning From Patient Safety Events). Central Triage now includes a separate triage for Near Misses to ensure lower-level incidents/near misses are captured and responded to when required.

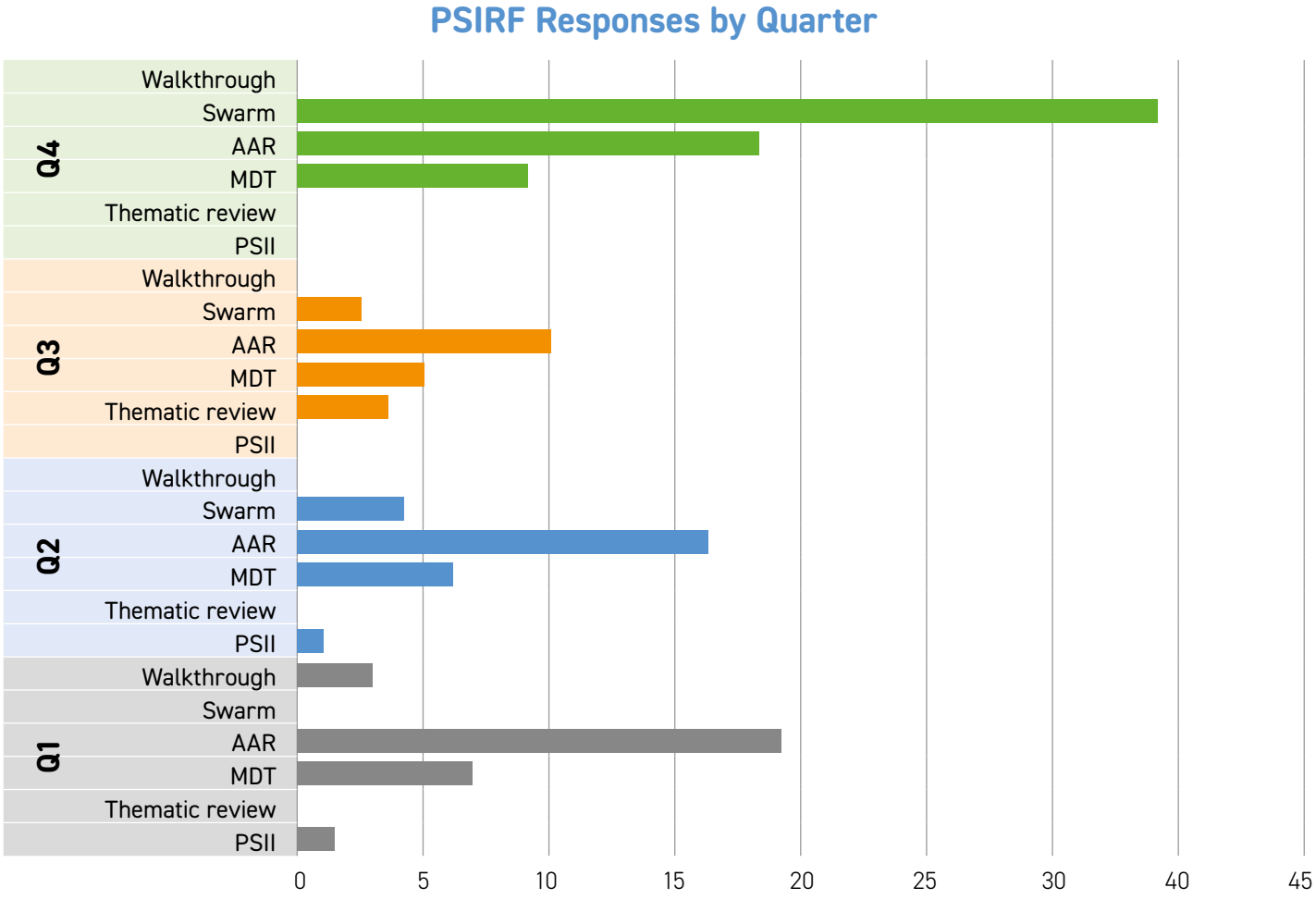
Our central team provides training sessions for divisions to ensure PSIRF responses are promptly and effectively utilised. Our central team consists of; Head of Patient Safety, Patient Safety Matron, Patient Safety Co-ordinator, 2x Patient Safety Practitioners.

Patient Safety are working with the wider quality team to ensure CQI projects and lessons learnt are embedded following patient safety incidents. This includes supporting the divisions to enter SMART actions onto the Quality Improvement Plans.

To ensure initial learning is generated and actions implemented – we have adapted the process to include a process of Swarm huddles[1] and the consideration of Patient Safety Action Notices where required.

Among the PSIRF responses, After Action Reviews continue to be the most frequently used throughout the year by the central team however there can be seen to be a spike in Swarm huddles since recently launched.

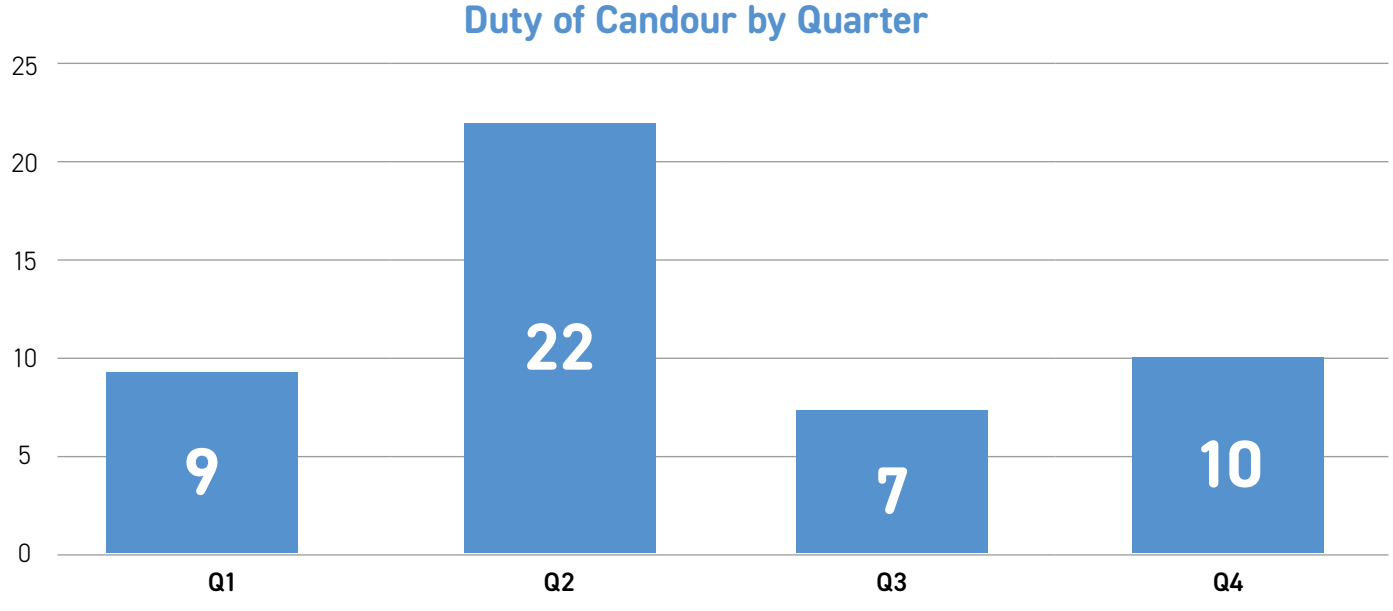
1. A swarm huddle is a rapid, multidisciplinary post-incident debrief, immediately after an incident/event (usually within 24 to 48 hours), the staff involved "swarm" to the site to quickly analyse what happened, identify system flaws, and agree on prompt actions to reduce risk.



Duty of Candour

The Charity aims to be proactively open and honest in line with the Duty of Candour requirements and to advise/include patients and/or family in investigations. The Charity's policy outlines Duty of Candour compliance in line with national regulatory and standard contract requirements. Under Patient Safety Incident Response Framework for a Patient Safety Incident Investigation, there is an allocated Engagement Lead who will work alongside the patient and family/carers to ensure they are supported. Part of the Engagement lead role is to ensure Duty of Candour is followed where applicable.

Since April 2025 there have been 48 Duty of Candours recorded as carried out on Datix.



One of the quality challenges that the Charity experienced in 2025/26 was the build-up of a backlog of incidents within our Datix system (3% of all incidents reported). This was highlighted by the CQC in their inspection report for Northampton Hospital. This backlog led to a delay in our ability to apply system learning from incidents. With support from NHS England additional resource has been put in place to eliminate this backlog, identify and apply learning, and changes to our approach have been made to ensure a future backlog doesn't build-up.

Mortality Review & Learning from Mortality Reviews

This report considers the data from 1 April 2025 to 31 March 2026 inclusive. There have been a total of 10 deaths in the Charity during this period in comparison to 18 deaths in the previous year.

This document is presented to the Board of Directors, to provide assurance regarding the efficacy of the Learning from Deaths (LFD) process, in line with the National Quality Board (NQB) guidance on learning from deaths (March 2017). The expectation from the NQB guidance is for the Charity to collect and publish information on deaths to generate learning.

All expected deaths were subject to the Mortality Surveillance Review (MSR) process, using a structured judgement review tool. Under the Patient Safety Incident Response Framework (PSIRF), a Patient Safety Incident Investigation (PSII) would be undertaken where it was felt that it was possible to gain more in-depth organisational learning. As per policy and procedure, the CQC and relevant commissioning bodies are notified in the case of all deaths.

Total summary figures are as follows:

Patient deaths recorded from 1 April 2025 – 31 March 2026	
Q1 (April, May, June)	3
Q2 (July, Aug, Sept)	2
Q3 (Oct, Nov, Dec)	2
Q4 (Jan, Feb, Mar)	3

Summary of Findings

Overall Findings

- The number of deaths this year (10) was lower than the previous year (18). There were no Covid-related deaths. However, this number should be considered with the reduction in beds at St Andrew's Healthcare Northampton together with the reduction of and closure of dementia services in Lowther.
- Most MSR's found that care was good or excellent. There was evidence of compassionate care, integrated care, involvement of external expertise e.g., secondary care for physical health, good quality documentation, good end of life care planning in a number of cases, and good communication with and involvement of families/carers.
- There were no deaths that were subject to PSII. There were 8 expected deaths and 2 unexpected deaths (which were subject to an AAR (After Action Review)). The case specific findings are discussed below for the unexpected deaths, however the MSR for case 2 is awaiting review by the Mortality Surveillance Group and any further learning recommendations will be considered/reviewed through quality and assurance processes at the Charity.

Improvement Opportunities

The table below lists learning and actions taken.

	Learning Theme	Actions	Assurance process
1	Ensuring specialist physical healthcare input outcomes are clearly documented and followed up.	Communication to medical managers and physical healthcare team .	Ward and service governance.
2	Where patients are transferred to a General Hospital, ensure that there is clear communication in relation to treatment needs prior to the patient returning to St Andrew's Healthcare's care.	Communication to operational and medical managers.	Ward and service governance.
3	Ensuring that physical health parameters are completed consistently, including fluid intake and NEWS2 .	Fluid intake monitoring and NEWS2 escalations are reviewed at ward and service huddle.	Ward, service governance and organisational quality assurance group.
4	Ensuring that liaison with previous care provider includes a comprehensive assessment of physical healthcare needs and considers the best interests of patient in relation to the appropriateness of transfer of care where there are end of life/palliative care needs .	Pre-admission assessments to ensure that there is effective information sharing between teams. Communication to operational and medical managers.	Ward and service governance.
5	Ensure that annual physical health form is completed with the right information	Audit of annual physical health forms. Communication to operational and medical managers.	Ward and service governance.
6	Patients with end-of-life needs should have timely access to advocacy	Clinical team to escalate to service leadership any issues with timely advocacy involvement	Ward and service governance.
7	Pre-admission process should ensure that we have all available past psychiatric and medical information (this learning relates to a death in October 2024 where the Mortality Surveillance Group discussed the MSR in July 2025)	The Charity's admission procedure contains comprehensive guidance on the information that should be gathered through the pre-admission process	Ward and service governance.
8	Protocols for physical conditions e.g., diabetes, would support proactive and consistent care, reducing reactive management	Development of procedures for relevant physical health conditions, including diabetes management	Quality Assurance Group (physical healthcare).

Safeguarding Annual Report

Introduction

Safeguarding continues to be a strategic priority for the organisation and a fundamental aspect of effective governance and quality assurance. It reflects our commitment to protecting individuals from harm while promoting their dignity, rights, and wellbeing.

This report presents an overview of safeguarding activity over the fourth quarter of 2025. Data on the functional risks are stated as well as key themes, learning, and areas for improvement across services. It demonstrates our ongoing work to strengthen safeguarding practice, respond appropriately to concerns, support staff, and collaborate effectively with partners and stakeholders.

It also highlights the challenges faced, the actions taken in response, and our priorities for the year ahead, reinforcing our commitment to transparency, continuous learning, and service improvement.

Safeguarding Data Analysis

- **Safeguarding incidents April 2025 - March 2026** - 499 open Safeguarding's 107 were referred to the local authority.
- Approximately 24.3% of all safeguarding referrals sent out were returned as requiring no further action (NFA). (26 were NFA)
- 47.7% of referrals that met requirements for a Section 42 enquiry (51)
- 2.8% completed by the charity, (3)
- 44.9% completed by the Local Authority. (48)

Comparative Data

Top 5 Nature of Events that were reported to the Local Authority from	Total April 24 - March 25	Total April 25 - March 26
Physical Aggression and Violence	194 - 28.7%	152 - 25.2%
Allegations of Abuse by Staff	122 - 18.1%	76 - 29.1%
Self-Harm	123 - 18.2%	80 - 13.2%
Medication	25 - 4.1%	Sexual Activity instead of medication incidents 36 - 5.3
Injury/Physical Health	44 - 6.5%	49 - 8.1%

The total number of safeguarding incidents referred to the relevant local authorities between 01 April 2025 and 31 March 2026 was 604. This indicates a decrease of 10.5% when compared with the number of referrals for the same period in 2024/2025. This can likely be attributed to improved training and improvement in understanding of referral process and decision making. The daily huddles have created opportunities for better and quicker decision making.

Stakeholder Engagement

The Charity continues to work collaboratively with external partners through regular meetings with both West Northamptonshire Council and Northamptonshire Integrated Care Board. Also, a bi-monthly safeguarding assurance meeting with key partners has been re-established to strengthen oversight and partnership working.

Feedback and challenge from partners continue to provide valuable opportunities for learning and service improvement. This is particularly evident in relation to the documentation of Section 42 enquiries and joint working with social care. As a result of this collaborative approach, improvements have been made to both the content and presentation of Section 42 documentation, providing clarity and supporting more effective safeguarding practice.

In Birmingham and Essex our Lead Social Workers meet with the local authority safeguarding teams to ensure referrals and investigations are timely and address safeguarding concerns.

The Charity continues its work with the regional Domestic Abuse Health Steering

Mentoring and support for the safeguarding navigators is ongoing

The Safeguarding team continues to provide developmental programmes and mentoring to the navigators. In 2026, there will be a review of the activities and support they provide to the wards.

Assurance

The Charity continues to participate in local SAB audits and assessments and recommendations are being embedded in the Safe Today programme. We continue to participate in the NHSE Midlands self-assessment tool.

There was a large-scale enquiry carried out by the local authority, this has now been closed, and recommendations embedded and remain as continuous learning for the Charity.

Review	What we are doing well	What we need to improve
Leadership & Governance	Safeguarding leadership has been strengthened at Board level through the Executive Director for Quality and Nursing	Further embed the principles of *Making Safeguarding Personal*, ensuring patients and carers are meaningfully involved in protection planning.
Communication & Engagement	A weekly safeguarding newsletter has been established, supporting effective information sharing, learning updates, and blogs via the "Must Read" on the Hub	Strengthen evidence of continuous learning and demonstrate how practice is adapted in response to lessons learned.
Training & Staff Development	The safeguarding team continues to deliver high quality training aligned with national guidance and updates	Provide additional support to divisions to improve understanding of safeguarding processes and embed a consistent safeguarding culture.
Safeguarding Supervision	Safeguarding supervision policy has been developed and training on delivering safeguarding supervision completed for some members of staff and more waiting to train. Safeguarding supervision commenced on selected wards in October, using the well-established *Signs of Safety* model.	Further strengthen and embed safeguarding supervision across all services to ensure consistency and sustainability
Policy Framework	The Charity has introduced key safeguarding policies, including: • Safeguarding Adults at Risk Policy • Managing Allegations Against Staff Policy • Safeguarding Supervision	Continue to embed new policies in practice and monitor compliance and effectiveness across services.
Guidance document	Standard Operating Procedure on In-Hospital patient transfers	To ensure all in hospital patient transfers (planned or unplanned) are carried out safely, with safeguarding considerations fully reviewed, documented, and enacted before and after the move

Safeguarding Priorities

The priorities for 2025/26 were partially met, the PIPOT policy is in place, and the Charity is now in the process of signing off a new Policy for Managing Allegations against staff and volunteers. Strengthening the role of Safeguarding navigators remain a priority for the Charity.

Safeguarding Priorities 2026–2027

1. Embed safeguarding supervision across the organisation, ensuring consistent participation by all relevant staff
2. Launch and implement the *Managing Allegations Against Staff and Volunteers / People in Positions of Trust (PIPOT)* policies
3. Strengthen and formalise the role of Safeguarding Navigators.

NHSE Specialised Services Quality Dashboard

Specialised Services Quality Dashboards (SSQD) are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by IMPACT collaborative. St Andrew's submits data to Mental Health SSQD on a quarterly basis.

NHSE Specialised Services

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospitals such as St Andrew's. As a part of the contractual arrangements with NHS England, St Andrew's works to provide its services in accordance with the service specifications. Staff from St Andrew's meet with colleagues from NHS England specialised services and IMPACT collaborative on a quarterly basis to scrutinise contractual achievement. St Andrew's is also required to make an annual self-declaration with the Quality Surveillance Team of its compliance levels with the service specification.

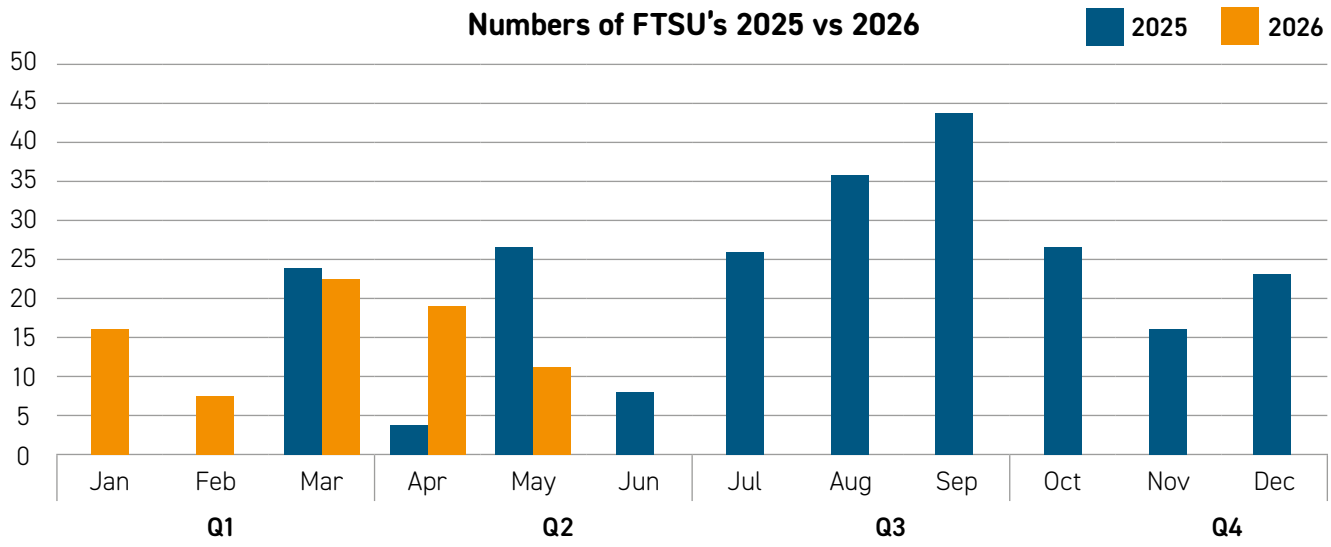
Freedom to speak up

The Charity offers multiple channels for staff to speak up with an overarching Freedom to Speak Up (FTSU) Policy. The primary methods to raise concerns are via individual line managers, our Freedom to Speak up Guardians and Safecall (confidential reporting line). All cases raised are investigated internally.

In the past year the Board has worked on an improvement plan for FTSU for leaders, including a Board Development session and agreeing an action plan for the Board. This was based on expert external input and an individual and collective self-assessment by the Board.

The Freedom to Speak Up Guardian Team currently consists of one Lead Guardian and 8 Freedom to Speak Up Guardians who are located across all sites including community services. The Guardians are recruited from a range of professions/teams. As a team, they have been actively working to raise the profile of 'speaking up' as well as sharing the learning from themes raised.

Following a Gap analysis, the FTSU communications are focused through the Charity's diversity networks to ensure that those who may find it more difficult to speak up have access to the service. Since the recruitment of the new FTSU guardian team the rates of speaking up have increased. This is due to an increase in visibility/promotion of the service. SafeCalls have reduced significantly since the increase in FTSU provision.



Quarter two saw a spike in the number of concerns raised through FTSU. This was due to us making concerted efforts to both simplify the pathway and actively promoting this as a route for staff to report their concerns. Initiatives were put in place including an enhanced communication drive, an increase in FTSU Guardian resources, increased visibility, and listening sessions across wards/teams and an updated policy, which includes a process for detriment cases. All of this contributed to a positive outcome of staff feeling more confident to speak up.

For 2026/27 additional resource has been put into our FTSU function across the Charity, including protected time for Guardians alongside their substantive roles.

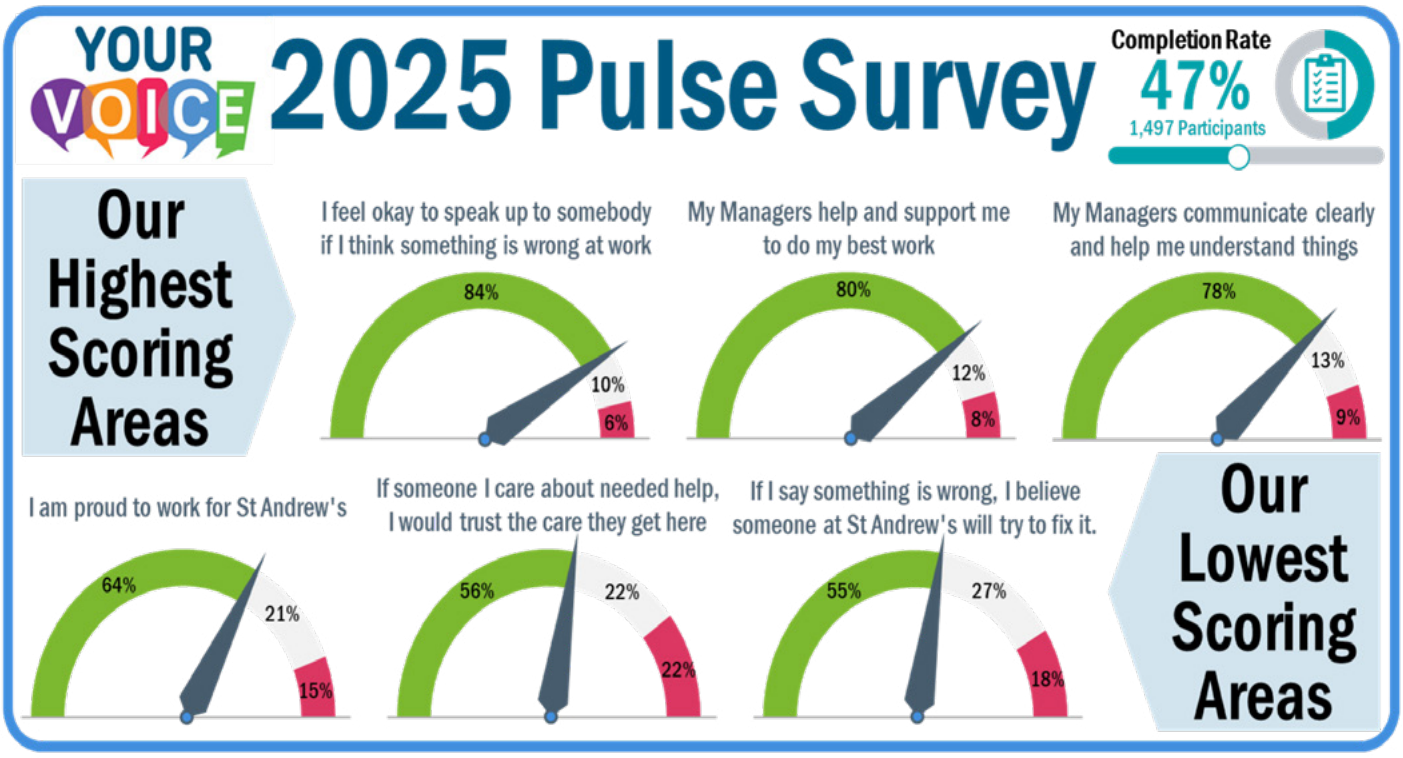
Staff Summary

The results: 2025 Your Voice Pulse survey

In 2025, our Your Voice staff survey was a smaller pulse survey, focusing on the key priorities of the charity.

- Patient Safety and Care
- Speaking Up
- Our Values
- Leadership

Our 2025 we received a 47% response rate, which means that almost 1,500 colleagues shared their thoughts on their experience of working at St Andrew's.



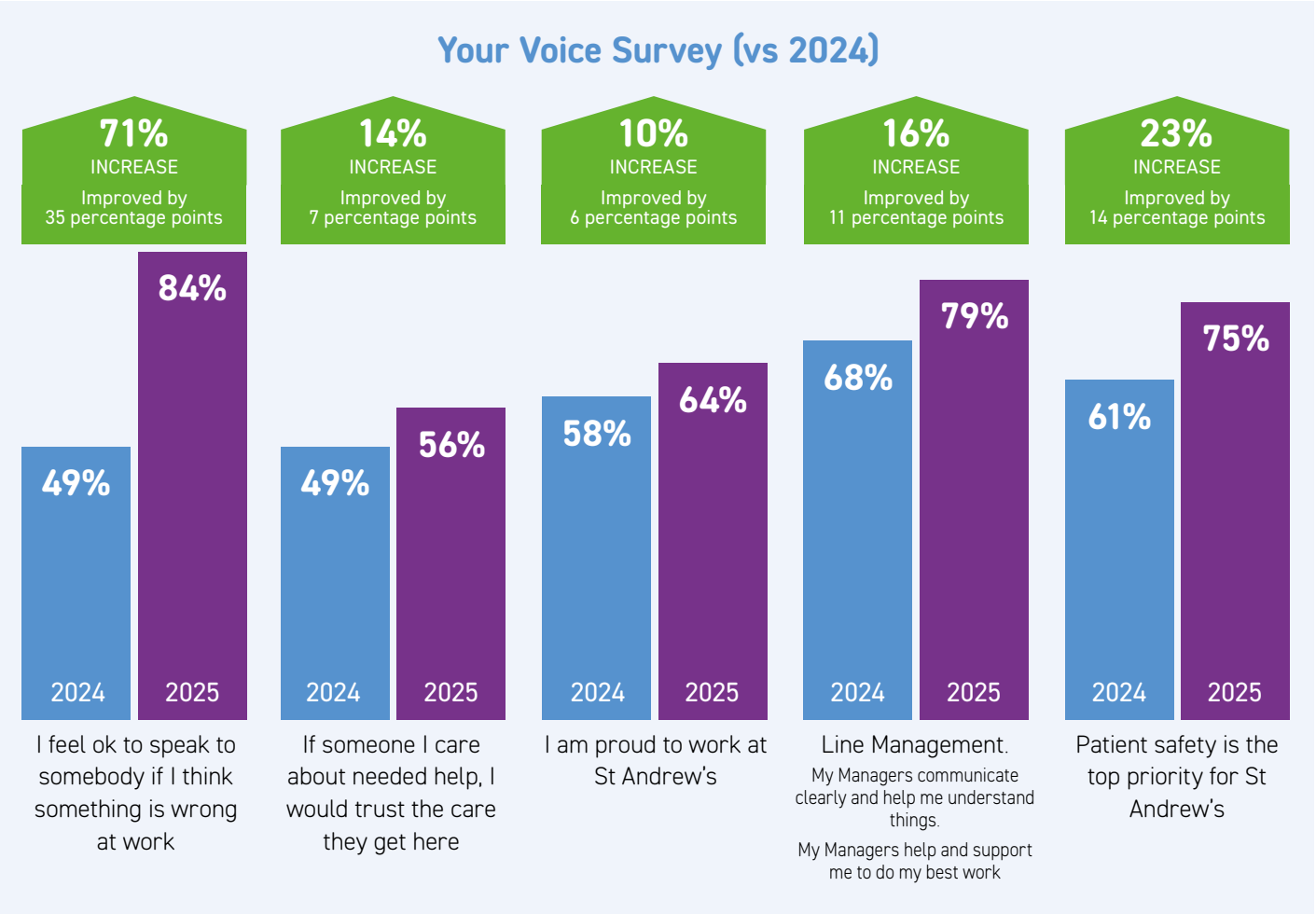
St Andrew's wants to be assured that our people are feel safe to speak up if they think is something is wrong and has heavily supported the work of our Freedom to Speak Up Guardian Team. Our Pulse Survey has reflected the charity's efforts, with a 71% increase from 2024. On the charity's key focus areas, there has been an

improvement against the comparable question from the previous year, as outlined in the following graphs.

The Your Voice pulse survey continues to provide valuable data and the voice of our colleagues, which is continually used to inform us what the charity does.

The results highlight some key areas for improvement:

- Develop trust and accountability in acting when people speak up, helping people to be heard
- Enhance training and support for staff to deliver patient safety and care
- Improve communication and responsiveness from leadership
- Consistent application of policies and values across the charity.



The results since 2020 have been:

	Response Rate	Engagement Score
2020	51%	57%
2021	57%	51%
2023	50%	64%
2024	60%	63%
2025	47%	64%*

* 2025 score based off a single question (I am proud to work at St Andrews') rather than a cumulative score

We are pleased with the steps we have taken and improvements in the key focus areas for the charity. We recognise that we have work to do to ensure that we have engaged and energised people across the charity, delivering and supporting good quality care for our patients and service users.

Staffing priorities for 2026-2027

In 2025, we identified 'Effective Leaders' as one of our top priorities and took a significant step forward in developing a leadership framework to set expectations for managers and leaders across the charity.

Our Leadership Commitment

Our Leadership Commitment is a framework that guides leaders at all levels. It supports the charity by:

- Acting as a common language and approach, and setting expectations
- Providing single point of reference to knit together processes and initiatives
- Supporting leaders through simplicity, relevance, and easy application

Our Leadership Commitment was co-developed with colleagues across the charity, with multiple inputs. It has three pillars **Be Curious, Set Standards and Enable Growth**.

Our Priorities

Improve and support the capability of our people through change

- Provide additional support leaders through change and uncertainty
- Ensure colleagues are skilled and trained to deliver quality and safe patient care

Operational Efficiency and Consistency

- Utilise our new systems, and emerging technology to deliver a more efficient HR service
- Drive more consistent application of policy and approach across the Charity

Wellbeing Support

- Support the emotional wellbeing colleagues at all levels through meaningful change and transition
- Provide tangible outplacement and career support for affected colleagues

Complaints – Learning from feedback

Between 01 April 2025 and 31 March 2026, 282 complaints were logged with PALS (Patient Advice and Liaison Service) and Complaints, (245 complaints were raised last year ((April 2024 – March 2025)). Due to the patient and carer safety conversations that were conducted twice this financial year we expected to see an increase in the number of complaints raised. This coincidentally impacted response timeframes, taking last year's 50.2% on time percentage to 32.2%. 295 compliments were received this year (169 compliments were received last year ((April 2024 – March 2025)).

This year focused on reviewing the effectiveness of patient and carer forums. Standardising processes and reiterating expectations in relation to patient and carer engagement, embedding patient and carer feedback into governance and ensuring that actions are completed in response to feedback are better communicated to patients and carers. As well as making information more accessible and delivering against our PCREF (Patient and Carer Race Equality Framework) plan as expected.

Overall number of complaints received April 2025 – March 2026	**282**
Percentage of complaints responded to within the agreed timeframe	32.2%
Number of complaints received via PHSO	1 (PHSO requested documentation only)
Most common theme of complaints this year	Poor staff attitude and behaviour
Most common theme of lessons learnt this year	• To ensure staff deliver effective, respectful and supportive communication with patients/carers • To ensure additional training is provided to meet patients/ carers needs
Most common complainant and source this year	Patient – Direct to PALS & Complaints
Number of compliments received	295
Most common theme of compliments this year	Overall quality of care & Staff excellence

People contacted PALS and Complaints via email, telephone, in person, via advocacy, and post. Patients can call PALS and

Complaints, and the advocacy service directly via 'hot keys' on their ward telephones. Patients can also directly contact the CQC (Care Quality Commission) and the PHSO (Parliamentary and Health Service Ombudsman) at any time, free of charge.

The timeliness of our responses to complaints fell well short of the standard that we aspire to with only 32.2% responded to within the timeframe agreed with the complainant. This illustrated a lack of robustness in our processes and limited resource. We have put additional resources into our PALS and complaints function alongside tightening up our processes with operational services. There is also improved governance with weekly reporting on overdue complaints to members of the Executive Team.

This year (April 2025 – March 2026) saw that feedback from complaints mainly highlighted that improvements were required to staff attitude and behaviour, specifically staff conduct, communication and additional training requirements. Compliments and positive patient and carer feedback (received via My Voice and patient and carer forums) told us that the overall quality of care patients and carers receive is good, particularly regarding certain staff members and teams, the support they have offered and excellence of care they have delivered. Positive overall life changing improvements to patients' lives were also referenced. Compliments were received by patients, carers and external professionals. Where feedback has been positive, continuity of this care and examples of good practice are shared across the Charity. Compliments highlighted both individual and team excellence.

My Voice: Patient & Carer Feedback System

Patients and carers can feedback at any time using the 'My Voice' feedback system. Results for this April 2025 – March 2026 are as follows:

Overall number of responses received April 2025 – March 2026	790
Highest rated questions (Based on 2025 and JAN-MAR 2026 data representation)	• 'Staff supporting me are kind and caring' • 'I know who I can talk to when needed' • 'I feel safe here'
Lowest rated questions (Based on 2025 and JAN-MAR 2026 data representation)	• 'Staff spent time with me' • 'I know everything I want to about my care' • 'I had my say about my care' • 'Being at St Andrew's is helping me'
Most common theme of 'What we do well'	• Psychology sessions, occupational therapies and activities • Support, guidance, care and help with recovery • Kind and caring staff that listen • 'Everything'
Most common theme of 'What can we do better'	• Regular, familiar and increased staffing • Staff attitude and behaviour • Food variety, portions and taste • More access to facilities, activities and leave • Estates and facilities improvements • Improve communication • -Nothing'
Positive Vs Negative response ratio (This excludes unanswered responses)	• Positive 68.10% • Negtaive14.05%

We recognise that our patients, service users, residents, families, carers and external professionals have a wide range of experiences of working with us and our services. Their knowledge and feedback are vital in ensuring that the Charity continuously improves, makes decisions in patients' and carers' best interests, promotes best practice and learns from where the Charity has fallen short of expectations.

The following are examples of what has been actioned in response to patient and carer feedback at ward level:

- Increased permanent staffing, reduction of agency staff and regular review of staffing levels and skill mix
- Specific staff training delivered
- Improvements and repairs to estates and facilities
- Developments and repairs to IT (Information and Technology) products and systems
- Development of menu options, variety and portion sizes
- Patient and carer activities, ideas and events delivered
- Recruitment of senior staff roles (including executives and non-executives) where a patient panel informed decisions
- Co-produced staff and patient training and delivery
- Key contacts and health records supplied
- Additional specific supportive care plans put in place

The following examples are larger scale improvements that have been completed via the Champion Committee. This is the group that has overseen and ensured the delivery of these relevant actions:

- Carers' feedback was built into the patient feedback system My Voice. Questions were created by carers, for carers. Putting feedback for all of St Andrew's services is one place.
- Optional PCREF demographics were embedded into the feedback system to help St Andrew's better highlight and address any potential health inequalities.
- An Expert By Experience Framework was produced.
- Improved Accessible information processes and alignment with AIS (Accessible Information Standards).
- A Patient and Carer Experience Policy began to be developed to help reinforce expectations of how to engage, collate and act in response to patient and carer feedback.
- Increased attendance at the Charity-wide patient and carer forums.
- Patient and carer feedback forums were reviewed and standardised where necessary.
- Governance of patient and carer feedback was reviewed and clarified within the new quality structure.

Patient and Carer Experience (including PALS and Complaints) Priorities for 2026-2027

The areas for next year's priorities were identified in response to the patient and carer feedback we received as well as ongoing related actions that need further improvement and embedding:

1. To ensure that improvement work completed by the Champion Committee, transitions into the appropriate groups within the quality governance and is embedded into everyday practice.
2. To ensure patient and carer feedback is acted upon and communicated back to the people it effects.
3. To continue the delivery and embedding of the PCREF plan.

Diversity and Inclusion

At St Andrews Healthcare we are proud of the diversity throughout our organisation with 43% of our workforce from global majority groups and minority groups from around the world (as of April 2025). This diversity does not just include race, with 60% of our workforce being female, representation from the LGBTQ+ community (4%) and people who are diagnosed/undiagnosed as Neurodiverse or have a disability (4%).

The Charity continue to monitor a number of inclusion statistics included in our annual report. The Charity's Gender Pay Gap ratio shows a median pay gap of 2.9%, significantly better than the national pay gap of 12.8%. This is calculated by listing all pay rates by gender and assessing the ones in the middle. A pay gap of 0% means that our median male and female hourly rates of pay are exactly the same.

The Charity's Ethnicity Pay Gap ratio shows a median of -2.7%. Our negative median pay gap means that employees from global majority groups and minority groups have a slightly higher overall rate of pay when considering total remuneration (i.e. including unsocial hour's payments).

We strive to achieve an environment where all colleagues feel respected, empowered, and supported from the moment they join us. We encourage all of our staff to engage and be part of the future of equality, diversity and inclusion (EDI) through our four staff networks, various initiatives and other forums which consider EDI as part of successful outcomes for our staff, patients and carers. Our staff networks include **PRIDE** (LGBTQ+), **DAWN** (Disability, Ability, Wellbeing & Neurodiversity including Men's Mental Health), **UNITY** (Support for colleagues from majority or minority groups and allies) and **WiSH** (women in St Andrews Healthcare) with the Co-Chairs forming part of STEER, our Employee Forum, where key issues are raised and discussed.

Key highlights for 2025/26 have been:

- Launching a Charity wide Anti Racism Campaign 'United Against Racism' including awareness videos from our staff, patients and carers.
- Running Listening sessions across our sites, wards and departments.
- Being the first independent Mental Healthcare Provider to join the Patient and Carer Race Equality Framework group pilot.
- Launching a support group for Men's Mental Health
- Working with Carers UK to support working carers.

Quality and Safety Committee (QSC)

The Quality Committee

This Board Committee is chaired by a Clinical Non-Executive Director, Anne-Maria Newham MBE (appointed July 2025, replacing Steve Shrubb who had been chair of the committee since October 2022), currently supported by two other Non-Executive Directors, Ruth Bagley and Richard Shoreland holding committee member positions, as well as three Executive Directors - Executive Medical Director, Executive Director of Quality and Nursing and Managing Director of Clinical Services. A Charity Governor also attends meetings of the committee. The Quality Committee seeks assurance on behalf of the Board on all aspects of quality and clinical safety, including standards of quality, safety, and effectiveness for clinical care, on the quality and effectiveness of the patient experience and on the effectiveness of clinical governance and clinical risk management systems.

The Committee seeks assurance on the effectiveness of training and eLearning programmes to ensure staff have the necessary skills and competences to deliver quality, safe and effective care and maintains oversight of clinical related incidents, lessons learned and improvement plans. The Committee oversees the creation, implementation and delivery of quality and clinical related strategies and seeks assurance on all matters relating to compliance within the Charity of statutory requirements relating to mental health legislation. The Committee also has responsibility for seeking assurance on the application of strategies and processes to ensure compliance with relevant Health & Safety requirements, including, where applicable, improvement plans.

The Quality Committee promotes learning and the sharing of best practice, both from within and outside the Charity, including benchmarking with areas of recognised best practice where appropriate. It meets bi-monthly, providing an escalation and assurance report to the Board of Directors following each meeting, and oversees the clinical risk processes by identifying associated risks and providing recommendations for mitigating controls.

Clinical Informatics

Overview

The 2025/2026 period has delivered continued progress in Clinical Informatics across St Andrew's Healthcare, building on previous digital foundations while improving safety, quality assurance and staff experience. A central development has been the creation of the Innovation Hub, which enables rapid evaluation, development, testing and implementation of ideas using the Double Diamond approach. Across clinical systems, better data capture, clearer visualisation and responsive problem-solving are producing practical gains in patient safety, care quality, operational oversight and administrative efficiency.

Innovation Hub

The Innovation Hub, supported by a dedicated SharePoint site, now captures and assesses innovative ideas from across the charity. Ideas are scored across agreed domains so that high-impact, feasible proposals can be prioritised. Weekly focused meetings bring together colleagues from data, clinical systems, IT and clinical services, creating a practical route from problem identification to testing and implementation.

The Hub has already supported significant work, including ward form digitisation, AutoScribe and AI-assisted auditing. It has also enabled a business plan for a Rio-based patient portal that would share correspondence, medication information, care plans, questionnaires and other relevant information directly with patients across outpatient and inpatient services. The charity is also exploring ambient voice technology to support clinician productivity and reduce the burden of administration.

Rio Developments: Clinical Workflows, Assurance & Oversight

Further enhancements to the Rio WardBoard have improved compliance and reinforced its role as the central overview for ward-based clinical activity. Clinical teams increasingly use it as the day-to-day hub for oversight, with alert functionality proving particularly valuable. Additional alerts now cover personal emergency evacuation plans, equality and diversity recording, food and fluid intake, bowel monitoring, HCR-20, end-of-life care plans, care plan reviews and other key processes, strengthening visibility of clinical quality and compliance.

Use of Rio tablets for point-of-care documentation has continued to grow. Further forms have been deployed through the mobile interface, including ad hoc meaningful activity recording, the Abbey Pain Scale, food monitoring, capillary blood glucose monitoring, falls checklists, neurological observations, post-fall assessments and post-rapid tranquilisation monitoring. Existing forms have also been refined to improve clarity and usability, supporting more timely recording at the point of care and improving accessibility for frontline teams.

Rio has also been extended to capture ward-level operational and assurance information. Clinic room and fridge temperature checks are now live across all wards, and the ward huddle form is nearing the end of its pilot before wider scale-up. Further checklists are being progressed, including safety, ligature, clinical equipment and green bag checks. Supported by data visualisation, these developments reduce reliance on paper and enable stronger live assurance rather than periodic manual audit.

The Care, Education and Treatment Review module is now fully operational. The referral module has been refined and is being used consistently, improving visibility of the admissions pipeline, helping identify bottlenecks and supporting resolution of delays. Pharmacy review forms have been added, improving oversight of Mental Health Act requirements including T2, T3 and Section 62 processes.

The previous mismatch between medication recorded in ward round entries and actual prescriptions has largely been resolved through importing the current EPMA medication list into ward round notes. Digital food and fluid recording, with configurable thresholds and a charity-wide dashboard, has materially improved monitoring in an area where significant concerns had previously been identified. Bespoke care plans and alerts now support routine monitoring such as NEWS2, bowel movements and capillary blood glucose, with near-live dashboards for NEWS2 and fluid intake updated at least every five minutes.

A new on-call long-term segregation review report brings together the previous 24 hours of observation records, PRN medication and incidents. Meaningful activity recording has been simplified, including revised activity lists and the ability to record overlapping activities. Key risk information is now visible on Rio mobile devices used for enhanced observations, helping frontline staff access salient risk information when it is most needed.

Artificial Intelligence, Automation and Digital Innovation

The organisation has made significant progress in using AI and LLMs to improve quality, monitoring and operational efficiency. The Innovation Hub has supported stakeholders to develop tools that apply AI safely and ethically, including a locally hosted model. Work is also progressing to move data into an appropriate cloud environment, enabling more flexible predictive analytics and future machine learning approaches.

AI-assisted auditing has been trialled across health record systems, including care plans, progress notes and assessments. A first-of-its-kind AI-assisted audit focused on NEWS2 variation has been completed and is expected to be published shortly.

AutoScribe, an AI-enabled tool for non-clinical Microsoft Teams meetings, has been developed to process transcripts and generate structured meeting summaries. Following successful trials, it has been deployed across the organisation and is available to all staff, supported by clear guidance on safe and appropriate use.

Safe-use guidance for LLMs has been developed and disseminated in collaboration with the communications team and in line with NHS England guidance. Enterprise-level access to Microsoft Copilot has been secured within existing licensing at no additional cost and made available to all staff. Guidance on acceptable and unacceptable use is being communicated, and the IT security team is discouraging unapproved alternatives through firewall controls that redirect users to the approved solution.

EPMA Performance and Optimisation

EPMA continues to present speed and responsiveness challenges. A system upgrade has been reviewed but remains on hold because trials of newer versions indicated worse loading times and additional performance risks. Work continues with the supplier, but there is currently no viable alternative system that meets organisational requirements.

Troubleshooting has identified prescriptions approaching approximately 1,000 administrations as a key cause of reduced loading speed. Clinicians are now periodically asked to review and amend these prescriptions where appropriate. Support from prescribers continues to deliver significant benefit, including savings of more than 30 hours per week of qualified nursing time across the charity, while current mitigation measures remain in place.

Datix Incident Reporting System

The Datix upgrade completed in November 2025, including LFPSE, was implemented without significant concern. The latest version is now being tested in the test environment, including the required new coding arrangements.

EMIS and Physical Health Data Reporting

EMIS remains the electronic health record for the physical health group. Although there are limitations in direct access to EMIS data, an automated robotic process has been developed to generate routine reports. These reports inform Rio and related dashboards, supporting compliance and service quality for long-term conditions and national screening programmes.

Further work is underway to improve EMIS outputs for cardiometabolic monitoring and support Lester tool-based approach to screening and intervention. This could substantially improve the systematic identification and response to cardiometabolic risk factors across the patient population.

Health Data Dashboards, Governance and Patient Feedback

A range of data reports and dashboards now support clinical decision-making, governance and quality improvement. Dedicated reporting has been developed for Infection Prevention and Control, the Quality and Safety Group and other governance processes. Additional outputs support ward and divisional quality improvement plans, ward huddles and the Integrated Quality Performance Report.

The MyVoice patient-reported experience measure has been significantly developed. It now enables completion by family members and carers, includes protected characteristics and Patient and Carer Race Equality Framework questions, and supports analysis through a PCREF lens. In response to patient group feedback, the questionnaire has also been simplified to a five-point Likert scale. Following patient journey work, Walton Ward in the Specialist Division was shortlisted and won the national Excellence in Clinical Care award at the LaingBuisson 2025 Awards.

Additional Rio Enhancements to Support Quality and Clinical Practice

Further Rio changes have improved recording, oversight and usability. These include attaching photographs to physical health referrals; amendments to Section 132 rights documentation and alerts; a consent-to-share alert; digitised personal emergency evacuation plans with ward, building

and divisional views; infection prevention and control forms; hospital transfer form amendments and additional checklists; search planning and recording; referral process automation; care planning consolidation; nutritional screening amendments; digital recording of Core 34, International Trauma Questionnaire, SDQ, DERS and CATS outcome measures; flags for veterans and family members of serving Armed Forces personnel; extended package of care forms; and simplified care plan update meeting print functions and progress note buttons.

Conclusion

This has been another year of meaningful progress in Clinical Informatics across St Andrew's Healthcare. Collaboration between clinical teams, digital and data colleagues, clinical systems and IT has strengthened the infrastructure that supports safe, effective and high-quality care. The developments described demonstrate increasing maturity in digitisation, automation, artificial intelligence, assurance reporting and patient-centred innovation. Collectively, they improve visibility, support decision-making, reduce administrative burden and enhance the quality and safety of care provided across the charity.

SECTION 3

Review of Quality Performance

Review of Quality Performance

2025/26 Quality Priorities

For the financial year 2025/26 we set the following priorities:

- Develop stronger links within our community services - **PARTIAL**
- Raise awareness and promote speak up with the newly established role of FTSU Ambassador - **MET**
- Moving forward we are developing outcome measures which we can use to help assess our effectiveness and benchmark ourselves against other providers – **NOT MET**
- Continue to develop the assurance process for speak up actions - **MET**
- Analyse feedback figures and narrative – via the electronic feedback form (confidentially submitted) - **MET**

Stronger Links within our community services

Through the year we have consolidated our community services and strengthened their leadership. There has been a focus on developing a robust clinical governance framework to ensure their safety and effectiveness. We have revised the process for routinely reviewing the quality and performance of the service to ensure more effective oversight and scrutiny. During the year the services have maintained a Good rating with the CQC.

Raise awareness and promote speak up with the newly established role of FTSU Ambassador

There has been an intense focus on opening closed cultures across all our services in 2025/26. We have made significant efforts to promote the role of Lead FTSU Guardian, support Guardians and the Ambassadors. This has borne fruit with a significant increase in people using FTSU as a route to raising concerns across the year. We have concurrently seen a significant reduction in the number of people anonymously raising concerns via Safe Call; an indication of people's confidence in the FTSU process.

Our staff survey this year focussed on staff openness and confidence in reporting, which demonstrated extremely positive results with high confidence across all staff groups in speaking up and in the leaderships likelihood to act on this. We have expanded the Lead Guardian Role to full-time for 2026/27 to continue a focus and to underline how important this is to St Andrew's.

Continue to develop the assurance process for speak up actions

Through the year we have revised our Quality Assurance processes, including the development of a new Quality Assurance Governance Framework, which incorporates how we act from issues that arise through FTSU. Within this framework there is a Workforce, Staffing & Culture group, which has responsibility for assurance of follow-up to FTSU concerns. This group reports through the framework to the Board.

Issues that are specific to one ward or clinical area, are added to the action logs locally; those that require a wider response are added to service/hospital action plans or charity-wide plans, as appropriate.

Moving forward we are developing outcome measures which we can use to help assess our effectiveness and benchmark ourselves against other providers

In 2025/26 we have worked with regulators and commissioners to develop a Safe Today Dashboard. This focusses on key metrics that are associated with patient safety and how we provide safe and effective services. Despite significant efforts it has not been possible to source external benchmarks to compare our performance against.

We have continued to work with colleagues in the East Midlands Alliance and other relevant benchmarking groups, such as the Restraint Reduction Network. This has provided us with some opportunities for benchmarking of outcomes.

Analyse feedback figures and narrative – via the electronic feedback form

Through the year we have analysed and used the data and narrative feedback to continually improve our services. This has been overseen through the IQPR process (Integrated Quality and Performance Reviews) monthly, reporting through the Executive to the Board. This has been enhanced with a full review of the IQPR process and use of feedback for improvement.

In 2025/26 we have added to how we receive feedback from patients and carers by undertaking two rounds of 'safety conversations. These were offered to all patients and carers in August 2025 and February 2026. This has given us rich insight into the experience of our patients and their carers which has informed local and charity-wide improvement plans throughout the year.

Involvement and feedback from Key Stakeholders

POhWER Advocacy

POhWER is a charity established in 1996 by people with lived experience who wanted equal access to information and a stronger voice in decisions affecting their lives. We exist to provide high-quality information, advice, support, and advocacy to individuals experiencing disability, vulnerability, distress, and social exclusion.

As the local authority commissioned provider of statutory advocacy services across West Northamptonshire, POhWER delivers Care Act Advocacy, Independent Mental Capacity Advocacy (IMCA), Independent Mental Health Advocacy (IMHA), and NHS Complaints Advocacy. Our services are designed to ensure that individuals understand their rights, are supported to express their views, and are actively involved in decisions about their care and treatment.

Within St Andrew's, our advocates provide independent, impartial support to patients, ensuring their voices are heard and their rights are upheld in the hospital setting. We are committed to promoting dignity, choice, and empowerment for every individual we support.

Access to our advocacy services is designed to be flexible and inclusive. Patients can engage with us through self-referral, professional referral, or through direct contact with our advocates while they are present on-site.

POhWER is dedicated to delivering a person-centred, rights-based service, working collaboratively with stakeholders to improve outcomes, reduce inequality, and amplify the voices of those who are often unheard.

NHS England

NHS England is accountable for the specialised mental health services provided by St Andrew's Healthcare and continues to work with other providers and Integrated Care Boards in a collaborative arrangement, to commission and monitor service provision. NHS England continues to work with St Andrew's Healthcare and wider system partners to address areas of concern.

Northamptonshire Integrated Care Board

Northamptonshire Integrated Care Board is Host Commissioner for St Andrews Healthcare, thank you for providing us with the opportunity to comment on your annual quality account for 2025/26.

The quality account was reviewed whilst in draft format.

The organisation is currently operating in a high-risk environment, with significant concerns identified - most notably the Inadequate CQC rating for Northampton, alongside challenges in leadership, governance, staffing, and aspects of patient experience. These issues are reflected in rising complaints, safeguarding pressures, and continued challenges in consistency of care delivery as reported in the Quality Account.

However, the organisation has clearly acknowledged these failings and has implemented a comprehensive, organisation-wide improvement programme, focused on strengthening leadership, embedding robust governance, improving staffing and skill mix, and creating a more open and safety-focused culture. Early signs of progress are evident, including reductions in severe harm incidents, improvements in clinical processes, and no reported Never Events. The organisation has shown commitment to working with partners including NHSE Recovery Support Programme Team whilst they navigate their improvement journey.

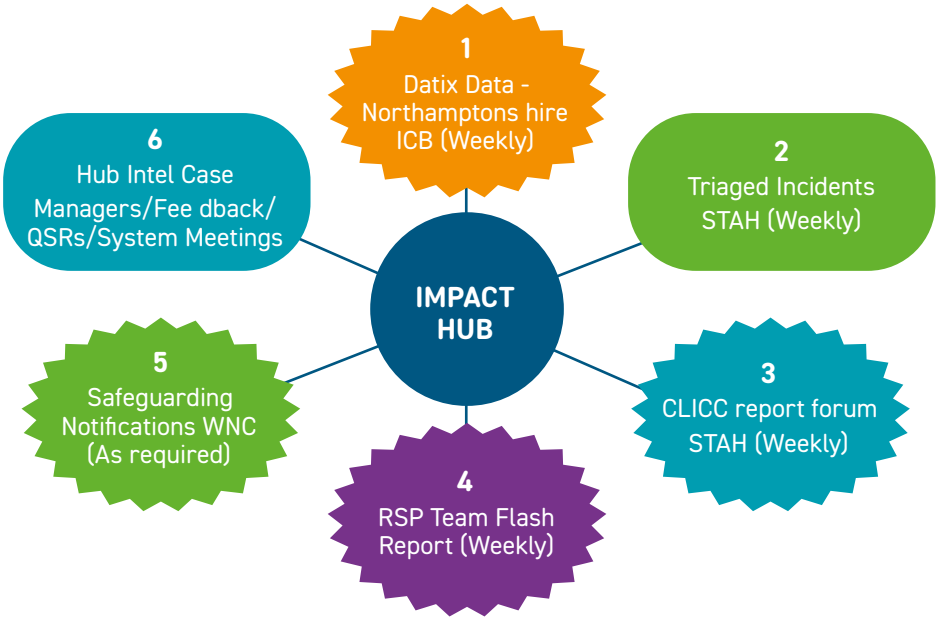
Performance across the organisation remains variable, with some services achieving and sustaining Good CQC ratings, demonstrating that high-quality care is achievable within the model. The key challenge for the organisation is therefore to deliver consistent standards across all sites, particularly in higher-risk services.

In summary:

There is a clear improvement trajectory, supported by strengthened governance and early progress. However, it is acknowledged that delivery risk remains, particularly around embedding consistent practice, demonstrating sustained improvement in quality and safety, and rebuilding confidence across commissioners, regulators, patients, and staff.

IMPACT

IMPACT provider collaborative has continued to commission St Andrews Healthcare Northampton to provide care for patients requiring low and medium secure service environments/services within MI/PD and LDA. IMPACT work with both operational and strategic teams to oversee the delivery of high quality and compassionate care. Assurance visits have continued throughout the year, alongside clinical case management visits. Due to enhanced support required and reflected within the quality account. IMPACT provide weekly face to face and online coverage to support services, jointly review risk and safety concerns and embed learning. From Q1 increased oversight has been exercised. The below outlines the processes for information sharing, including the exchange of data its sources, timeliness and management. it also reviews key points of contact across systems, incorporates clinical intelligence and provides updates on safeguarding. Additionally, the report includes analysis of information as well as a summary and review of events/incidents. The diagram below demonstrates the sources of information which support quality oversight of St Andrews. Those shown in a star shape are additional measures IMPACT have put in place and/or in receipt of to support robust oversight and are outside of standard quality oversight arrangements.



Healthwatch North and West Northamptonshire

Thank you for the opportunity to review St Andrew's Healthcare's Quality Account for 2025–26. Healthwatch West Northamptonshire welcomes the transparency shown within this report and recognises the significant challenges faced by the organisation during the reporting period. We appreciate the openness with which St Andrew's has engaged with stakeholders and acknowledge the efforts being made to improve quality, safety, governance and organisational culture.

As members of the St Andrew's Intensive Assurance and Oversight Group, we have valued the opportunity to receive updates and engage in discussions regarding the organisation's improvement journey. The openness demonstrated through this process has been important in providing assurance to partners and enabling constructive challenge. We hope this commitment to transparency continues as improvement work progresses.

Whilst we recognise the positive developments outlined within the report, it is important to acknowledge that many of the issues identified remain significant and require sustained focus. The CQC rating brought a need for action within the organisation, including inadequate ratings in safety, caring, well-led and overall status, which we felt was well addressed within the accounts.

The increase in complaints during the year, alongside a reduction in the proportion responded to within agreed timescales, highlights the need for continued improvement in how concerns are managed and addressed. We note that the most common themes of complaints continue to relate to staff attitude, behaviour and communication, which are areas that can have a profound impact on patients' and carers' experiences of care.

We welcome the organisation's recognition of these themes and the actions being taken in response. However, it remains essential that patients, carers and families feel listened to, respected and meaningfully involved in decisions about their care. The findings from the My Voice feedback system, particularly around patients wanting greater involvement in their care and better understanding of treatment plans, reinforce the importance of strengthening communication and co-production throughout the organisation.

We are encouraged by the continued development of patient and carer engagement mechanisms, including patient forums, the My Voice programme and work to embed the Patient and Carer Race Equality Framework. These initiatives provide valuable opportunities to understand people's experiences and should continue to be central to service improvement. It will be important that feedback is not only gathered but that patients and families can clearly see how their views have influenced change.

We also welcome the ongoing focus on safeguarding and patient safety. The strengthening of safeguarding governance, introduction of safeguarding supervision, partnership working with local authorities and the organisation's willingness to identify areas for further improvement demonstrate a commitment to learning and improvement. Given the complexity and vulnerability of the patient population, maintaining a strong safeguarding culture must remain a key priority.

We note the continued investment in workforce development, leadership and Freedom to Speak Up arrangements. The reported increase in staff confidence to raise concerns is encouraging. During periods of organisational change, it is particularly important that staff feel safe to speak up, that concerns are acted upon, and that staff wellbeing remains a priority. We welcome the organisation's acknowledgement that further work is required to build trust, improve communication and ensure consistency across services.

Overall, Healthwatch West Northamptonshire considers this Quality Account to be open and reflective, acknowledging both progress made and areas where further improvement is required. We encourage St Andrew's Healthcare to maintain its focus on listening to patients, families and staff, strengthening communication, and ensuring that learning from feedback, complaints and safeguarding concerns is translated into meaningful and sustainable change.

We look forward to continuing to work with St Andrew's Healthcare and system partners to support improvements and ensure the voices of patients, carers and families remain central to service development and delivery.

SECTION 4

St Andrew's Healthcare Showcase

Showcase Section

Essex

Over the past year, our Essex hospital has continued to strengthen its commitment to delivering compassionate, safe, and patient centred care through a focused programme of quality improvement, staff engagement and governance development.

A key area of improvement has been embedding the patient voice in a more meaningful way within care planning. Following a thematic review of patient feedback, we identified opportunities to improve how individuals are involved in decisions about their care and treatment. We implemented targeted one-to-one training sessions with staff to strengthen collaborative care planning practices, improve therapeutic conversations, and ensure care plan better reflect patient goals, preferences and lived experience. This work supports a more personalised approach to care and increase patient involvement in their recovery.

We have also strengthened our learning culture through the application of the principles of the NHS Patient Safety Incident Response Framework (PSIRF) creating psychologically safe spaces. Staff are encouraged to openly reflect, share learning, and discuss incident constructively, with a clear focus on understanding systems and improving outcomes rather than assigning blame. Learning themes and service improvements are communicated through monthly "lessons learnt" bulletin, helping teams to remain informed, connected and engaged in continues improvements across the hospital.

To further promote openness and staff engagements, we have introduced regular "Conversation cafes". These forums provide a supportive space where staff can ask questions, share experiences and discuss challenges openly with leaders and colleagues. This initiative has improved communication, strengthened team cohesion, and reinforced a culture where staff feel listened to, valued and empowered to continue to service development and delivery the best quality of care to patients.

The Care Premiership Programme has continued to deliver measurable improvements across patient experience and governance standards. By focusing on purposeful activity, therapeutic engagement, and quality of patient experience, this initiative has enhanced overall patient care. Alongside this, the programme has strengthened governance compliance through improved timeliness of audits, documentation standard, supervision, clear accountability, and oversight of all care processes.

External agency visits have reflected the positives of all these initiatives. Patients and visitors have consistently described feeling cared for, valued, and safe within the service with patients quoting "the staff saved my life, I am treated like a person". Feedback has highlighted the hospital's clean welcoming environment, alongside the warmth, professionalism and kindness demonstrated by all staff.

Collectively, these improvements demonstrate a strong culture of safe, compassionate, and well led care which contributed to the hospital recently achieving an overall CQC rating of "Good". Feedback from patients, carers and external stakeholders consistently reflected positive experiences of care, safety, and staff engagement. Together, these initiatives demonstrate this service is responsive, caring, and committed to delivering high-quality mental health care we aspire to and aligned with standards expected from the CQC.

Birmingham

Over the past year, the service has undergone significant organisational and operational change, following the departure of the Service Director, General Manager and Associate Director of Nursing in early 2025. In response, a smaller and more focused leadership structure was established, comprising the Interim Improvement Director, General Manager, two Matrons and, more recently, our Quality Business Partner. This streamlined leadership model has enabled clearer oversight, faster decision making and a more coordinated approach to improvement.

A major development during the summer was the creation of a single, comprehensive Turnaround Team and plan, known as Project Rabbit Hole. This brought together departmental leads from across the site to drive forward service improvements in a structured and collaborative way. The team meets every Tuesday to review progress and prioritise actions arising from CQC feedback, Reach Out visits and internal quality concerns. At the point of formation, the turnaround plan contained 24 high priority and 11 medium priority actions. To date, 19 actions have been fully closed, reflecting sustained effort and improved cross team working.

Quality oversight has also strengthened considerably. The service underwent a CQC inspection in the summer, and although the draft report is still awaited, multiple Reach Out quality visits took place during the period of intensive surveillance. These visits identified no new concerns, and both staff and patients described the hospital as lighter, brighter and safer. As a result, our surveillance level was reduced from intensive to enhanced at the end of January 2026. We remain in the intensive category only due to wider system concerns linked to the closure of St Andrew's Northampton, rather than issues specific to our site.

Workforce stability and investment have been major areas of progress. Shortly after taking up post, a full out of cycle establishment review was commissioned and completed, leading to executive agreement for staffing uplifts across all wards for both day and night shifts. Notably, night staffing increased from one qualified nurse to two. A further establishment review in March 2026 resulted in additional uplifts for Moor Green and Hazelwell, strengthening frontline capacity and improving the safety and resilience of the wards.

Alongside this, we have successfully appointed a new Hospital Director, Care Director and a dedicated Quality Business Partner for Birmingham, further enhancing leadership capability.

Collectively, these developments reflect a year of focused improvement, strengthened governance and meaningful progress towards a safer, more stable and better led service.

Adult Care Services

We have achieved a number of significant successes across our services that we are particularly proud of. Two services, Broom and 17 The Avenue, have maintained good ratings, demonstrating consistent quality of care. At Winslow, one Key Line of Enquiry was improved from Requires Improvement to Good in the Well-Led domain, reflecting strengthened leadership.

We have supported positive patient pathways, including one admission from a Medium Secure Unit into the deaf community houses, and another successful transition from a blended secure ward into the STS, which has been a very positive move for the individual. In addition, two individuals were successfully discharged from STS into the community, highlighting effective rehabilitation and discharge planning.

Clinically, we have sustained an increase in supervision since April 2025, alongside a reduction in overdue Datix reports, indicating improved governance and oversight. There has also been a consistent month on month reduction in restraints, seclusions, and rapid tranquilisation, demonstrating our commitment to least restrictive practice. Furthermore, we have developed a suite of ACS specific policies.

What are our patients and carers saying?

'X's participation in the interview and induction process for new staff and the production of the patient newsletter has greatly increased his confidence and he very much enjoys being involved. I also believe it is very important for the patients to have their voices heard and are able to contribute their ideas and opinions.... The care John is receiving both physically and mentally is exemplary and I thank everyone involved'.

– Carer, Birmingham MAR 2026

'I just want to say thanks again to you and the whole of the team for the outstanding care and support you've all provided X and us as a family. We are beyond grateful for everything you have done, and we won't ever forget you all as you've been the most important part of his recovery over these past six years and you have shown nothing but kindness throughout. As you know, I have serious worries about the next steps but with the strong foundations you have provided I have a lot of hope that X can move forward and make trusting relationships and will be able to look forward to a meaningful future and life worth living. Thank you again so much'.

– Carer, Northampton DEC 2025

'...Operation Courage has literally saved my life. This is no exaggeration. For years ago, when I tried to end my life, I saw no hope for the future. And even a year ago it looked bleak to me. The work I have done with Operation Courage has given me the tools I need to learn to cope. Every day is still a learning day for me, but I have skills now. The work I did with the physiotherapist helped process the trauma I had been living with for the last 34 years!....

– Outpatients, OCT 2025

'Thank you for your endless compassion and patience with us. We have all experienced awful things, so also thank you for showing us the kindness that humanity is capable of and allowing us to make meaningful and supportive relationships with you. When it is often hard to trust people, you help us to learn too again. I just think it's so important to remind you of your impact and know that I can see your care and the genuine passion that nearly all of you have in helping us to create a life worth living again, or for the first time'.

– Patient, Northampton, JUL 2025

'I recently when through a very tough time with my depression. For a week I didn't leave my room and didn't eat or drink. But every day X came to see me. She offered to talk, asked if I wanted anything, even got me a drink. Sometimes she would pop in for a few minutes, sometimes longer, even if it meant she didn't leave straight after her shift. She cared, and I know it. If that doesn't deserve recognition, I don't know what does'.

– Patient, Essex, APR 2025

APPENDIX 1

Clinical Audit and Research

Appendix - Clinical Audit and Research

Participation in National Clinical Audits

During 2025/26 – the Charity participated in five National Clinical Audits. The National Clinical Audits that the Charity participated in, and for which data collection was completed or submitted during 2025/26, are listed below, alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Topic	Submissions
National Audit of Care at the End of Life (NACEL), NHS Benchmarking Network	9 (100%)
The use of clozapine, Prescribing Observatory for Mental Health (POMH-UK)	64 (100%)
Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services, Prescribing Observatory for Mental Health (POMH-UK)	36 (100%)
Improving the quality of valproate prescribing, Prescribing Observatory for Mental Health (POMH-UK)	84 (100%)
Use of antipsychotic medication for relapse prevention in patients with a diagnosis of schizophrenia (POMH-UK)	Ongoing
National Audit of Inpatient Falls, Falls and Fragility Fracture Audit Programme, Royal College of Physicians	1 – Ongoing to December 2026

During 2025-26 the Charity was eligible to participate in audits under the following programmes but did not have any cases in scope:

- Maternal, New-born and Infant Clinical Outcome Review Programme
- Mental Health Clinical Outcome Review Programme

The Charity's Quality and Safety Group oversaw participation and learning from national audits and confidential enquiries in 2025/26.

Improvement Following National Audits

Following the National **Audit of Inpatient Falls** recommendations, several improvements have been implemented. Spot checks were carried out to review the quality of Multifactorial Falls Risk Assessments and the multi professional response, with a focus on physiotherapy input into gait and balance assessment, mobility care planning, walking aid prescription, and falls prevention exercises. This work has led to the following changes:

New Physiotherapy Falls Prevention Care Pathway

- Baseline mobility assessment for all at risk patients on admission.
- Reassessment every six months, or sooner if function changes.
- Three monthly assessments for patients with neurodegenerative conditions.
- Physiotherapy assessment after any new fall.
- Falls prevention exercise programmes for moderate/high risk patients.
- Encouragement to remain active for low risk patients, supported by staff education.

Review of Best Practice

- Best practice guidance reviewed to standardise physiotherapy assessments.

Falls Management Procedure

- Procedure under review to incorporate updated NAIF recommendations and revised NICE guidance.

Walking aids accessibility

- Physiotherapy team has been granted ongoing annual budget to purchase and then replenish required walking aids. Walking aids library allows immediate provision of walking aids when necessary.

As part of hospital wide falls data relating to delirium - where there was poor evidence of 4AT delirium screening tool usage, SQiD (Single Question in Delirium) tool was proposed to improve compliance and approved by the Falls and Frailty Group. Staff education about this tool is to follow.

Participation in Local Clinical Audits

Inpatient Division specific local clinical audits are completed either by clinicians or other key stakeholders, as stand-alone assignments or jointly with members of the Clinical Audit and Assurance Team. Recommended actions from these audits were monitored locally by the Divisions.

Charity-wide audits are completed by the Clinical Audit and Assurance Team or other key stakeholders. Recommended actions from these audits are monitored and followed up by the staff and/or groups responsible for implementing them, with reports and analysis shared and discussed at relevant groups, e.g. Divisional Clinical Governance Groups, Clinical Effectiveness Group, Quality and Safety Group, etc.

The annual programmes of Clinical Audit and Assurance assignments, which incorporate audits and reviews against specified categories/drivers are maintained by the Clinical Audit and Assurance Team.

Since April 2025, 15 local Clinical Audits were published (these are included in the table below), and three further audits are currently in various stages of completion. Actions arising from each local clinical audit are addressed at Divisional level or Charity-wide level.

Completed and/or published local clinical audits
Patients Discharge Follow-up
Care Co-ordinator Sessions
Care Planning
Community Meetings
Search Practice
Clinical Peer Reviews
NEWS2 Care of Deteriorating Patient
Patients and Staff Debrief
Daily Huddles
Closed Culture and Culture of Care
Nasogastric Audit
Food and Fluid Chart
Lying and Standing Blood Pressure Monitoring on Admission
IDDSI Dysphagia Food Compliance Follow-up
Rapid Tranquilisation Use in CAMHS
PRN Use in CAMHS
Bowel Monitoring Follow-up
ECG Monitoring for QT-Prolonging Antipsychotics
Culture Review in Meadow
Duty of Candour (In progress)
Clinical Supervision (In progress)

Improvement Following Local Clinical Audits

Following completion of audits, action plans based on the findings are formulated and delivered with improvements monitored through Quality Improvement Plans or follow-up reviews. Some examples of actions taken to improve the quality of care following audit recommendations include:

- **MAPPA** audit – The MAPPA procedure has been updated to be more user friendly by streamlining and merging appendices where appropriate, ensuring that information already covered in the main procedure is not duplicated. Responsibilities, notification requirements, and the expected timeframes for each stage have also been clarified.
- **Safeguarding** audit – All safeguarding-related training was reviewed, including a full revisit of safeguarding thresholds related to the Level 3 safeguarding training.
- **Mental Capacity** audit:
  - Enhancements were made to the RiO Capacity Assessment templates, including separating the 'Refused' and 'Did not understand' options within the Section 132 documentation to improve clarity and accuracy.
  - The RiO progress note type previously titled 'Capacity Assessment' was updated to 'Capacity Assessment/Best Interest' to more accurately reflect the scope of clinical decision making and recording.
  - The Mental Health Law Steering Group agreed to align the Mental Capacity and Best Interest recording forms on RiO with nationally used templates, for improved documentation standards, particularly in relation to appropriate consultation.
- **Patients Discharge** audit - Improvements implemented on the Discharge Policy and Procedure, following audit recommendations included:
  - References within the procedure were updated to reflect the latest versions of external standards.
  - A new section on delayed discharge was added to strengthen guidance and support safer discharge processes.
  - A new discharge checklist has been created to ensure effective communication and handover, support the timely sending of reports, and help ensure patients leave with all the necessary information and documentation.
  - The procedure was updated to include clearer guidance for divisions on evidencing completion and sharing of discharge summaries.

- **Patient Involvement in Least Restrictive Practice** – following the audit recommendations, a Best Practice Guidance has been developed to support running inclusive and well prepared community meetings that openly discuss restrictions and explore improvements; ensuring clear, consistent recording and regular review of all restrictions; enabling patients to provide feedback through multiple accessible formats with all responses securely stored, routinely reviewed, and used to demonstrate service improvements; and ensuring any issues raised are addressed promptly through clear ownership, defined timescales, progress monitoring, appropriate escalation, and regular updates to both patients and staff.

- **NEWS2 Care of Deteriorating Patient** (Follow-up) - Following the previous NEWS2 audit recommendations, substantial progress has been achieved across key domains. NEWS2 observations for all newly admitted patients are now being completed within the required timeframe, demonstrating a significant strengthening of early clinical monitoring. Documentation practices have also advanced, with required NEWS2 and non contact forms being completed far more reliably and with greater consistency and accuracy. Escalation procedures have shown clear improvement as well, with a higher proportion of raised NEWS2 scores receiving the appropriate follow up action. Taken together, these developments reflect a marked uplift in clinical oversight, documentation standards, and escalation responsiveness, signalling a more robust and safer approach to patient monitoring.

- **Lying & Standing Blood Pressure** audit - Following the audit the Falls Procedure is being amended to specify timeframes and responsibility in relation to orthostatic hypotension, and educational session regarding L/S BP, L&S BP are being included in Nurses handbook for quick navigation.

- **Post Falls Protocol** audit - Following the audit, a BI dashboard has been developed to monitor compliance, including injury assessments and required neurological observations, and to record concerns for discussion during daily huddles.

  Training needs for first responders have been escalated to the L&D team, and a face to face module has been produced with input from the Falls Prevention Lead.

  The Post Falls Protocol is under review to reflect updates to NICE QS86 and new NAIF guidance on post fall medical examinations.

  Due to lessons learned, including delays in recognising injuries, nursing competency gaps are being re escalated to the L&D team for action.

Clinical Peer Review Process

Clinical Peer Review (CPR) is a process where clinicians review the clinical practice of their peer group using a set tool, with the aim of providing a supportive and collaborative approach to identify areas of improvement and also highlight areas of good practice.

In 2025/26, 14 CPRs took place encompassing 70 patients' records. The CPR recommendations were addressed at ward level.

The CPR results are analysed and reported to the Divisional Clinical Governance Groups, Clinical Governance Oversight Group and Quality and Safety Group.

Examples of good practice highlighted by the CPRs include:

- Language used in patients' records being free of inappropriate examples
- Capacity assessments for consent to treatment completed timely and by the current Responsible Clinician
- Capacity to understand Section 132 rights
- Best Interests being recorded where patients lack capacity
- Evidence of following up with a patient if they refused a GASS assessment, blood test or ECG
- NEWS2 follow-up evidenced as required
- Restrictive practice care plans including a clear exit plan and medical reviews evidenced as required

Examples of areas for improvement:

- Capacity to consent to admission
- Capacity to consent to flu/COVID vaccine.

Participation in Clinical research

Research and Innovation

Our strategy focuses on four core research themes: Physical Health & Mental Health; Developmental & Complex Trauma; Forensic Mental Health, Progressive Neurological Conditions. These are underpinned by cross-cutting approaches to applied research and service evaluation, alongside the use of technology and data to improve outcomes and quality of care.

Service developments within these themes are informed and assessed through robust service evaluations, ensuring that changes to care are evidence-based. Collaborative working across these areas has delivered a range of impactful projects that support improved outcomes for our patients. In the past year, 96 of our patients and 146 members of staff were recruited to take part in research and service evaluation projects. In addition, data from 3,595 patient records were analysed to enhance our understanding and treatment of mental ill health.

This year, the STEP@STAH trial has been fully established and is now well underway. This clinically led service development is exploring the effectiveness of semaglutide in addressing antipsychotic-induced weight gain in patients prescribed clozapine and olanzapine, a significant concern in secure care settings where opportunities for lifestyle modification are limited. The study is generating valuable clinical data to inform future practice, with elements contributing to a PhD programme in collaboration with Loughborough University and plans for wider dissemination through publication.

Building on the work of Clinical Research Fellow Dr Inga Stewart, now lead for the Progressive Neurological Conditions research theme, we have developed a dementia co-production toolkit to support meaningful involvement of people with lived experience and their carers in service design and improvement. This work strengthens our approach to inclusive, evidence-based service development within this growing area of need.

In parallel, academic collaboration and co-production with patients and staff have supported developments in addressing patients' relationships and sexuality needs. This has resulted in a combined Sexual Wellbeing and Sexual Safety Policy, reflecting a more holistic, evidence-informed approach to care, alongside the development of a comprehensive staff resource, Supporting Patient Relationships and Sexuality. Work is now underway to produce a patient-facing resource, ensuring this area of practice continues to be shaped by the voices of those who use and deliver our services.

Building strong relationships and partnerships with external expert stakeholders remains key to our success. We currently have eight live research projects, including four collaborations with UK universities and mental health charities. Our strong partnership with Loughborough University focussing on the role of improved physical health on mental health recovery continues to develop with two do-funded PhD studentships and a number of potential projects in the planning stage. We foster a positive research-active culture across our care teams, benefitting patients and clinical staff. Additionally, our portfolio includes seven service evaluations aimed at improving service quality and ensuring we provide the best care for our patients and service users. We strive to ensure that the findings from our service evaluations are implemented appropriately. For more details on applying to conduct research or seeking collaboration, visit our Research page on St Andrew's Healthcare: Research » St Andrew's Healthcare

The number of patients receiving NHS services, provided or sub-contracted by St Andrew's Healthcare between April 2025 to March 2026, who were recruited to participate in research approved by a Research Ethics Committee within NRES, was 24 This number refers to patients participating in Research approved by an NHS Research Ethics Committee specifically.

Research data for the Quality Accounts 1 April 2025 – 31 March 2026:

Publications		
Published Articles	Accepted for Publication	In submission
24	2	14

Conference Attendance	
Oral Presentation	Poster Presentation
16	6

Patient Participation in Research Studies						
Medium Secure	Specialist Recovery	Outpatients	Neuro	LD/ASD	Essex	B'ham
18	29	0	19	29	1	0

Organisations we have worked with this year

1. Cardiff University
2. Centre for Mental Health
3. Decently
4. London South Bank University
5. Loughborough University
6. Memjo
7. MeOmics Precision Medicine Ltd
8. Northamptonshire Healthcare Trust Foundation (NHFT)
9. Nottingham Trent University
10. Sheffield Hallam University
11. Staffordshire University
12. The Alzheimer's Society
13. University College London
14. University of Birmingham
15. University of Brighton
16. University of Derby
17. University of East Anglia
18. University of Leicester
19. University of Manchester
20. University of Northampton
21. University of Portsmouth
22. University of Roehampton

Ref no.	Short title	Start date	End date	PGR	Status	Project type	Short description	Division	Partnerships	Lead researcher
154	ACES and Women's DBT	01/10/19	20/03/26	No	In write up	Service Evaluation	Strand of the three projects exploring trauma and its relationship to engagement and outcomes of DBT	Specialist Recovery		Deborah Morris
156	Auto-induced PTSD	01/08/19	30/06/26	No	In write up	Service Evaluation	Clinicians' experiences of working with people with auto-induced PTSD	Medium Secure		Deborah Morris
173	Dramatherapy	01/03/21	30/12/25	No	Complete	Service Evaluation	Breathing Life into "Lifeless" Patient: An Evaluation of a Dramatherapy intervention for the treatment of trauma-related symptoms of depersonalization and derealisation for patients in a secure hospital	Birmingham	University of Roehampton	Katie Greenwood
178	Staff Moral Injury	16/11/20	10/02/26	No	Complete	Research	Prevalence of Moral Injury and its relationship to wellbeing in healthcare professionals in forensic services	Charity wide		Deborah Morris
182	Sleep quality and patterns	26/01/21	30/08/25	No	Complete	Service Evaluation	Assessing the sleep quality and sleep patterns for people with dementia in secure care, using AAS scores	Neuro		Inga Stewart
188	Hypnotherapy, medication, CBT Comparison	07/04/21	01/06/27	PhD	In write up	Research	A comparison of curative Hypnotherapy, medication and CBT as treatment for anxiety: a mixed methods study	Outpatient Services	University of Brighton	Aile Trumm
199	Male Childhood Trauma	05/07/21	03/02/24	No	In write up	Research	Male childhood trauma: Experiences, barriers and outcomes of disclosure and accessing mental health services	Medium Secure Specialist Recovery Birmingham Essex Outpatient Services		Deborah Morris
218	ACER	01/04/22	30/06/26	No	In write up	Research	Assessing the Clinical and cost-Effectiveness of inpatient mental health Rehabilitation services provided by the NHS and independent sector	Specialist Rehab and Essex	University College London	Helen Killaspy
224	Occupational Distress	30/05/22	01/07/26	No	In write up	Research	Patterns of Occupational Distress in Healthcare	Charity wide		Deborah Morris

Ref no.	Short title	Start date	End date	PGR	Status	Project type	Short description	Division	Partnerships	Lead researcher
228	ASD/LD Sleep Evaluation	18/07/22	01/08/25	No	Complete	Service Evaluation	Evaluation of sleep-in adult ASD/LD wards, Northampton, St Andrew's Healthcare: Collection of qualitative patient data and existing quantitative data for sleep quality, variable health parameters and current management strategies	ASD/LD		Hiba Duhaimi
238	Guidance preventing MI in workforce: Delphi Study	03/02/23	10/02/26	No	Complete	Research	Developing guidance for defining and describing organisations that manage, mitigate and prevent moral injury workforce: A Delphi Study	Charity wide		Deborah Morris
247	Head banging study	02/10/23	15/06/25	No	Complete	Research	A study of headbanging among patient groups as a form of self-injurious behaviour	Charity wide		Kieran Breen
248	Patient awareness of R&I	03/10/23	28/07/26	No	In write up	Service Evaluation	Assessment of STAH patient awareness of R&I activity and interest in getting involved	Charity wide		Sarrah Fatima
249	Delphi Study deaf population	03/10/23	30/06/25 (overrun)	No	In write up	Research	Establishing consensus on the communication, assessment and treatment of psychological trauma in deaf populations: A Delphi study to inform best practice guidelines and priorities	Charity wide		Deborah Morris/Alex Hamilton
251	Naseby Delayed Discharge	01/11/23	06/08/25	No	Complete	Service Evaluation	Exploring delayed discharges on Naseby: A comprehensive study of factors influencing discharge delays in St Andrew's acute male mental health ward	Specialist Recovery		Tharshania Tharmendra
258	Veterans' exercise engagement	01/07/24	30/06/26	No	In write up	Research	Understanding exercise engagement among post military veterans: a qualitative analysis	Outpatient Services	Staffordshire University	Roisin Hampden
259	Ethic minority experiences of detention	01/09/24	19/08/25	DClin	Complete	Research	Exploring the lived experiences of adults from ethnic minority and racially motivated backgrounds who have been involuntarily detained in hospital for mental health reasons	Birmingham	Staffordshire University	Krishna Chauhan
260	Discharge preparation patient perspectives	10/02/24	28/02/26	No	In write up	Service Evaluation	Patient perspectives on preparations through discharge process: a service evaluation	Charity Wide		Sarrah Fatima

Ref no.	Short title	Start date	End date	PGR	Status	Project type	Short description	Division	Partnerships	Lead researcher
264	BMI trajectories	12/08/24	10/12/26	PhD	In write up	Research	Body mass index trajectories of adult psychiatric in-patients with severe mental illness following admission: an exploratory, longitudinal study	Specialist Recovery Medium Secure ASD/LD Birmingham Essex	Loughborough University	Kristina Brenisin
265	Evaluating NEW You PA awareness E-Learning	01/03/25	01/03/26 (overrun)	No	In write up	Service Evaluation	Understanding Barriers to Physical Activity and Developing Solutions: Evaluating the NEW You Physical Activity Awareness E-Learning	Charity Wide	University of Leicester	Justine Anthony
266	Psychological therapists needs-suicidal clients	15/10/24	31/07/25	DClin	Complete	Research	What are the support, training, and clinical supervision needs of psychological therapists when working with suicidal clients? A Delphi-study investigation of therapists' views and perceptions	Charity Wide	University of Manchester	Jessica Woodley
267	Service Evaluation of MDTIR Programme	15/10/24	25/09/26	No	In write up	Service Evaluation	Service Evaluation of the Multi-Dimensional Approach to Trauma-Informed Recovery (MDTIR) Programme	Essex		Beata Kozaczuk-Wislocka
269	Delayed Discharge	14/01/25	30/04/26	No	In write up	Service Evaluation	Service Evaluation of delayed discharges at St Andrew's Healthcare: A data review of historical delays	Medium Secure Specialist Recovery ASD/LD CAMHS		Kieran Breen
273	Sedentary Behaviour	30/02/25	29/12/26	PhD	In write up	Research	Prevalence and characterisation of sedentary behaviour in adult psychiatric inpatients: an observational study	Medium Secure Specialist Recovery	Loughborough University	Sarrah Fatima
275	REDS Engagement	19/03/25	02/07/25	No	Complete	Research	Exploring Recovery College Team Perspectives on Barriers and Enablers to patient engagement in Recovery College Programmes in an inpatient Mental Health Setting	Recovery College	University of Northampton	Libby Boffa
277	Story Telling	21/05/25	31/07/25	No	Complete	Research	Testing a dementia-friendly card game in an inpatient setting – a feasibility study	Neuro	University of Northampton	Tracey Redwood

Ref no.	Short title	Start date	End date	PGR	Status	Project type	Short description	Division	Partnerships	Lead researcher
278	PICU SE – Staff attitudes	21/05/25	18/08/25	No	Complete	Service Evaluation	Do staff attitudes influence patient activity? A Service Evaluation of Physical Activity on Bayley and Heygate PICU Wards	PICU		George Lakatos
280	Physical Health Risks	23/06/25	01/09/25	No	Complete	Service Evaluation	What do they know? A service evaluation of awareness of physical health risks associated with schizophrenia among patients, staff and carers	PICU		Georgina Lowe
281	DATIX Data - Machine Learning	07/08/25	25/11/25	MSc	Complete	Research	Investigating the viability of machine learning for predicting risk with DATIX and supporting data	Charity Wide	University of Portsmouth	Callum Aldridge
282	Staff Violence Attitudes	19/06/25	04/12/25	DClin	Complete	Research	Attitudes of Mental Health workers towards offenders with mental disorders in low secure settings: A Comparative study of sexual offences and general offences cases	Essex	University of Derby	Emma Sullivan
285	Art Psychotherapy	12/08/25	30/11/25	DClin	Complete	Service Evaluation	How art psychotherapy can benefit deaf sign language users who have minimal language	Medium Secure	Sheffield Hallam University	Elizabeth Corbett
288	Autism & PD prevalence, co-existence & clinical profiles	12/05/25	31/12/26	No	In write up	Service Evaluation	The prevalence, co-existence and clinical profiles of Autism and Personality Disorder in adult inpatient mental health divisions	Medium Secure Specialist Recovery LDA		Deborah Morris
291	Staff Understanding trauma sex offending	16/09/25	01/07/26	No	In write up	Research	Exploring staff understanding of trauma and motivation in working with people who have committed sexual offences, and the impact on treatment attitudes and staff wellbeing	LDA		Kian Wright
293	Attendance Pattern DWF Programme	09/07/25	01/05/26	No	In write up	Service Evaluation	Attendance Patterns and Associated Factors in the Dealing with Feelings Programme: A Service Evaluation	Outpatient Services		Samantha Thoms
294	DBT Evaluation	05/11/25	09/12/25	No	Complete	Service Evaluation	Evaluating the effectiveness and fidelity of an inpatient Dialectical Behaviour Therapy (DBT) Programme: A Service Evaluation	Specialist Recovery		Jonathan Baggott

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