**CHARITY NO: 1104951**
**COMPANY NO: 5176998**

# BOARD OF DIRECTORS – PART TWO

Thursday 26 November 2020 at 10.30 am

Microsoft Teams and Meeting Room 9 St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

| | | Info / Dec | LEAD | | *Page No.* | *Timing* |
|---|---|---|---|---|---|---|
| **1.** | Welcome and Apologies | Info | Paul Burstow | | *2* | *10.30* |
| **Administration** | | | | | | |
| **2.** | Declarations of Interest | Info | Paul Burstow | | *3* | *10.33* |
| **3.** | Minutes from the Part Two Board of Directors Meeting on 24 September 2020 | Dec | Paul Burstow | ✓ | *4-13* | *10.35* |
| **4.** | Action Log and Matters Arising | Info | Paul Burstow | ✓ | *14-15* | *10.40* |
| **Executive Update** | | | | | | |
| **5.** | CEO Report | Info | Katie Fisher | ✓ | *16-21* | *10.45* |
| **Patients and Quality** | | | | | | |
| **6.** | Divisional Presentation: Mansfield Lessons Learned | Info | Alastair Clegg *(Paul Stankard and Patient)* | | *22* | *11.05* |
| **7.** | Non-Executive and Executive Visibility Reports | Info | Alastair Clegg | ✓ | *23-24* | *11.30* |
| **8.** | Quality Account | Dec | Andy Brogan *(Julie Meikle)* | ✓ | *25-58* | *11.40* |
| **Break at 11.45 pm** | | | | | | |
| **Operations** | | | | | | |
| **9.** | Integrated Performance Report Overview and Presentation | Info | Alastair Clegg And Sanjith Kamath *(Murtz Daud)* | ✓ | *59-61* | *11.55* |
| **Governance and Assurance** | | | | | | |
| **10.** | External Governance Review – Terms of Reference | Dec | Paul Burstow and Katie Fisher | ✓ | *62-66* | *12.15* |
| **11.** | **Sub Committee Updates** | | | | *67* | |
| | • Quality and Safety Assurance Committee | Info & Dec | David Sallah | ✓ | *68-74* | *12.25* |
| | • People Committee | Info | Tansi Harper | ✓ | *75* | *12.30* |
| | • Pensions Committee | Info | Martin Kersey | ✓ | *76-77* | *12.35* |
| | • Research Committee | Info | Sanjith Kamath | ✓ | *78-79* | *12.40* |
| **Any Other Business** | | | | | | |
| **12.** | Questions from the Public for the Board | Info | Paul Burstow | | *80* | *12.45* |
| **13.** | Any Other Urgent Business (notified to the Chair prior to the meeting) | Info | Paul Burstow | | *81* | *12.55* |
| **14.** | Date of Next Meeting – 28 January 2021 | Info | Paul Burstow | | *82* | *13.00* |
| **Meeting Closes at 13.00 pm** | | | | | | |

# Welcome and Apologies

(Paul Burstow – Verbal)

# Declarations of Interest

(Paul Burstow – Verbal)

# Minutes of the Board of Directors Meeting Part Two on 24 September 2020

(Paul Burstow)

**CHARITY NO: 1104951**
**COMPANY NO: 5176998**

# ST ANDREW'S HEALTHCARE

## BOARD OF DIRECTORS MEETING IN PUBLIC

**Microsoft Teams Meeting and Meeting Room 9, William Wake House, St Andrew's Healthcare, Northampton**

**Thursday 24 September 2020 at 12.35 pm**

| Present: | |
|---|---|
| Peter Carter (PC) | Chair |
| David Sallah (DS) | Non-Executive Director |
| Elena Lokteva (EL) | Non-Executive Director |
| Stanton Newman (SN) | Non-Executive Director |
| Tansi Harper (TH) | Non-Executive Director |
| Katie Fisher (KF) | Chief Executive Officer |
| Alex Owen (AO) | Chief Finance Officer |
| Sanjith Kamath (SK) | Executive Medical Director |
| Martin Kersey (MK) | Executive HR Director |
| Jess Lievesley (JL) | Deputy Chief Executive Officer |
| Alastair Clegg (AC) | Chief Operating Officer |
| **Apologies:** | |
| Andrew Lee (AL) | Non-Executive Director |
| Stuart Richmond-Watson (SRW) | Non-Executive Director |
| Paul Parsons (PP) | Non-Executive Director |

| In Attendance: | |
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| Duncan Long (DL) | Company Secretary |
| John Clarke (JC) | Chief Information Officer |
| Julie Meikle (JM) | Director of Quality |
| Dan Cox-Stone (DCS) | Deputy Director of Nursing |
| Jennie Goode (JG)(Minutes) | Board Secretary |
| Nicola Lintott (NL)(Agenda Item 6) | Head of Patient Engagement |
| Rob Bode (RB)(Agenda items 7 & 8) | Clinical Director |
| Michelle Sayer (MS)(Agenda items 7 & 8) | Social Worker |
| Deborah Morris (DM)(Agenda item 12) | Consultant Psychologist |

| Agenda Item No | | Owner | Deadline |
|---|---|---|---|
| 1. | PC welcomed the Committee to the Part 2 (Public) session of the Board of Directors meeting, this part being a further trial of future public meetings, however, DL confirmed there were no invited observers on this occasion. PC acknowledged apologies from AL, SRW and PP, and that TH needed to leave the meeting at 3.30 pm. | | |
| **ADMINISTRATION** | | | |
| 2. | **DECLARATIONS OF INTEREST**<br><br>All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting as they were required to disclose under s.177 of the Companies Act 2006 and the Charity's Articles of Association. | | |
| 3. | **MINUTES OF THE BOARD OF DIRECTORS MEETING PART TWO (PUBLIC) ON 23 July 2020**<br><br>The minutes captured at the meeting of the Board on 23 July 2020 were reviewed and agreed as an accurate record of the discussions. | | |

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| **4.** | **MEETING PART TWO ACTION LOG**<br><br>The Board reviewed the action log with a focus on those actions without a written update in the papers or items that changed significantly since the update had been provided.<br>• 23.07.20 **02** *Service Improvement Timelines*: PC confirmed that this had been discussed in this morning's Part 1 (confidential) Board Meeting and that more detail would be included within future Part 2 (public) Board meetings.<br>• 23.07.20 **03** *IPR*: It was confirmed that NEDs should be able to access the IPR in real time from October 2020.<br>• 23.07.20 **03** *IPR Parameters*: This was discussed in this morning's Part 1 (confidential) Board meeting and SK/AC would pick up with SN directly as to what he would be looking to see.<br>• 23.07.20 **05** *Staff Dismissal Rates*: PC confirmed that this would move to Part 1 (confidential) of the meeting and that the action relating to Part 2 (public) should be closed. | | |
| **5.** | **MATTERS ARISING**<br>There were no matters arising. | | |
| **PATIENTS AND QUALITY** | | | |
| **6.** | **COMPLAINTS INFORMING LEARNING AND DEVELOPMENT**<br><br>NL, Head of Patient Engagement joined the meeting to discuss the paper on how complaints regarding staff behaviour and attitude informed our learning and development. The paper was taken as read.<br><br>NL confirmed the themes of staff of attitude and behaviour were very broad and included how staff communicated with patients including verbal communication and body language. NL stated that there were also sub-themes i.e. not just a staff attitude or behaviour but that often these were linked how care was delivered and for that reason the way these were addressed differed from case to case. The most common practice being for localised training and supervision to address the issues at divisional and ward level.<br><br>NL explained that wider issues were currently reported through various channels across the Charity, but a more robust process was needed for handling complaints, Serious Incidents (SIs) and safeguarding incidents so that these could inform Charity-wide learning. She confirmed the Deputy Director of Quality was currently working with subject matter experts and reviewing this process to recommend improvements.<br><br>NL gave examples of how learning from complaints had informed changes in practice, giving the specific example of MAPA training where complaints had historically been received about how staff spoke to patients before or during a restraint and these, together with the use of CCTV examples have been embedded within the MAPA training.<br><br>NL outlined how patients had been involved, specifically in addressing some of the needs that have been identified from the complaints. For example, a patient on a PICU had complained about some of the treatment she had received and how staff had spoken to her. As a result, that patient had been involved as part of the solution to inform the changes needed and they were attending the restrictive practice advisory group.<br><br>SN thanked NL for the comprehensive outline and asked whether she expected to see the impact of this work resulting in a reduction in the number of complaints, if NL could provide a timescale to realise these improvements, and what was NL's approach towards the key issue of reassessment and reviewing training?<br><br>NL advised her team were involved with part of the induction training for new starters and that subject matter experts would review the training potentially on a 6 monthly basis. NL didn't know the detail of the review but confirmed it would | | |

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| | include the content and how the training was impacting behaviour, for example, with MAPA training and how it affected the number of restraints.<br><br>SN felt another issue was reviewing those trained some time ago and asked was this in hand? NL advised it was, the expectation being to undertake regular refresher training determined by subject at specified regular intervals for that topic.<br><br>TH asked how this would tie in with the performance management and appraisals and whether there were direct links to that process. MK advised that the training had been reviewed with greater emphasis placed on induction training and MAPA (including refresher training). It was also important that managers reinforce this when they see the behaviours on the wards; that they were constantly talking to people and revisiting the basics of the training. MK confirmed that good examples of behaviour should be mentioned in the management supervision and similarly if staff were not exhibiting the right behaviours this should also be recorded.<br><br>DS stated he believed that a lot of the behaviours could be dealt with when focussing on the values of an organisation. Values of accountability would deal with a lot of the issues that were being raised. Looking at a values based approach during induction would clearly layout what was and wasn't expected of staff. MK agreed and confirmed that this was the case; the selection and assessment process was key to recruiting successful health care assistants and that this was reinforced with patients starting the induction process by saying what was important to them.<br><br>JM responded to SNs' question about reducing the number of complaints as she felt this was not the appropriate measurement as it was important for people to speak up. JM wanted to see the seriousness and the concerns raised in the complaints reducing, and that where a complaint was staff or values related this would be fed back into the division. JM confirmed the complaints team would work with the divisions to drive change, but it would be owned by the divisions themselves.<br><br>PC and JM both advised that they were interviewed by patients during their recruitment and it was a really positive experience. PC thanked NL for her paper and for her work within the Charity | | |
| **7.** | **PATIENT AND CARER PRESENTATION.**<br><br>RB, MS and patient S, a new resident to Smyth House joined the meeting.<br><br>The presentations to the Board focussed on progress made with the CAMHS move to Smyth House including co-production with patients on the design and move, and an update following the two inadequate inspection outcomes from the CQC in March of this year.<br><br>RB reflected on his previous presentation to the Board which detailed the downsizing and other changes to the CAMHS service, and summarised the recent history of the CAMHS service. RB advised that, in his opinion this remained the right decision and it had been instrumental to the growth and improvement of the culture within the CAMHS service, he thanked the Board for their support in making this decision<br><br>RB updated the Board on the CQC's re-inspection of CAMHS which started on the 7th September and confirmed this was an ongoing, extended inspection that hadn't yet finished and the CQC had indicated they would be visiting Smyth in the coming weeks. RB advised that at this point it was difficult to comment on the outcome of the inspection however, high level feedback had been given indicating that the report would be received prior to Christmas and RB felt there was a positive tone to this feedback. RB advised that the CAMHS team had worked with the inspection team over the past six months to engage them in the changes being made and that they had facilitated engagement through three staff engagement sessions which were well received. | | |

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| | RB went on to summarise some of the initial verbal feedback given by the CQC concerning the visibility of the local leadership and improvement in standards of record keeping and the compassionate and positive language used within these records. RB highlighted that trauma informed training was due to be delivered at the weekend by CAMHS trainers, and that it now included contributions from parents, patients and carers in its delivery and that this training had also started to be offered to parents and carers.<br><br>RB advised the Board that the CAMHS service was starting to admit patients again, the first of these being in August and that the condition of these admissions was that weekly reports and updates on progress including sessions offered and any incidents that have occurred would be given. RB confirmed that for the first patients the CQC had advised the weekly reports were no longer required and they were pleased to hear reports of progress for the most recent admissions which was a sign of confidence.<br><br>RB advised that, after a settling in period, the CAMHS team intended to apply to the CQC, with the support of SK and AC, to vary the condition around seeking permission to admit which, if granted, would be a mark of confidence in the changes being made. RB advised that, even with the freedom to admit, the CAMHS service wouldn't seek to rapidly fill beds but would admit patients only after the previous admission had settled.<br><br>RB advised that over and above improving the CQC rating of the services, a further goal for the next 12 months was for all wards to join the Quality Network for Inpatient CAMHS (QNIC) and seek accreditation from them.<br><br>MS introduced patient S and gave an update on the co-production group which was formally set up in August 2019 and which patient S had been part of since its inception. S advised that at the start of co-production, the group was asked to identify what they wanted to improve or change within the service. S then summarised some of the areas which this group had looked at including; the use of mobile phones by patients, updating the CAMHS brochure and welcome pack, and the move to Smyth House. S confirmed that most of the ideas were achieved, and in the case of the move to Smyth House the patients had chosen the furniture, colour schemes, artwork and room layout in the new building.<br><br>S advised that regular patient feedback was needed. Community meetings weren't generating this because patients found it difficult to attend so the Patience Experience Questionnaire had been refreshed to make it more interesting and relevant. The feedback would be displayed on the You Said, We Did notice boards so that patients could see that changes that had been made. S had been involved with local induction staff training for CAMHS including trauma informed training using their own experiences of being hospitalised. S found this had been very rewarding because staff now had a better perspective and outlook on looking after patients and delivering good care. S had also started work experience within the StAH recruitment team and had attended job fairs to recruit new nurses and helped review job applications for St Andrew's in Northampton and other sites.<br><br>TH welcomed S to the meeting, congratulated S on the impressive volume of work completed and asked if S had changed and grown in confidence, S confirmed this was the case.<br><br>TH asked whether S was able to help and encourage fellow patients. S responded that the group were heavily involved in supporting others due to their own experiences, progress and where they were now on their recovery journey. S advised TH that when patients were first admitted, their focus was on recovery, that it wasn't possible for them to focus on other things. It was important for them to get to a place where they had a sense of control, of feeling empowered and able to make decisions about their future before they were ready to engage positively and productively. Being involved with others had really helped S in their development. | | |

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| | DS congratulated S on being so successfully involved with the co-production and asked whether there had been any problems on the way? S advised that Covid had been frustrating as it limited the levels of direct involvement and that some of the larger issues took longer to resolve due to the number of people that needed to be involved. S felt that St Andrew's had done really well on leading change and offered the best experience of co-production patients had experienced, S had been involved in many projects and a wide range of items had been covered in just over a year.<br><br>MK thanked S for their involvement and advised that the recruitment team had really enjoyed working with S on the work placement and had learned a lot, such as improving the calibre of the interview techniques used. As a consequence of S's involvement, the team had been able to recruit good quality staff. SN felt that S's role had been critical and gave credit to the ward team for opening it up and allowing this level of involvement. SN encouraged S and everyone involved to take it to the next step and write up guidance on how to make co-production a success, including ward structure and activities, during Covid. RB responded stating that CAMHS were discussing a co-produced piece of research into restraint for young people with a view to writing something up for publication.<br><br>EL thanked S for their presentation and acknowledged the importance of patients as contributors to the Charity's development. EL asked whether the Executive Team planned to seek patient feedback on CQI initiatives. SK confirmed this would happen wherever appropriate, as there was a requirement to explicitly state which projects affect patients and how patients were involved co-production.<br><br>SK advised he had already linked in with Royal College of Psychiatrists and put forward St Andrew's for the work in CAMHS. NL would discuss this with RB and CAMHS staff/patient teams with a view to publishing their work to evidence this at national level.<br><br>PC thanked RB, MS and S, on behalf of the Board for their work, particularly under such trying of circumstances, and for their presentations which PC felt would go down really well in external press reviews. In particular, PC wished S well for the future. | | |
| **OPERATIONS** | | | |
| **8.** | **DIVISIONAL PRESENTATION – CAMHS - covered by RB in 7 above** | | |
| **9.** | **COVID-19 UPDATE**<br><br>Alistair Clegg updated the Board on Covid-19 as follows:<br><br>- Currently there were no Covid-19 positive patients across the hospitals sites.<br>- The 128 day record for days with no positive patients ended on 9 September when a patient returned from NGH and tested positive as part of the quarantine process. AC confirmed this was an extremely challenging scenario for the ward, as the patient had complex personal care and communication needs. The patient was no longer positive or symptomatic.<br>- A team from NHSE/I visited on the same day, led by Professor Susan Fairley as part of NHSE/I project to look at helping providers both in the acute and mental health sectors prepare for a second wave. They wanted to see the progress made at St Andrew's and confirmed there had been a positive turn around since their previous visit giving extremely helpful and constructive feedback. They suggested IPC was an area needing investment, but they were impressed with some of the changes made over the last year. They were working with St Andrew's to provide expertise in certain areas and it had been a supportive and positive engagement from them. | | |

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| | - Currently 45 staff were self-isolating, which was a reduction in numbers from the peak and whilst was a manageable amount, it was being closely monitored.<br>- Availability of PPE was a serious concern in March/April and NHSE pallet push after Easter had made a significant difference to this challenge. AC confirmed he had heard that this would last until (at least) Christmas. This remained an area of increased focus for the Charity.<br>- Tracing internal staff, Murtz Daud, Head of Business Intelligence has been developing an app for tracking individual members of staff to alert when symptomatic or tested positive. MK was forming a team to provide over the phone tracking and provide more detailed information. There has been an isolated incident of a symptomatic member of staff who went for a test, then worked a night shift without telling anyone they were symptomatic and returned positive the following day. Fortunately none of the patients or staff on the ward subsequently tested Covid positive. This was being investigated thoroughly and staff were being reminded of their responsibilities.<br>- The approach to IPC and PPE had significantly improved but was not yet where we wanted it to be. Some staff were still not always following PPE guidance and a disciplinary approach would now be taken, as the risk couldn't be tolerated.<br><br>EL commented that it seemed common sense for the movement of patients to increase the risk of Covid infection and it posed the question whether it should be mandatory for the care provider to carry out testing prior to discharge so we did not put our patients at increased risk. SK advised that the current protocol was for patients to be tested when being discharged from non-healthcare to healthcare setting. Agreement had been made with providers that as soon as a patient came to St Andrew's, they would be tested and then quarantined pending result. SK confirmed the reason people were not tested before they left hospital was because of the chance of contracting the virus between receiving a negative result and being admitted. Test results were currently being received within 12-24 hours, however the Government had encountered testing issues nationally and these lead times had increased slightly, however a process was in place to manage this and it appeared to be effective.<br><br>JL advised that as part of our commitment to IPC and supporting staff to be bare below the elbow the Charity would be investing in uniform for patient facing ward based and therapy staff. This would in the form of a branded polo shirt colour coded by profession and levels of seniority within the profession. The colours of the shirts emulated those from NHS and these were now on order. AC confirmed he was working through the communications plan prior to launch but that feedback from staff had been mixed, the majority realising it was a sensible measure. Two professions originally not included in the rollout, pharmacists and CAMHS teaching staff, had also asked to be in uniform to help them being identified as part of the ward based teams and this had now been included in plans.<br><br>JC advised that discussion took place in yesterday's CEC around the growing number of virus cases nationally and how we may tackle this in non-clinical Covid Secure areas. It was agreed that the Charity would form a small group to review this concern as a matter of urgency.<br><br>SN was pleased to hear of the tightening of restrictions in the Charity as well as the research done around meeting room ventilation. DS accepted that the Charity had done well in keeping patients internally safe, but he asked what preparation had been made to prevent the spread from staff coming in from the community and patients going on leave into community. Could this be raised within co-production to make a decision about good practice?<br><br>SK advised the Board that CEC had considered the phase three letter from NHSE/I about reopening services and resuming pre-Covid levels of activity however, there were other actions that even non-statutory providers of services needed to address. These had been considered and some of them | | |

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| | implemented, including MK being the named Executive responsible for tackling inequalities at Board level. There were also requirements about monitoring the outcomes for at risk individuals. PC confirmed he was impressed with way the Charity had handled the Covid situation and he was happy with the move into uniform. | | |
| **10.** | **EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE AND BUSINESS CONTINUITY UPDATE**<br>AC took paper as read.<br>The Board raised no questions. PC commented that it was good paper, insightful and clear. | | |
| **FINANCE** | | | |
| **11.** | **FINANCE UPDATE**<br>AO took the report as read and highlighted the key points in the report.<br><br>AO had received confirmation from Barclays and HSBC that they would provide a waiver for the forecast covenant breach at the end of September. The receipt for the sale of the Mansfield site would support the Charity to return to a position well within all of the covenant limits before the end of the following quarter. AO confirmed that following this receipt she would seek Board approval to reduce the revolving credit facility down to circa £30-£35m which will satisfy working capital needs going forward and save a proportion of the costs associated with the facility.<br><br>AO confirmed that the CEC had identified a number of proposals to achieve the full £10m (22%) run rate saving target by the end of the year, and they would continue to work towards achieving this as a priority. EL asked for assurance from AO that the £10m run rate saving would be realised and that the second half was already backed by visible plans to deliver it. AO confirmed that the first half of the savings target was backed by detailed plans and had been incorporated into the budget. Plans to achieve the second half of the savings target were being worked through by CEC colleagues and these plans would be refined as the year progressed. AO felt it was important to confirm that in the cost saving target for the current year was not the full £10m, the target was to achieve the equivalent of a £10m saving run rate by the end of the year which was already incorporated into the budget as discussed.<br><br>TH asked if anyone had sat in on the National briefings of Economy and Health. AO advised she had not and TH agreed to send her notes from the briefings to AO. TH advised that she felt the economy wouldn't recover until 2024 and she was worried that there was a significant risk in predicting new material revenue streams. EL asked whether that meant the Board would have to be more involved with Local and National Commissioning going forward. The Board discussed the importance of the Charity being involved with the new Provider Collaboratives in future periods and the implications of the changing way services were going to be commissioned.<br><br>JL advised that part of the challenge of the new commissioning arrangements was the geography of the new regions and also that the Charity was funded in a significantly different way to NHS counterparts. There were also challenges as the funding assumptions made at regional levels were predicated on a reduction of investment in independent sector organisations like St Andrew's. JL highlighted the future importance of the Charity being part of the commissioning infrastructure in specific geographical locations such as East Midlands. | | |
| **WORKFORCE** | | | |
| **12.** | **ACADEMIC DEPARTMENT UPDATE**<br><br>MK introduced DM who had joined the meeting to give key highlights from her paper.<br><br>DM confirmed that the programme would focus on those that had experienced the most trauma and that there were 32 projects within the programme, but that a large number of studies were interlinked. The programme involved | | |

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| | divisions and other internal services as well as external collaborators helping to re-build relationships between St Andrew's and external parties.<br><br>DM confirmed that many papers were being published and that there were plans to publish new papers up to a year ahead with a number of CPD events and conferences also planned as part of the programme.<br><br>KF mentioned that the Board had had conversations about co-production work that had recently occurred in the CAMHS service and asked how the research findings from this could link into the programme being developed. DM responded that service users from CAMHS had been involved at the beginning of the programme to incorporate what they believed the programme should be looking at and that it also included development of care plans and staff training. DB added that the programme also helped to establish if the right outcomes measures are in place.<br><br>DS commented that he was pleased work was being linked to long term conditions and recommended post Covid rehabilitation as a potential area for focus. PC commented that he had enjoyed recent conversations with DM regarding moral injury and that this was a great example of the tremendous work being done at the Charity. | | |
| **REGULATORY** | | | |
| **13.** | **HEALTH AND SAFETY UPDATE**<br><br>JC introduced the paper and took it as read.<br><br>TH raised two questions; Did Commissioners ever ask for evidence of the standards of Health and Safety? Secondly, did the Board fully understood its duty around corporate manslaughter if it was found to be unsafe? In response JC stated that he was currently working with JL's team to prepare the information pack to be sent to Commissioner. JC confirmed that there were currently no routine requests for information from the Commissioner that occasionally adhoc requests were received and responded to and JC's team were currently working to include this in the Integrated Performance Report (IPR) so that reporting would be automatic.<br><br>In terms of corporate manslaughter, it was confirmed that responsibility falls within the Board's remit. Board level awareness training had been arranged but this was face to face training so it had been postponed. An alternative training method was currently being sought.<br><br>The Board had no further questions | | |
| **14.** | **MODERN SLAVERY STATEMENT**<br><br>MK advised the Charity was required each year to approve and then publish the modern slavery statement. The Board had no questions and the statement was approved. | **Decision** | |
| **GOVERNANCE AND ASSURANCE** | | | |
| **15.** | **COURT OF GOVERNORS, BOARD OF DIRECTORS AND COMMITTEE MEETING PLANNER OCT 2020 TO MAR 2022**<br><br>DL presented the proposed planner for Board and Committee dates. DL advised of two proposed date changes in addition to the paper, these being the Court of Governors AGM to move to September 2021 and ARC to move from September into October 2021.<br><br>EL asked for dates for the Board development programme to be block booked. DL agreed to look at whether this could be achieved by using the second half of a standard Board meeting or by linking into the Board strategy days.<br>The Board planner was Approved. | **DL**<br><br>**Decision** | **16.12.20** |
| **16.** | **SUB COMMITTEE UPDATES**<br>**QUALITY AND SAFETY ASSURANCE COMMITTEE**<br>DS summarised the QSAC update for the Board. | | |

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| | DS confirmed that TH had attended QSAC and would like to continue to do so to support the Committee that she chairs. TH believed there was potential for triangulation of work and that Quality was at the centre of all that we do. DS supported this and was of the opinion that committees should not operate in silos but needed to be connected. EL confirmed she had found the opportunity to observe other Committees useful and welcomed the open invitation to attend all Board Committees.<br><br>DL confirmed that the Committee Groups within Teams had been opened to all Trustees and that this would provide access to all Committees papers and aid open communication in the Board. SK asked which Board Committee would now have oversight of Health and Safety. KF confirmed she felt this should sit with TH's PCSE Committee, this was agreed by the Board.<br><br>JC asked to continue to provide an annual update to QSAC due to the overlaps in duties, DS agreed and DL confirmed he would include this in the Committee schedule of work.<br><br>**AUDIT AND RISK COMMITTEE**<br>Discussed in Part One of the Board<br><br>**PATIENT, CARER AND STAFF ENGAGEMENT**<br><br>TH gave an overview of the paper and progress of the new Committee.<br><br>TH confirmed that the new Committee was 'forming and storming' and was commonly now being called the People Committee for short. Currently the Committee was short of patient and carer representation but that this was an area of focus. TH confirmed that the Terms of Reference had been shared separately. These were approved subject to the amendment relating Health and Safety being made. | **Decision**<br><br>**DL**<br><br>**Decision** | **26.11.20** |
| **ANY OTHER BUSINESS** | | | |
| **17.** | **ANY OTHER BUSINESS**<br><br>No any other business was raised.<br><br>KF thanked PC for his leadership and support over last year.<br><br>Meeting closed at 15.15pm. | | |
| **18.** | **DATE OF NEXT MEETING – 26 NOVEMBER 2020** | | |

**Approved – 26 November 2020**

**……**
**Paul Burstow**
**Chair**

# Action Log & Matters Arising

(Paul Burstow – Verbal)

**St Andrew's Healthcare Board of Directors Part Two Action List:**

| Meeting in Public | ACTION | Owner | Deadline | Open / Closed | STATUS |
|---|---|---|---|---|---|
| 23.07.20 **03** | **IPR**<br>KF explained that an IPR was under development and would be able to provide this level of detailed insight at the meeting in November. | SK / AC | 26.11.20 | Closed | **26/11:** IPR overview and presentation included within agenda.<br>It is proposed that the action is closed. |
| 23.07.20 **04** | **IPR Parameters**<br>SN responded that he would like to see a view across Divisions for all parameters given in the report and a comparison over time to review if they are making positive progress. | SK / AC | 26.11.20 | Closed | **26/11:** SK, AR and MD met with SN to discuss the issue of suitable targets as well as the possibility of developing a composite harm measure that would allow us to weigh different measurements from the IPR and track progress over time. This work is being progressed and will form a strand of the IPR development programme.<br>It is proposed that the action is closed. |
| 24.09.20 **01** | **Board Development plans**<br>EL asked for dates for the Board development programme to be block booked. DL agreed and he would look at whether this could be achieved by using the second half of a standard Board day or by linking into the strategy days. | DL | 16.12.20 | Open | **26/11:** Initially training, such as the agreed Safeguarding for Board members is to be accommodated during the second half of pre-existing board dates. Further discussions are needed to agree the Board development programme content and then schedule appropriately throughout the year. |
| 24.09.20 **02** | **QSAC review**<br>JC recommended an annual update on Health and Safety is presented to the Quality and Safety Assurance Committee as there are overlaps with the Patient, Carer and Staff Engagement Committee. DS agreed DL will include this in QSAC's schedule of work | DL | 26.11.20 | Closed | **26/11:** An annual H&S report item has been added to the rolling/standing agenda for QSAC.<br>It is proposed that this action is closed. |

| Paper for Board of Directors |
|---|
| **Topic: CEO Board Update** |
| **Date of Meeting:** 26 November 2020 |
| **Agenda Item:** 5 |
| **Author:** Katie Fisher |
| **Responsible Executive:** Katie Fisher, Chief Executive |
| **Discussed/Approved at Previous Board Meeting(s):** Standing Board agenda item |
| **Discussed/Reviewed by Patients and/or Carers and/or Staff:** A number of these items would have been discussed with patients, carers or staff. |
| **Report Purpose/s:** For discussion |
| **Key Lines Of Enquiry:** **S ☒ E ☒ C ☒ R ☒ W ☒** |
| **Strategic Focus Area:** All areas |
| **Charity group or committee meetings where this item has been considered:** Updates have been discussed at the Charity Executive Committee meetings |
| **Report Summary and Key Points to Note:** The attached is the Chief Executive's report to the Board of Directors from the Charity Executive Committee (CEC) meetings.<br><br>The nature and content of this report is currently under review and will be further refined following the external governance review. |

# CEO Report

This is the CEO report to the Board of Directors to provide information and assurance on the key areas of focus for the Charity Executive Committee over the last reporting period that are not dealt with under other agenda items for the Board.

1. Covid-19 update

   Since the board meeting in September, the national (and global) second wave of COVID-19 has impacted the Charity. In particular, there have been three outbreaks involving 14 patients and 7 staff.

   All three outbreaks were/are being managed in close partnership with NHSE, and with support from PHE and the respective local authorities. None of the cases resulted in further transmission once the initial outbreak was identified.

   Staff COVID-related absence is currently manageable though increasing.

   PPE supplies remain strong, and NHS Supply Chain have indicated that the pallet push is expected to continue until March 2021

   The Charity's response to the second wave is being managed by a daily Covid Command meeting, which looks at patient and staff data, PPE supplies, and environmental and cleaning issues. Covid Command produces a daily report for CEC and Divisions, and CEC receive a weekly sit rep update.

   Further support is being provided by NHSE/I following the visit on 9 September, and the DIPC and COO meet with NHSE/I colleagues weekly. Most recently, workshops have been launched for key clinical staff to encourage a CQI-informed approach to tackling IPC challenges; IPC training has been launched; and Link Nurse training has been offered.

2. CPAC update

   The Clinical and Professional Advisory Committee (CPAC) has met on a regular basis and with the government announcement of further restrictions – initially the Tier system and more recently a nationwide lockdown – CPAC has increased the frequency of meetings to twice a week. CPAC continues to review the various pieces of guidance and advice issued by professional and national bodies and adapts SAH procedures to align with these. The challenges over recent months has once again been to balance the measures needed to keep staff and patients safe through minimising Covid transmission risk while ensuring that any restrictions imposed are proportionate and necessary and interfere minimally with patient recovery and rehabilitation. To that end CPAC has reviewed a number of issues and provided guidance on different subjects, some of which are described below:

   - The Government's three tier system and the implications for our patients
   - Student placements
   - Community leave issues for patients in Birmingham and Essex (Tier 2)
   - Transition and discharge planning

- Specific additional measures for wards with a high proportion of high risk or extremely vulnerable patients
- Review of guidance for transfer, discharge and re-admission of patients
- REDS academy attendance
- Absconding patients and Covid

3. CQC update

**Women's Service** – the final report from the comprehensive inspection undertaken on the Northampton site in March 2020 was published on 10 June 2020. Improvements across Women's wards were already underway at the time of the last inspection and further immediate changes were made following CQC feedback. Preparation has started to prepare the wards that constituted the women's service for a further inspection six months after the publication of a report in line with the CQCs guidance on special measures.

**Spencer South Focused Inspection-** the final report and an associated warning notice was published on the 24 September. This responsive inspection was triggered by complaints and concerns from patients direct to the CQC.

The warning notice focuses on Regulation 12 Safe Care and challenges in providing effective care to those patients on the ward suffering from an eating disorder. A lack of staff training, specialised equipment and direct support for those patients through effective observations was highlighted. The specific evidence was around reported omissions in the care of individual patients. The deadline for compliance with the requirements of the warning notice is 3 March 2021.

As we know, the Coronavirus pandemic put unprecedented pressure on the UK healthcare system. At the height of the pandemic there was a real concern from NHS England that patients with eating disorders should not stay in acute care hospitals due to their high risk status. As a specialist mental health provider, it was also recognised there was an increasing demand for a service which was able to meet the needs of people with personality disorders, alongside issues with disordered eating- a service which previously did not exist anywhere.

Having to open this service more swiftly than was originally planned meant that while we had staff who were fully trained in disordered eating awareness, not all staff in the service had received the extensive training we would normally provide, and this was further hampered by Covid-19. This meant that at the beginning, the ward was not operating at the high standard we aspire to.

An action plan to address service shortcomings has been developed with implementation well underway and improvements are being made.

The Charity has made note that the triggers for the Spencer South inspection came from the concerns of patients. There has been a review of other complaints made in that service to deepen the lessons learnt direct from the Spencer South report. Further work is also underway to support ward teams in working more effectively with families and carers.

**CAMHS-** the CQC inspection of the CAMHS unit continued with an onsite visit to Smyth House on 30 September to assess the new ward environments. The final data request was submitted to the CQC on 14 October. The draft report is expected by the end of November.

There have been no further CQC inspections in this month.

**Mental Health Act Reviews -** the CQC have carried out one new remote Mental Health Act review in October, this was on Sunley and their provider action response is due for submission 16.11.20.

**Registration –** requests have been submitted for all services in Northampton to be registered in line with the new divisional structure. The Registered Managers will be the Heads of Nursing. However, there have been delays in these requests being processed. Julie Meikle is liaising directly with the CQC to ensure these changes are made promptly and the new divisional structures are recognised.

In October the CQC published their thematic review of Restraint, Seclusion and Segregation, this document was discussed in the Charity's Least Restrictive Practice meeting and its recommendations reviewed to action relevant learning for SAH.

A Charity wide engagement meeting with the CQC took place on the 10 November.

4. Finance Update

The Charity continues to perform slightly ahead of expectations in terms of its financial position for the first seven months of the financial year and remains on track to achieve the agreed financial outturn for the full year.

As highlighted to the Board in previous meetings, the significant financial pressures associated with the lower bed occupancy, and spend associated with the sales of the Mansfield site, as well as changes on the Northampton site have materialised. These have been managed with external stakeholders and as a result of these discussions, and with the receipt from the sale of the Mansfield site during November, the financial pressures on the Charity have now reduced and the Charity is forecast to operate well within its banking facilities and associated covenants for the remainder of the year.

The financial reforecast has been completed over the month of October and shows no significant variation in terms of net deficit or closing balance sheet position from the Budget agreed by the Board in July 2020.

5. Capacity utilisation project update

The programme has successfully completed the transition of the CAMHS service from FitzRoy into Smyth House and the College will be completing its move early in December when the medium secure windows have been installed.

The next planned moves for the programme are Spring Hill House into Ashby (17 Nov), the Harlestone's into Fitzroy (by 11 December), the opening of the Women's Blended Extension in Fitzroy, and a second Medium Secure Men's ASD ward in Fitzroy, all of which are on track to be completed by 11 December, although repair

work needed to Isham House might result in a small delay for three of the patients moving to Ashby from Spring Hill House.

The timetable for these next ward moves and the remainder of the programme is ambitious, but progress and risk are being managed weekly, and the overall programme is on schedule to complete by the end of July 2021.

6. Sale of Mansfield

The Board will be pleased to know that the final formal stage of the sale of our Mansfield hospital site concluded on the 16 November 2020 with Nottinghamshire Healthcare clarifying that no remedial actions were required to prevent completion going ahead. The sale concludes 18 months of negotiations and planning and has been delivered ahead of time and within the agreed financial parameters set by both Boards.

7. Links with external stakeholders

The Charity continues to progress work as a key member of the East Midlands Alliance which draws upon the expertise of system partners and is increasingly engaging the Chairs of the constituent Boards.

The Charity also remain actively engaged with the NHS Confederation and Independent Sector Provider Network, particularly focusing on issues currently relating to the UK's wider response to COVID 19.

Links with Provider Collaboratives in the Midlands remains a strategic priority for the Charity and strong engagement is in place across our executive team as well as via clinical experts. This is ensuring that St. Andrew's contributes to the development of these new structures and enables improved outcomes for collective populations and the most efficient use of available resources.

Good relationships continue with system and regulatory colleagues within NHS Wales, The Care Quality Commission and NHS England across a range of areas including the response to the pandemic, as well as business as usual activity.

Local Northamptonshire links with Primary Care Networks and Health & Wellbeing forums are starting to progress again, having stalled over recent months because of the reduction in local activity in these areas.

8. Communications update

**Patient firework events**
Firework events for patients were held at all sites. Although the events were slightly curtailed due to COVID, positive feedback was received from patients who attended.

**Your Voice 'Snapshot' Staff Survey**
The annual staff employee engagement survey is being run in November. This year's survey is shorter, including just the six questions related directly to engagement. The results and an updated engagement score will be known in December. (Last year's engagement score was 68%).

**Flu vaccine campaign**
In order to protect staff and patients, we're making it extremely easy for everyone to get the flu jab, with vaccinations available in clinical areas and without an appointment. Our 'Flu Fighters' campaign started in October. To date over 700 staff have responded, which is higher than at the same stage last year.

**Let's Talk About…**
Four videos in our #LetsTalkAbout campaign have now been shared externally. These aim to shine a light on some of the most misunderstood mental health conditions. The videos cover Dementia (with Dr Inga Stewart), Borderline Personality Disorder (with Dr Emily Fox), Schizophrenia (with Dr Katina Anagnostakis) and PTSD (with Dr Pete McAllister). To date these videos have achieved 139,795 views.

**Estelle's story – de-stigmatising mental health**
The story of Estelle, a 23 year old Peer Support Worker at St Andrew's, who is living with borderline personality disorder, has been viewed by 41,000 people in the 3 weeks since it was first shared on social media.

**Student Nursing Times Awards – 'On the Ward Podcast' a winner**
Another initiative aimed at de-stigmatising mental health, this podcast recently won a Student Nursing Times Award in the Student Innovation in Practice category. The brainchild of John Barry-Waldron, a staff nurse at our Essex hospital who studied for a nursing degree as part of the ASPIRE programme, the podcast was one of his university projects. Our win achieved some positive press coverage, including in the Northampton Chronicle and Echo, and BBC Radio Northampton,

**Nursing Times Awards**
As we mentioned in our last update, St Andrew's has been shortlisted for two Nursing Times Awards, including the Nurse Leader of the Year category and Nursing in Mental Health.

Jodie Maloney, our Divisional Head of Nursing, has been shortlisted in the Nurse Leader of the Year category. Additionally, our Patient Engagement team have been shortlisted in the Nursing in Mental Health category, for their recent overhaul of our patient forum. The awards, a virtual affair, has been pushed back from 14 October and will now be held on 18 November.

**Community Partnerships coverage**
Promoting our work in the community is one of the objectives with the media. *'I spent most of my life offending – until decades later someone finally asked me about my mental health',* published by Inside Time magazine, is a piece where service user Chris shares his story. After speaking to Ellie, a psychologist in our Probation service, he has turned his life around.

**Lowther coverage in Digital Social Care**
This feature from Digital Social Care gives an in-depth preview of Lowther, our new Dementia village, explaining how technology is at the heart of the new service to improve the lives of our patients.

# Divisional Presentation Mansfield Lessons Learned

(Alastair Clegg – Verbal)

| Paper for Board of Directors |
|---|
| **Topic:** Non-Executive and Executive Director Visibility Reports |
| **Date of Meeting:** 26 November 2021 |
| **Agenda Item: 07** |
| **Author:** Alastair Clegg |
| **Responsible Executive:** Alastair Clegg, Chief Operating Officer |
| **Discussed/Approved at Previous Board Meeting(s):**<br>Not discussed previously |
| **Discussed/Reviewed by Patients and/or Carers and/or Staff:**<br>Board and Executive visits were discussed with patients at community meetings of what was the Men's Service in 2018 |
| **Report Purpose/s:**<br>Review and comment |
| **Key Lines Of Enquiry:**<br>**S ☐ E ☐ C ☐ R ☐ W ☒** |
| **Strategic Focus Area:**<br>Quality, People |
| **Charity group or committee meetings where this item has been considered:**<br>Charity Executive Committee – 9th September 2020 |
| **Report Summary and Key Points to Note:**<br><br>The report provides some clarity on the proposed rota for NED visits to wards and clinical areas, and seeks NED views on whether and how best the proposed visits can work, given lockdown. |
| **Appendices:**<br>None |

# Non-Executive and Executive Visibility Reports

In common with other healthcare providers, and other organisations, we consider it important that Board and CEC colleagues visit our front-line teams in order that (a) Board colleagues can see and experience our patient-facing work first-hand, (b) staff and patients can see the extent of senior colleagues' commitment. Such visits have been helpful in raising staff morale, and have enabled Board members to see some of our challenges, and successes.

In 2019 it became clear that some wards (particularly CAMHS wards) were receiving a lot of visits, whereas others rarely saw CEC or Board members. We therefore agreed to establish a rota, splitting Execs and Non-Execs into teams, and asking those teams to focus their visits on particular groups of wards and other clinical and therapeutic services, in order to ensure good coverage. Teams could visit together, or individually, and informal feedback was sought after visits. Initially, the rota was intended to run for six months, after which it would be refreshed.

COVID, associated lockdowns, and a change in Board membership disrupted this process. However, in August, we circulated a revised rota. We also took the opportunity to seek more formal feedback and have introduced a feedback form (and guidance) based on the NHS 15-step challenge approach.

Since then, we have entered another lockdown period, which may not be our last.

Regardless of lockdown, several Board members have indicated that they will not be able to visit wards, and have raised some questions about the process. Some responses to those:

- The approach is designed to be flexible: teams do not need to visit together, and visits can be as short or as long as colleagues wish
- Although we'd welcome feedback, and completing the 15-step challenge forms would be helpful, they aren't mandatory. Where feedback is provided, we will feed it into our Operational Quality meetings.
- We are absolutely not restricting Board colleagues to the wards assigned to them on the rota. Board colleagues can visit any wards. We would ask, however, that, wherever possible, Board members do try to ensure at least one visit to each of the wards assigned to them, to ensure all wards get a visit.
- COVID and lockdown clearly make this more challenging. We're happy to try to arrange Teams meetings with Board members who can't visit wards in person. However, at the risk of stating the obvious, it can be quite difficult to get nursing staff and/or patients onto Teams calls, but we can certainly get something set up.
- We'll keep the rota open for long enough to see us through the next wave of COVID (however long that might be!).

Hopefully that provides a bit of clarity, but happy to discuss any of this further.

| Paper for Board of Directors |
|---|
| **Topic:** Draft Quality Account – Not Yet Submitted |
| **Date of Meeting:** 26 November 2020 |
| **Agenda Item: 08** |
| **Author:** Michael Fenwick/Julie Meikle |
| **Responsible Executive:** Julie Meikle, Director of Quality |
| **Discussed/Approved at Previous Board Meeting(s):**<br>N/A |
| **Discussed/Reviewed by Patients and/or Carers and/or Staff:**<br>External comments included and content discussed in various fora. |
| **Report Purpose/s:**<br>For Approval |
| **Key Lines Of Enquiry:**<br>**S ☒ E ☒ C ☒ R ☒ W ☒** |
| **Strategic Focus Area:**<br>Quality |
| **Charity group or committee meetings where this item has been considered (specify date):**<br>QSAC on 5 November 2020 |
| **Report Summary and Key Points to Note:**<br>This report provides the Board of Directors with the draft Quality Account for the financial year 2019/2020 for St Andrew's Healthcare. This is a legal obligation for all NHS funded providers and is usually submitted in June.<br><br>This year NHSE has extended the deadline for submission for all providers to December 2020 due to the pressures faced by the Covid-19 situation across the country.<br><br>The structure and content of the report follows the guidance by NHS England/Improvement and includes statements from external stakeholders. The Account covers our strategic direction and progress against this up until March 2020. |
| **Appendices:**<br>*n/a* |

## 1. Front Page

Design work yet to be completed.

## 2. Contents Page

Contents page yet to be formatted.

## 3. Section 1 - Introductions "Progress and Plans"

### A Welcome from Katie Fisher, our Chief Executive

Welcome to this year's Quality Account. It has been a challenging year, both for the Charity and for the world, as together we fight the Coronavirus pandemic. Our staff have worked around the clock in order to support our patients' health and wellbeing, and I have seen and heard so many examples of truly excellent, compassionate care. I am exceptionally proud to be leading the Charity during this time, and appreciate the hard work our staff have put in.

As an organisation, we are urgently looking at the services we provide. There are many areas where we are delivering excellent patient care, but this is inconsistent; in some places our care is unacceptable and urgently needs to improve. We are working hard to address this. Our patients and carers have the right to expect the very best from us, and we are committed to driving forward change. At the start of the year, we announced that we are significantly reducing the number of beds in some of our services, with quality our driving principle and patients at the heart of all that we do.

Against this difficult landscape, St Andrew's has much to be proud of. Over the past 12 months, we have updated our strategy to ensure that we have a truly clinically led approach to patient care, and I am proud to share that we now have a strong and clinically-focussed Executive Committee in place, who are ensuring that patient safety and outcomes underpin every decision that we make.

The Charity continues to be committed to education; every individual in our care is given access to learning opportunities to enhance their lives and provide them with the skills they need to live independently. We know that education and learning contributes to the recovery of our patients, and our professional staff help people to learn in ways that suit their particular needs, often leading to awards or qualifications. Over the last year, we have offered 21,378 teaching sessions across our hospitals, and 202 separate qualifications were achieved by the people in our care. As well as the awards, these patients have had the opportunity to enhance their skills, knowledge and self-esteem, all of which will help them to realise their full potential.

Education is not just a focus for patients; all of our staff are offered training and opportunities for development to improve the way they work with the people in our care. Over the past year, staff have completed over 23,000 days of learning – that is six days of learning per staff member. The learning opportunities on offer range from entry level support to nursing degrees, leadership and development. I am particularly proud of our ASPIRE programme, which supports our Healthcare Assistants to qualify as nurses. There are currently 90 staff members at various stages of the ASPIRE journey. This year, 25 have successfully graduated, 18 with First Class Honours. They will all return to St Andrew's with not only academic qualifications but also a great working knowledge of our wards and patients.

In the last 12 months, we have looked after 1398 patients in our hospitals and community homes. During the year, we were able to discharge 722 individuals and help 228 move either into the community or to a lower level of security. I am proud that these patients left our care with their lives back on track, equipped with the skills and knowledge they need to succeed.

Looking forward, we are developing new, community-focussed ways to help people recover. We are also collaborating with both the NHS and universities to develop new therapies and treatments, aiming to improve patient outcomes with innovative ideas and new technologies.

These are changing times for St Andrew's, and despite the many challenges in mental healthcare please be assured that, as always, our first and greatest priority is to deliver the best possible care, with patients at the heart of everything we do.

### Executive Medical Director: Dr Sanjith Kamath

This has been a year of ongoing development at St Andrew's, with a significant amount of work focused on strengthening the foundations on which we continue to build to deliver safe and effective care. This year, we have introduced a new, more robust clinical governance framework across the clinical services supported by class leading data analytics and information flows. We have continued to work towards the objectives set out in our clinical effectiveness strategy, systematically monitoring and measuring patient outcomes, while including and engaging our patients and carers to support our efforts in delivering co-produced care.

As an organisation, we pride ourselves on the expertise and experience of our clinicians and we have continued to strengthen the clinical voice across the organisation, with greater clinical representation on the Charity Executive Committee, ensuring that all decisions are clinically focused and keep the patient at the heart of all we do. A number of our senior clinicians are being supported through leadership and management development and our programmes for medical students give the next generation of doctors the opportunity to train with our frontline clinical teams.

I am particularly pleased that we are on track with our programme of reducing restrictive practices, in line with the ambitions we set ourselves. Our community partnerships continue to grow from strength to strength delivering a wide range of services, including offender mental health and mental health services for armed forces veterans.

Our Research department continues to explore the frontiers of new treatments through new partnerships and I am really excited about the inroads we are making in using Virtual Reality technology in delivering innovative care approaches. St Andrew's has also been selected as one of three national pilot sites for a blended secure women's unit, as well as being a trial site for the NIHR funded study into the use of medication in treating personality disorder. In other areas, we have made much needed investment in physical healthcare over the year and this has provided a greater focus on the holistic health of our patients so that we ensure they achieve good outcomes with their physical health as well as with their mental health. However, while we have made huge strides in improving the quality of our services, we know there are places where we have not met the standards we have set ourselves and we are focusing urgently on addressing these challenges head on. To do so, we have to further strengthen clinical leadership at all levels across the organisation to reduce unwarranted variations in the standards of care. It is our opportunity to ensure that collectively we provide excellent patient centred, outcomes driven care in all areas aligned to the CARE values of the Charity.

The last few weeks have brought an unexpected challenge in the form of the global Coronavirus pandemic and every day I hear stories of staff going the extra mile to provide compassionate, excellent care to our patients in difficult circumstances. I am so very grateful to the hard work and efforts of all our staff and clinicians – it makes me so proud to be part of the St Andrew's family.

### Chief Nurse: Lisa Cairns

The focus on Nursing Quality is high on our agenda with a real push to set the Nursing Strategy for the next two years. The senior nursing leaders have been working closely with the ward teams, through a number of forums and workshops to identify three key priorities.

These three priorities will help us to achieve the Charity purpose of relieving suffering, giving hope and promoting recovery, and comprise a number of work streams. Through our nursing strategy, we will ensure that all individuals receive high quality, compassionate care that allows them to live their best life. We will develop our nurses, to have the time and skills to work confidently and flexibly and create the nursing leaders of the future. Finally, we will empower all of our nurses to lead on improving the quality of care for all. We will regularly review progress against our strategy, with ward metrics and KPIs, and endeavour to evidence real change that all of our nurses can be proud of.

Looking forward, we are planning on shifting our organisational model for clinical services from our Integrated Practice Unit model, to larger Divisions. This will help us overcome some of the challenges of siloed working within IPUs and allow the development of consistent and effective clinical governance processes. As part of this work we are looking to invest in our nursing teams at all levels to strengthen the voice of nursing throughout the Charity. By doing this we will increase the clinical leadership within the newly defined Divisions by introducing a Head of Nursing role. These senior, experienced nurses will work closely with Operations and the Clinical Directors to identify and implement the strategic goals of the Divisions. These nurses will be credible and visible leaders to the nursing teams, with a clear focus on patient safety, safeguarding and improved patient outcomes. Alongside this is the introduction of Specialist Nurses who again will influence the clinical nursing practices within their sphere of responsibility.

## 4. 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:
  - Robust and reliable.
  - Conforms to specified data quality standards and prescribed definitions.
  - Subject to appropriate scrutiny and review.
  - 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 2019/20.



## 5. Section 2 – Quality Priorities

The Charity's strategy sets out the quality priorities that we are working on to achieve our aims. We continue to focus on an outcomes driven care approach that is clinically led and designed in order to support mental and physical health but also to improve the experience of our patients who receive care. This year we will carry on the work we commenced last year in progressing co-production, further embedding clinical effectiveness while focusing on reducing unnecessary restrictions. We will also be expanding our programme of continuous quality improvement across the Charity.

### Co-production of Care

Over the last year we worked with our patients and carers to refresh our approach to care planning. This included reviewing our processes and records system with a change to the way we now record care plans. We have focused on carer and patient engagement through better representation at our patient led Birmingham, Essex Nottinghamshire, Northampton Service User (BENNS) meetings. There is still much work to be done and this will continue over the next year.

### Clinical Effectiveness

We have been working steadily towards achieving the goals set out in our Charity strategy with clinician led NICE related audits and peer reviews of practice being undertaken across the Charity. Through the development of our clinical record and data analytic systems, we now have a series of dashboards providing clinicians with important information that is readily available in real time to support decision making. Patient outcomes continue to be measured and monitored across the Charity and a new robust clinical governance framework is providing greater assurance on the quality and effectiveness of our clinical services.

**Restrictive Practices**

Our work in this area has resulted in a significant reduction in the use of unnecessary restrictive practices, in particular the use of seclusion, which has reduced in line with our plans. We continue to progress with our focus on the seclusion environments; refreshing and refurbishing these where required, as well as decommissioning a number of seclusion rooms. We have made changes to our policies and procedures to better align with the Mental Health Act Code of Practice while working with commissioners, external partners and other providers to ensure that we maintain momentum in this area.

**For the next year, our quality priorities will be:**

**Continuous Quality Improvement**

We have already introduced a programme of Continuous Quality Improvement (CQI), where we have enabled frontline clinicians and teams to identify areas where quality can be improved and then provided them with the tools and resources to introduce change, which can be evaluated, improved on and then disseminated more widely. An early example of the success of this approach is a project driven by staff and patients in one of our Medium Secure units that enabled much easier access to mobile technology for patients. This year we will be rolling CQI more broadly across the Charity, promoting a grounds up culture of improvement and innovation

**Improved External Quality Ratings**

As we continue to embed our governance structures, the effectiveness strategy and our clinically led approach to quality, we will be seeking to improve our quality ratings from external stakeholders and organisations including commissioners, regulators and those bodies responsible for accreditation such as the Royal College of Psychiatrists (RCPsych) Centre for Quality Improvement. As an example, the high standards of care being provided by our Brain Injury service were recently recognised by the National Brain Injury charity Headway who accredited the service. We recognise that there are areas where we need to improve the standards of care and doing this is a priority for the Charity.

**Better staff, patient and carer engagement**

We want to make further progress this year with our staff and patient engagement programmes. We recognise that highly engaged, clinically led teams will enable a better experience of care for our patients and we are building on the extensive work of our Patient Experience Team to ensure that we deliver services that are valued by our patients and carers. Listening to, and working with our staff, patients and carers will help us design and develop services where co-produced care can be delivered effectively. This is an opportunity to capture the energy from our BENNS forum and carers groups and work with all our staff to make significant progress in this area.



## 1. Statements of Assurance from the Board

### Review of Services

From 1 April 2019 to 31 March 2020 St Andrew's provided services in the field of mental health, learning disability and brain injury to 1398 patients, commissioned by 180 different bodies, of which 96% were NHS services or organisations. Non-UK organisations, private funders or individuals fund the remaining 4% of patients. St Andrew's has reviewed all the data available on the quality of care in respect of its services which provides clinical NHS care.

### Never Events

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

## National Core Indicators of Quality

The core set of indicators are defined in the quality accounts regulations. All providers are required to report against these indicators using standardised statements as set out in the table below. Providers are only required to include indicators in their quality accounts that are relevant to the services they provide. The table below includes all of the core indicators that are applicable to St Andrew's Healthcare.

| Indicator | Measure | 2018/19 | 2019/20 |
|---|---|---|---|
| The percentage of patients aged:<br><br>(i) 0-15 and<br>(ii) 16 or over<br><br>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. | <br><br>Percentage<br>Percentage | <br><br>0%<br>2.52% | <br><br>0%<br>1.73% |
| Patient safety incidents | Number | 22949 | 27445 |
| Patient safety incidents that resulted in severe harm or death | Number (Percentage) | 17 (0.07%) | 19 (0.07%) |

1. The percentage of patients aged:
   I. 0-15 years and
   II. 16 years 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.

| | 2018/19 | 2019/20 |
|---|---|---|
| Percentage of patients 0-15 years | 0% | 0% |
| Percentage of patients 16 years or over | 2.52% (10) | 1.73% (11) |

St Andrew's Healthcare considers that this data is as described for the following reason: The readmission rate has decreased for the 16 years or over age group – all of these readmissions were from our Psychiatric Intensive Care Units (PICU) wards. We now have four PICU wards in total (two in Northampton and two in Essex). Our PICU services provide tailored treatment programmes that are developed to recognise individual need. All of our PICUs are members of the National Association of Psychiatric Intensive Care and low secure Units (NAPICU) and comply with their standards and admission criteria.

St Andrew's Healthcare has taken the following actions to improve this percentage and so the quality of its services by moving to a value based healthcare approach centred on patient outcomes.

2. Number of patient safety incidents and patient safety incidents resulting in severe harm or death.

| | 2018/19 | 2019/20 |
|---|---|---|
| Patient Safety Incidents | 22949 | 27445 |
| Patient safety incidents that resulted in severe harm or death | 17 | 19 |

St Andrew's Healthcare considers that this data is as described for the following reason: 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.

St Andrew's Healthcare has taken the following actions to improve this percentage and so the quality of its services by active monitoring, investigation and learning from incidents. The Executive Leadership Team has oversight of all serious incidents that occur across the Charity on a weekly basis. The Charity operates a serious incident review group, which sets the terms of reference for serious incident investigations, the membership of which is made up of clinicians from across the organisation. The Charity utilises a red top alert system through which any learning from incidents can be cascaded Charity wide with immediate effect. On a quarterly basis the Quality and Safety Assurance Committee meets with standing agenda items including Safety, Effectiveness and Quality.

## Mortality Review

During the reporting period Q1-Q4 (April 2019 - March 2020) 18 patients who were in the care of St Andrew's Healthcare died.

Ten deaths were due to natural causes and therefore subject to the Mortality Review process.

Eight deaths were considered unexpected deaths and therefore investigated through the Serious Incident (SI) investigation process.

Seven of these patients were detained inpatients and one death was that of a patient accessing one of our community-based services.

## Learning from Mortality Reviews

In line with guidance issued by the National Quality Board, St Andrew's has collaborated with local and national partners to develop a Standardised Mortality Review Tool (SMRT), which also incorporated the Structured Judgement Review (SJR) by the Royal College of Psychiatrists (RCPsych). The tool has semi-structured questions, to quality check against the relevant recognised holistic standards in End of Life care and is used to review deaths, which can be seen as expected. Following a death from natural causes, a mortality review is undertaken using the SMRT and considered at the Mortality Surveillance Group (MSG), chaired by the Executive Medical Director. This group has wide multi-disciplinary involvement and includes an external independent Consultant in Palliative Care and an expert in End of Life care. Learning from the mortality reviews is then shared through the Clinical Governance Oversight groups to ensure Charity wide dissemination.

The findings from the mortality review process suggested that overall there was good engagement with families; capacity assessments and best interests meetings were undertaken appropriately and that there was good end of life care, although ongoing work was needed to improve integration of physical healthcare and to embed advance care planning. We have put in place measures to support better integration between the physical healthcare teams and the wards, as well as the sharing of expertise in the area of advance care plans.

We have changed our annual mortality reporting processes to align with NHS providers, in that the reporting periods to the Board and the Quality Account are now based on the financial rather than the calendar year. We have also incorporated the work from the Mortality Surveillance Group as well as the SI group to inform the annual mortality report with more in depth analysis of both expected and unexpected deaths.

## Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in the quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and improve value for money. St Andrew's is taking the following actions to improve data quality:

- Implementing a Data Governance Strategy to ensure data is treated as an asset and also drive data quality improvements.
- Creating a Data Warehouse where all data is put through strict quality measures.
- Profiling, assessing and cleansing data to increase the accuracy of information used to drive decisions.
- Defining communication protocols to improve the alignment of all stakeholders involved in the data lifecycle.
- Adopting a structured approach to managing data, deriving insight and driving action.

## NHS Number and General Medical Practice Code Validity

St Andrew's is submitting the Mental Health Services Data Set (MHSDS) in line with national requirements. Codes are checked and validated on a regular basis against national lists.

## Clinical Coding Error Rate

St Andrew's Healthcare was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

### 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 NHS England. St Andrew's submits data to Mental Health SSQD on a quarterly basis. From 1 May 2020, these dashboards will be submitted monthly.

### 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 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 (QST) of its compliance levels with the service specification. This self-declaration is made in June of each year; at last submission, (June 2019) full compliance was declared.

### Duty of Candour

During the CQC Well Led inspection in September 2019, it was highlighted that there were some discrepancies between the Duty of Candour data from our register and the quality report. We have addressed the immediate discrepancies identified during the well-led inspection, ensuring that any required actions to share events and findings with families and/or key stakeholders took place.

We have also revised our Datix and wider systems to ensure that all potential incidents that may meet the thresholds set out by Duty of Candour guidance are reviewed daily by the Charity's quality team. We will monitor the implementation of our Duty of Candour guidance and continue to promote a principle of transparency and openness across our organisation - with an explicit approach to err on the side of full disclosure in incidents that have resulted in significant harm or death. In all incidents where unexpected death occurs, our expectation is that a member of the Charity's Executive team will engage directly with families concerned.

The current Policy is being revised to reflect these changes.

### Participation in National Clinical Audits

The national clinical audits relevant to St Andrew's are those co-ordinated by the Royal College of Psychiatrists Prescribing Observatory for Mental Health UK (POMHUK). The topics we participated in for 2019 -20 included:

- Use of Long Acting Depot Antipsychotics for Relapse Prevention.
- Antipsychotic Prescribing in People with LD.

The Medicines Management Operational Group and the Quality, Safety and Assurance Committee review the reports of these national audits.

During the year ending 31 March 2020, St Andrew's did not participate in any national confidential enquiries as none related to NHS services that St Andrew's Healthcare provides.

### Participation in Local Clinical Audits

Local Clinical Audits are completed by clinicians and Multi-Disciplinary Teams using the Charity's "Clinical Audit & Service Evaluation Proposal" process. These local audits can be completed in conjunction with members of the Clinical Audit and Assurance Team or as stand-a-lone assignments. Local Clinical Audits may be undertaken based on Individual Practice Unit (IPU) requirements, personal interest, personal development, or as part of an educational or training programme.

All Local Clinical Audit assignments within the Charity are registered and approved prior to commencement, whether through the on-line proposal form or via the Charity's Effectiveness Group. This allows for monitoring of audit activity to maximise organisational learning and supplement information responses to commissioners and regulators.

Local Clinical Audits support the delivery of the Charity's Clinical Effectiveness Strategy.

During 2019/20, 11 local Clinical Audits were completed and 14 are in progress following approval via the St Andrew's review process, these are detailed in the table below:

| **Completed 2019-20 - 11** |
|---|
| Staff Training Survey |
| Monitoring of Physical Health Parameters of Patients on Antipsychotics |
| DBT in CAMHS |
| Antipsychotic Drug Monitoring and Metabolic Syndrome |
| Comparison of Burnout, Self-efficacy and Life Satisfaction in Clinical Staff, Before and After the Launch of ASD/LD IPU Structures |
| Staff Wellbeing in ASD/LD IPUs |
| Staff Wellbeing in Women's Medium Secure IPUs |
| Evaluating Patients' Views of Ward Round |
| Prescribing of Antipsychotics for Children & Adolescents |
| Accuracy of Recordings using the Overt Aggression Scale |
| Individuals with ASD engaging in terroristic related activities |
| **Approved 2019-20 & Currently Underway - 14** |
| Mental Capacity Act Assessments |
| The Impact of a New Model of Mentorship |
| START Strength, Vulnerability & Risk Estimates |
| Patients Progress and Violent Behaviours |
| Evaluation of a Pilot Adapted Adherent DBT Programme |
| Assessing the Burden of Physical Healthcare Needs |
| CPUM: A Qualitative Review of Patient Experience |
| Physical Health Needs of PICU population |
| Trans Inclusive Healthcare |
| Peer Support Worker Project |
| The Consistency and Efficacy of Feedback |
| Roll out of VR |
| DHD Service Evaluation |
| Ageing and Secure Psychiatric Care |

A number of proposals were approved prior to 2019-20 and are at various stages of completion, some of these are delayed for a number of reason - changes of structure or priorities within the team, staff changing role, leavers. The CAAT follow up on all proposals at the anticipated end date and updates the tracking information to monitor proposals through to completion.

### Clinical Audit and Assurance Team

A programme of Clinical Audit and Assurance assignments that incorporates audits and reviews against specified categories/drivers is maintained by the Clinical Audit and Assurance Team. These audits and reviews are in addition to the audits completed by clinicians as part of the Local Clinical Audit proposal process and the audits or compliance checks performed at an IPU and Ward level. The Internal Audit team also complete a number of assignments on key clinical and quality processes.

Recommended actions from these audits are monitored and followed-up with the staff responsible for implementing them, with reports and analysis shared and discussed at the Effectiveness Group, Quality and Safety Assurance Committee and Charity Executive Committee.

During 2019/20, 23 audits and reviews were completed by the Clinical Audit Assurance and Internal Audit Teams and four are currently underway at various stages of completion. A further four were completed by clinicians, with support from the Clinical Audit and Assurance Team, these are detailed in the following table:

| **Completed & Published Audits by the Clinical Audit and Assurance & Internal Audit Teams** |
|---|
| High Dose Antipsychotics (including GASS) |
| Advance Statements and Decisions – follow-up |
| Community Services Compliance and Assurance Check |
| Handover Processes – follow-up |
| Patient Care Plans Deep Dive (quality of completion and patient involvement) |
| Clinical Governance Mapping |
| Seclusion Documentation – Women's Mental Health Service |
| Clinical Peer Review Process – development and implementation |
| Enhanced Support Process |
| Hourly Observation Records |
| Clinical Records Deep Dive |
| Green Light Toolkit |
| Care Plan Quality – Patient Care Plan Reviews Report and Trend Analysis |
| Mental Health Act Compliance |
| Complaints Management – follow-up |
| Outcome Measures (quality of data) - follow-up |
| Care Programme Approach Process |
| Professional Registration |
| Lessons Learned |
| Clinical Governance Framework – progress review |
| Physical Healthcare |
| Whistleblowing |
| Management of RiO (Patient records system) |

| Provided assistance to other clinicians and medical staff in supporting with their audits |
|---|
| NICE Charity Review – NG10 Violence and Aggression |
| IPU Clinical Peer Review - Neuro |
| IPU Clinical Peer Review – CAMHS |
| NICE IPU Support (Community Partnerships) – CG142 Autism in Adults – DRAFT |
| **Ongoing audits and reviews at various stages of completion** |
| Restrictive Practice Interventions - DRAFT |
| Safeguarding process - DRAFT |
| Long Term Segregation – Completed and awaiting sign-off |
| Clinical Records - DRAFT |

### IPU NICE Assurance Audits

Guidance and quality statements from the National Institute for Health and Care Excellence (NICE) are recognised as important quality standards, drawn from the wider evidence base that can improve clinical outcomes if implemented.

In keeping with our Clinical Effectiveness Strategy, a programme of local and Charity wide assurance audits and reviews is maintained to provide assurance against NICE standards and guidance. The programme includes a schedule of regular Charity wide deep dive reviews completed collaboratively by clinicians, auditors and other support staff, as well as specific IPU led NICE assurance audits, as selected in consultation with the IPU leadership, Effectiveness Group and Clinical Audit and Assurance Team.

The final reports for all NICE audits and reviews are published on the Charity's intranet and shared to promote learning, with periodic re-audits and reviews taking place to provide on-going assurance that recommendations have been implemented and practices maintained. Action plans for these audits are owned by the IPU, with progress tracked via the Charity's Effectiveness Group and the IPU Clinical Governance Meeting.

The tables below detail work currently underway or completed:

| Ongoing IPU NICE Assurance audits at various stages of completion |
|---|
| CG159 - Social Anxiety Disorder |
| QS80 - Psychosis and Schizophrenia |
| NG31 - Care of dying adults in the last days of life |
| CG136- Service user experience in adult mental health: improving the experience |
| CG178 - Psychosis and Schizophrenia in Adults (Schizophrenia aspects) |
| NG10 – Violence & Aggression (focus on rapid tranquilisation) |
| PH38 - Type 2 diabetes: prevention in people at high risk |
| NG87 - Attention deficit hyperactivity disorder |
| CG138 - Patient experience in adult NHS services. |
| QS111 - Obesity in adults: prevention and lifestyle weight management programmes |
| NG43 - Transition between Inpatient mental health and community settings |

| Completed & Published NICE IPU Audits |
|---|
| PH56 - Vitamin D: Increasing supplement use amongst at-risk groups |
| NG43 - Transition from children's to adult's services for young people using health or social care services |
| QS94 - Obesity in children and young people: prevention and lifestyle weight management programmes |
| CG138 - Patient experience in adult NHS services |
| NG7 - Preventing excess weight gain |
| NG10 - Violence and aggression: short-term management in mental health, health and community settings |
| QS14 - Service user experience in adult mental health services. |
| NG97 - Dementia: Assessment, management and support for people living with dementia and their carers |
| NG11 - Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities |
| CG142 - ASD in adults: diagnosis and management |
| NG54 - Mental health problems in people with learning disabilities: prevention, assessment and management |
| CG170 - ASD in under 19's :support and management |
| CG120 - Coexisting severe mental illness (psychosis) and substance misuse: Assessment and management in healthcare settings. |
| QS88 Personality Disorder - Borderline & Antisocial |
| CG77 - Antisocial personality disorder: prevention and management |
| NG7 - Preventing excess weight gain |
| NG53 - Transition between inpatient mental health settings and community care or care home settings. |
| PH53 - Overweight and Obese adults: lifestyle weight management |
| NG108 Decision making and mental capacity |
| CG161 - Falls in older people: assessing risk and prevention. |
| NG116 ( was CG26) - PTSD An audit of Sodium Valproate use within the Women's Medium Secure IPU against the MHRA's PREVENT programme |



### Learning from Clinical Audits

The Clinical Effectiveness Strategy and supporting procedures ensure clarity in the use of auditing and embedding clinical quality at all levels of the Charity. This helps to create a culture that is committed to learning and continuous organisational development. It also helps to deliver demonstrable improvements in patient care through the development and measurement of evidence based practice. This is further enhanced by the introduction of the Charity's Clinical Governance Framework and the forming of the Clinical Governance meetings at Ward, IPU and Clinical Director oversight levels. Four audits undertaken this year have been detailed below as examples of our learning:

### Clinical Peer Review Process

A clinical peer review is the professional assessment of clinical practice to provide a supportive and collaborative learning culture of continuous improvement. Standards relate to core medical and MDT practice and will be a vital part of ensuring high quality care is being delivered on wards, identifying areas of good and poor practice through which best practice can be shared and changes can be made.

The development of peer review processes can help deliver a clinically led organisation, in which every clinician plays an important role in the overall clinical governance framework. It provides a broad and flexible response capable of addressing the challenges raised by variations in standards of care, while maintaining professional and clinical autonomy. It will allow our staff to foster consistent good quality and to minimise selective poor performance and unwarranted variations in care, to which healthcare is susceptible.

Pilots were carried out on numerous wards and involved Clinical Directors and Responsible Clinicians from across the Charity, to trial the standards and review tools across a variety of environments. These looked at a number of patients selected at random and identified that good practice was being followed in some areas, with others identified that require improvement to gain a higher level of assurance.

The pilot reviews identified a number of areas of good practice, including valid consent to treatment, completeness of medication related records, additional care plans were in place where required, mandatory assessments were present and in date, and accurate and complete records for blood tests. Some areas for improvement were also identified, such as capacity assessments being recorded relating to consent to treatment, discharge date completed and reviewed, updated GASS and completion of annual health check forms. Both the areas of good practice and areas requiring improvement have been shared with all peer reviewers as part of the review roll-out in order to improve the quality of care.

Following the pilots, the tool was refined and the supporting systems and processes developed to incorporate a twice yearly cycle of reviewing all Responsible Clinicians in the Charity.

The Peer Review Process involves a Consultant Psychiatrist, with a clinical colleague (or member of the Clinical Audit & Assurance Team), reviewing a Responsible Clinician's Patients. Although primarily centred on RCs, the reviews will cover all wards and services as the review cycles progress.

An active dialogue between the reviewers and the RC will lead to effective action plans, based on review findings, and future review cycles will then check on issues raised within action plans. Most RCs will also be participating as reviewers so will have a good understanding of the benefits of Peer Review from both sides.

The review schedule comprises alternating quarters of completing reviews and agreeing actions plans, with quarters set aside to address any issues raised by the reviews. The first tranche of completed reviews included 70 patients, these identified:

Highlights of good practice (over 75% of patient records fully met the standard):

- A fully valid and correct consent to treatment in place.
- The correct MHA section recorded on EPMA, the remainder were either not recorded or did not reflect the current status of the patient.
- Monthly CPUM/ward round meetings recorded in patient records.
- Patients were invited to attend CPUM/ward round where able.
- Patient records had evidence of blood tests carried out in the past 12 months.

Areas for improvement

- A copy of the T2/T3 (consent to treatment) transcribed into the Electronic Prescribing and Medicine Administration system (EPMA).
- Capacity assessments for consent to treatment completed within the past year.
- For patients on a T3, a new capacity assessment carried out when there is a change of Responsible Clinician (RC).
- An estimated discharge date documented in the patient record.
- For patients on antipsychotics, a Glasgow Antipsychotic Side Effect Scale (GASS) assessment completed within the last six months.

### Patient Care Plan Reviews

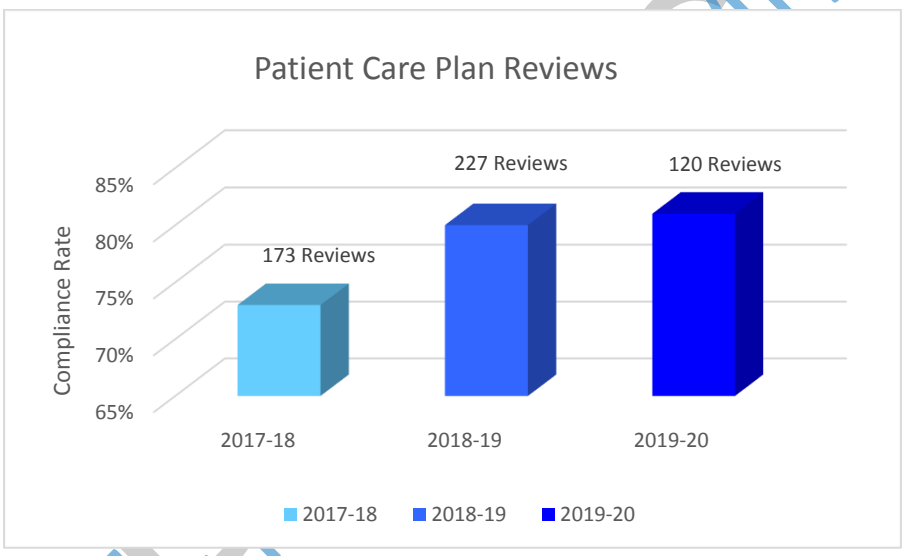
NHS contracts and applicable regulations identify the need for the review of individual Personalised Care Plans and the ability to evidence accurate and complete record keeping on an on-going basis. Reviews, using a specific and continuous audit programme are completed on a monthly basis ensuring a sample of care plans for patients from all IPUs is reviewed on at least a quarterly basis. One of the key benefits of

the continuous approach is the ability to provide the Wards with an immediate action plan and an overall assurance rating based on the level of compliance. The review assists management in gaining assurance that the care and risk of each patient is assessed, planned and managed based on individual needs, and that patient views are documented in the care plans, and also that patients' and their carers' are involved in care planning, wherever possible.

Identified actions are implemented by Ward personnel and are followed up on the return audit, through periodic spot checks on progress and by the Operational Support team via the monthly IPU meetings and performance dashboards.

The outcome of all Patient Care Plan audits are collated and maintained on a trend analysis, with summaries provided to management (by IPU), highlighting areas of good practice as well as areas that require improvement.

During 2019-20 we have completed 120 individual patient care plan reviews, with an overall compliance rate of 81%. This continues the improvement seen in prior years, whereby the rate was 80% (2018-19), 73% (2017-18), demonstrating an overall improvement in the completion and on-going management of care plans since the introduction of the reviews.




## Patient Care Plans Deep Dive

In conjunction with the continuous review of Patient Care Plans, an in-depth audit was also completed during 2019-20 in order to further measure the actual quality of the plans against required standards. Care plans from across a selection of IPUs including CAMHS, Neuropsychiatry and Women's were reviewed in detail to establish the quality of personalisation, patient involvement, interventions, outcomes and evaluations, and the involvement of the whole Multi-Disciplinary Team in the individual patient's care.

The review highlighted areas of good practice within the care plans and the monthly care plan reviews. The care plans were found to reflect patients' holistic needs and included aims, outcomes and interventions, and contained timely and relevant evaluations.

It was good to see that there was clear evidence that patients either attended the care plan review meetings or had been invited, and where they did not attend, there was a reason. Patient views were also evidenced in the care plan review meetings and there was effective recording of the session outcomes in the progress notes.

The deep dive identified areas for improvement, such as care plan formulation, personalisation, continuous review and the detail recorded relating to interventions. Clear actions and recommendations were documented to address these areas, and currently there are ongoing actions in response to them. The open recommendations have since been superseded by a recent Clinical Records audit.

### Handover Process Review - Follow-up

It is acknowledged that effective handovers and continuity of information is vital to the safety and quality of care of our patients. Handovers are carried out when there is a change of shift, from day to night and vice versa and may also be carried out for staff that are working a half shift or alternate hours to the main shift.

A full assurance audit on the handover process was completed in 2018-19 and raised a number of key recommendations to improve and enhance the handover process. Follow-up audits are completed regularly by the Clinical Audit and Assurance Team to determine how effectively the previously raised and agreed actions have been implemented and embedded.

The original Handover audit highlighted improvements were required in relation to the timekeeping and length of handovers, the level of detail recorded and discussed; the location and attendance at handovers, as well as how handovers were being recorded (manually or within the patient record system – RiO).

Whilst many of the original issues had been addressed, with the recommendations implemented and embedded, the follow-up review did highlight areas where further work was required, including timekeeping and length of handover and how handovers were being documented.

Since the completion of the follow-up, all remaining actions have been implemented and are being embedded within the wards.

### Goals Agreed with Commissioners

The Commissioning for Quality and Innovation (CQUIN) programme provides a national framework for improving quality and innovation within NHS funded care to realise better patient outcomes. First launched in 2009/10 the scheme sets annual quality improvement goals.

We are proud of our ongoing participation and achievements in the CQUIN programme. We know that the improvements we have made as a result have positively impacted on the lives of the people receiving care from the Charity.

The CQUIN programme underpins our wider quality and innovation work and the culture that we are building within the Charity. For the current year 2019/20, the national CQUIN for d/deaf MH Communication Assessment has been based on the innovative work we have been doing for a number of years with deaf and d/deaf patients.

A proportion of St Andrew's income for the year ending 31 March 2020 was conditional on achieving quality and innovation goals relevant to the specialist care provided by the Charity. These are summarised below along with our quarterly achievement scores:

| CQUIN Title | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Healthy Weight in Adult Secure Mental Health Services | 100% | 100% | 100% | 100% |
| Addressing CAMHS T4 Staff Trainings Needs | 100% | 100% | 100% | 100% |
| D/ deaf MH Communication Assessment | 100% | 100% | 100% | 100% |



### Freedom to Speak Up

At St Andrew's we actively encourage staff to "speak up" if they have any concerns about their colleagues and working practices. There are a variety of avenues available for staff to do this:

- Safecall – An independent whistleblowing service, who provide independent and confidential conversations for staff and escalate concerns on their behalf.
- Your Voice Survey – An anonymous yearly staff survey, to enable staff to raise issues they wished to be addressed, rate management and support received. The results of the survey are published Charity wide and action groups are set up in order to address the areas for improvement. In 2019 over 2,500 staff took part.

- Your Voice Live – This is an opportunity for staff to speak directly to the Executive Team and ask questions about changes and practice in person. The Executive Team rotate venues to cover all sites and ensure all staff have the chance to have their voice heard.
- Your Voice Online – This is an online forum for people ask their questions to the Executive team, and the questions raised are public. Responses are published on the forum and are catalogued by subject, so if anyone wants to see what other questions have been asked they are all accessible.
- Freedom to Speak Up Guardians – This year we recruited four "Freedom to Speak Up Guardians". They are here to provide confidential advice and support to employees about any concerns they have about risks, malpractice or wrongdoing in the workplace, and to help to raise the profile of raising concerns in St Andrew's and the different routes available to do this. They will also provide guidance to employees about speaking up, working to ensure there are no barriers to prevent staff from raising concerns.

## 2. What others say about St Andrew's

### Care Quality Commission

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 1 April 2015 all providers are expected to meet the fundamental standards as laid down by the CQC.

St Andrew's is required to register with 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.

During the year, the CQC carried out six inspections to locations within St Andrew's Healthcare.

The first of these was at our Nottinghamshire site in June 2019, where the service rating improved to Requires Improvement from a previous rating of Inadequate. Significant improvements were noted in the Safe, Caring and Well Led domains where all three improved from a rating of Inadequate to Requires Improvement. The CQC had noted improvements in measures taken to keep our patients safe, with new ligature assessments being completed, along with the implementation of new infection control procedures. A reduction in the use of restraint and seclusion was also noted. It was also reported that the service had made further improvements; supported by new governance systems and action to address poor staff conduct. However, areas for further improvement were identified around procedures for delivering safe clinical observations and improving the standard of record keeping around incident reporting.

The second of these was to Winslow, where the service was rated as Good overall and in four of the five domains. This was an improvement from the previous rating of Requires Improvement following a report published in September 2018. The report reflected that the service had been developed and designed in line with the principles and values that underpin registering the right support and other best practice guidance. It was reported that people who use our service can live as full a life as possible and achieve the best possible outcomes, also having maximum choice and control of their lives and it was recognised that staff supported them in the least restrictive way possible and in their best interests. However, the CQC did raise some concerns around where people lacked the mental capacity to consent to the use of physical interventions, not all mental capacity assessments had been completed. There were also some inconsistencies noted in risk assessments and some care records were found to be incomplete in relation to nutritional needs.

In December 2019, CAMHS wards at Northampton were re-inspected in December 2019 and rated as inadequate. The CQC placed the service into special measures as a result. The CQC did note positively

how we had ensured that our patients are cared for in safe environments and that significant change to blanket restrictions had been made. It also noted how we involve our patients in decisions about the service; an achievement that the Charity is extremely proud of.

The CQC's main concerns related to the care and monitoring of those patients whilst on enhanced observations and that our staff were not always carrying out their duty in line with our policy and procedures, and that our governance processes has failed to identify staff failures in following procedures. We identified staffing as a concern, in that we did not have enough nursing and support staff to keep our patients safe. The CQC correctly raised concerns around record keeping and inappropriate language that was used in our patients records, in that we did not always treat our patients with kindness, dignity and respect

We regret that in a few individual cases, quality of care provided fell short of the high standards we strive for. Any instance where we have let patients down is one too many and is unacceptable.

All actions identified by the CQC are subject to regular monitoring. We monitor actions arising from all CQC inspections via the Patient Safety Group, Quality and Safety Assurance Committee and the Charity Executive Committee.

We will continue to work with staff and patients, patients' families and carers, as well as the CQC, to address these concerns promptly. We recognise that these services need to improve, and we have taken immediate steps to address the concerns raised and we welcome the CQC back to our CAMHS services to review improvements within the next six months and are confident these services will have improved.

Two focussed inspections followed to our Essex site in February 2020 and Seacole ward in our Women's service across February and March 2020. Our final inspection for this period was a comprehensive inspection in our Women's Service, which was carried out in March 2020. The inspection reports for these three inspections were not published in this reporting period.

The latest ratings across the Charity are detailed in the tables below:

**Birmingham**

**Last Inspection – 26th June 2018**

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with a learning disability or autism | Requires improvement | Good | Good | Outstanding | Good | Good |
| Forensic inpatient or secure wards | Requires improvement | Good | Good | Outstanding | Good | Good |

**CAMHS**

Last Inspection – 3rd December 2019

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Child and adolescent mental health wards | Inadequate | Requires improvement | Inadequate | Good | Inadequate | Inadequate |

**Essex**

Last Inspection – 26th June 2016

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Acute Wards for Adults of working age & psychiatric intensive care units | Good | Good | Good | Good | Good | Good |
| Forensic Inpatient/ Secure wards | Good | Good | Good | Good | Good | Good |

**Men's Services**

Last Inspection – 26th March 2018

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Acute Wards for Adults of working age & psychiatric intensive care units | Good | Good | Good | Good | Good | Good |
| Forensic Inpatient/Secure wards | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Long stay/rehabilitation mental health wards for working age adults | Good | Good | Good | Good | Good | Good |
| Wards for older people with mental health problems | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Wards for people with learning disabilities or autism | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement | Requires improvement |

**Neuropsychiatry**

Last Inspection - 15 May 2017

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Wards for older people with mental health problems | Good | Good | Good | Good | Good | Good |

**Nottinghamshire**

Last Inspection-11 June 2019

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with learning disabilities or autism | Requires improvement | Requires improvement | Requires improvement | Good | Requires improvement | Requires improvement |
| Forensic inpatient or secure services | Requires improvement | Requires improvement | Good | Good | Good | Requires improvement |

**Winslow**

Last Inspection - 12 September 2019

Accommodation for persons who require nursing or personal care, Learning disabilities, Mental health conditions, Treatment of disease, disorder or injury, Caring for adults under 65 yrs

| Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|
| Good | Requires improvement | Good | Good | Good | Good |

**Women's Services**

Last rated inspection- 15 May 2017

| | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| Forensic inpatient/ secure wards | Requires improvement | Good | Good | Good | Good | Good |
| Long Stay/ rehabilitation mental health wards for working age adults | N/A | Good | Good | Good | Good | Good |
| Wards for people with learning disabilities or autism | Requires improvement | Good | Good | Good | Good | Good |
| Overall | Requires improvement | Good | Good | Good | Good | Good |



In addition to the fundamental standards inspections described above, the CQC undertook 30 unannounced visits by Mental Health Act Reviewers across the Charity during this year. Overall, our position with regard to findings in these reports is positive, where action plans have been required, 100% of these have been returned to the CQC within the defined timescales.

The CQC also carried out a Well-led Inspection of our Charity in October, which assessed the governance and procedures in place across our hospitals. The report was published in January 2020. The CQC recognised our strong values, commitment to staff wellbeing and development, and our collaborative partnerships, which are improving peoples' access to mental health treatment. The report also comments on the robust systems and processes that we have in place to monitor our compliance with the Mental Health Act, and the new data systems and IT developments that are underway.

Areas for improvement highlighted in the report included the appropriate use of restraint, seclusion and long-term segregation. We have recently completed a Charity wide review of our restraint, seclusion, and long-term segregation processes and we are implementing changes under the leadership of senior clinicians across our Charity. This will ensure that, when safety concerns make it necessary to restrain, seclude or segregate a patient, that the facilities provided and monitoring undertaken, are consistently safe and robust.

The other key area for improvement was around staff being supported to raise concerns. We are committed to creating a culture of openness, honesty and transparency to make sure that we are always doing the right thing. We have recruited four "`Freedom to Speak Up` Guardians". They provide confidential advice and support to employees about any concerns they have about risks, malpractice or wrongdoing in the workplace and are there to help create a culture of openness across St Andrew's, encouraging people to speak up and enable lessons to be learned that will in turn improve care. They are also tasked with helping to raise the profile of raising concerns in St Andrew's and the different routes available to do this in addition to providing support and guidance to staff about speaking up.

All of the areas for improvement raised in the Well Led review have been addressed with robust actions and will be subject to ongoing monitoring.

### Data Security and Protection Toolkit

All NHS providers 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 Data Security and Protection Toolkit. As part of the Charity's contract with NHS England, the Charity is required to meet a 'Standards Met' compliance status. The Charity met this requirement in March 2019 and is currently working to retain this status in March 2020 when the toolkit submission is due.

### Information Governance

Following a proposal to align information governance and data governance requirements, the Data Protection Officer and the Head of Business Intelligence have proposed a new structure for managing information and data across the Charity, and an action plan to ensure this work is completed is underway. This work is being overseen by the Information Governance Group. The aim of the work is to ensure:

- That data entered into systems is of the highest quality, and is regularly checked to ensure it is up to date and not held in multiple locations.
- That there is a single "owner" of an item of data and the data owner will ensure that where the same data item has to be entered into multiple systems, that it is consistent across systems.
- Ensure that regular spot checks are carried out to ensure that policy and procedure are being adhered to, for example, access control and data quality audits are carried out on a regular basis.
- Information is classified in terms of legal requirements, value, criticality and sensitivity to unauthorised disclosure or modification in line with the Charity's Information Classification & Handling procedure.
- Staff understand requirements in managing and handling information and are fully aware of their responsibilities.
- Ensure that information is reviewed and disposed of in line with the Charity's records retention procedure.

### Subject Access Requests

Under data protection legislation, individuals have the right to find out if an organisation is using or storing their personal data and to request copies of that information. The Charity receives a very large amount of requests, which tend to come from patients and/or their representatives. The Charity also has to deal with a number of third party requests under the law (mainly regarding patients) from other third parties such as Solicitors, the Police, and other government agencies.

On average, we dealt with 110 information requests per month over the last year. There has been one occasion where we failed to respond to the requestor within the one calendar month deadline. This was a complex issue relating to a CCTV request, which has now been resolved.

### Complaints to the Information Commissioner's Office

The ICO is the UK's independent body set up to uphold information rights in the public interest. Under the Data Protection Act, individuals are entitled to raise a concern or complaint with the Information Commissioner's Office (ICO) if they are unhappy with how an organisation has managed their personal data or addressed their data protection rights.

For the period that this report covers, the organisation has not received any complaints from the ICO.

### Data Protection Breaches

In the last year, we have reported two data protection breaches to the Information Commissioner's Office. On both occasions, the Information Commissioner decided to take no further action, because they were satisfied with the actions that we had taken to mitigate the breaches, and assessed that they were both isolated incidents, caused by human error, rather than systemic failure. When these breaches occurred, the response to them was overseen by the Charity's Data Protection Officer, Caldicott Guardian and Information Governance Group.

### Staff Summary

In 2019, we conducted a full staff survey including six engagement questions, along with 53 supporting questions on topics that drive engagement (e.g. leadership, reward, environment etc.). The survey ran for three weeks from 4 November 2019.

**The results since 2015 have been:**

| | Response Rate | Engagement Score |
|---|---|---|
| 2015 | 49% | 59% |
| 2016 | 64% | 64% |
| 2017 | 62% | 64% |
| 2018 | 56% | 66% |
| **2019** | **67%** | **68%** |

Our 2019 response rate of 67% is 11% points higher compared with 2018, which also compares very favourably to the 52% average response rate for NHS Mental Health Providers.

A snapshot of our results are as follows:


Given the amount of change across the Charity last year, the overall engagement score of 68% is also very encouraging; +2% points from 2018.

Our strengths: Staff are willing to give extra effort, training and development, cross-team collaboration, and improved leadership visibility.

Our focus areas: To clarify our future plans, communication effectiveness (Charity-wide and local), work-related stress, and a greater understanding of our reward offering.

We have developed a Charity-wide action plan for these focus areas, and progress will regularly be shared with staff throughout 2020/21.

We are also reviewing all of the team (IPU and Support Function) action plans to identify any other areas that would benefit from Charity wide focus or change.

### Complaints

The total number of complaints received between April 2019 and March 2020 was 245, 21 were dealt with as Serious Incidents (SIs) and 224 as complaints. By comparison, 249 complaints were received April - March the previous year.

The complaints are broken down by IPU in the following table:

| IPU | Number of Complaints | % of total |
|---|---|---|
| Brain Injury – Rehab & Care | 10 | 4.5% |
| Dementia & HD Care | 4 | 1.8% |
| LD & ASD Secure Care Nottinghamshire | 20 | 8.9% |
| LD Secure Care | 10 | 4.5% |
| ASD Secure Care | 13 | 5.8% |
| MMH Medium Secure | 11 | 4.9% |
| MMH Low Secure/Locked | 7 | 3.1% |
| Mental Health & ASD Secure Care Birmingham | 17 | 7.6% |
| PICU | 4 | 1.8% |
| WMH Medium Secure | 21 | 9.4% |
| Women's Low Secure & Locked | 12 | 5.4% |
| Women's DBT | 19 | 8.5% |
| Mental Illness & Personality Disorder Essex | 35 | 15.6% |
| CAMHS | 22 | 9.8% |
| CAMHS Developmental Disorders | 10 | 4.5% |
| Other Departments | 9 | 4% |

Over the year, 91% of complaints opened were closed within the 30 working day deadline. During the year, changes to our process to enable greater accountability from the service contributed to the closing of complaints going overdue; improving the response rate was a key priority. Over the last quarter, there has been significant improvement because of weekly updates and targeted communication. The key themes for complaints in this period were Staff Attitude, Behaviour, and Communication/Information followed by Privacy and Dignity and Clinical Treatment. All complaints received give us the opportunity to improve and are used to help us to identify when and how we can make changes. Our key improvements following complaints during the year have included:

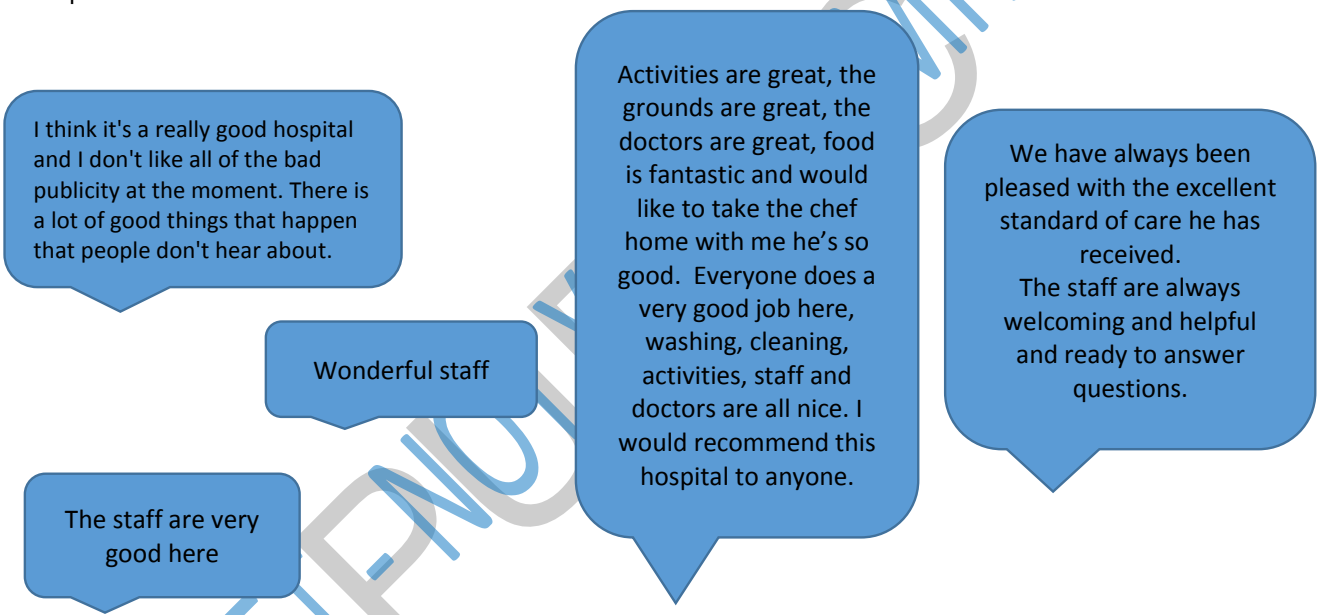
- ✓ A comprehensive action plan developed regarding discharge, and consideration is being given to developing a Charity-wide Discharge policy.
- ✓ Staff training - correct communication procedure for the cancellation of family visits.
- ✓ Staff to promote and encourage carers to use the Carers Centre as support for their own wellbeing.
- ✓ A number of staff have undergone additional supervision or training following complaints about their attitude, competence or behaviour.

- ✓ Improved communication method established between the ward and physical healthcare for the facilitation of GP appointments.
- ✓ Privacy boards erected in the ward office.
- ✓ Closer monitoring of patient property – patients who had made complaints about property were invited to contribute to the Patient Personal Possessions procedure review.
- ✓ Use alternative method to ensure family receive invitations to CPA meetings.
- ✓ Diabetes management.

During 2020/21, our focus will be to ensure staff receive comprehensive training on handling complaints, with an emphasis on the culture of complaints handling and the importance of learning from complaints. This will enable a culture of quality improvement because of the feedback received. We will continue with improvements to Datix to support the reporting and tracking of complaints. We will also be focusing on the quality of complaint investigations and responses to increase satisfaction and reduce the number of re-opened complaints.

What are our patients and carers saying?

We received 346 compliments, the majority about staff and 35 stories have been captured on Care Opinion






## 3. Involvement and Feedback from Key Stakeholders

### Northamptonshire County Council Overview & Scrutiny Committee

Northamptonshire County Council operates a model for Overview & Scrutiny (O&S) based on a single O&S Committee with a remit that is focussed on the following areas:

- Delivery of Northamptonshire County Council's budget and savings plans.
- Development of the Council's future budget proposals.
- Major risks to the Council, the local community and the county.
- Engagement, alignment and support for the Council's improvement plans.

The O&S Committee's remit formally includes the statutory function for scrutinising the planning and provision of health services in Northamptonshire. In practice, at the request of the Commissioners appointed to improve the finance and governance of the Council, the Committee's work during 2019/20 has focussed solely on matters within the areas set out above.

The O&S Committee Chair and Vice Chairs therefore consider that the Committee is not in a position to provide detailed comments on local healthcare providers' draft Quality Accounts / Reports for 2019/20. This response in itself should not be interpreted as representing or implying a comment on the specific Quality Account / Report concerned or on the healthcare provider responsible for producing it.

### NHS England

NHS England /Improvement commissions many of the specialised services provided by St Andrew's Healthcare. Our engagement and monitoring is via performance reporting and site visits.

During the year a Quality Assurance Board was initiated that included key stakeholders to support St Andrew's in delivering its quality improvement agenda. This has been initiated following some important quality concerns identified within St Andrew's services. They have worked alongside all partners and there has been good progress made across several key domains.

The Charity has achieved its CQUIN targets across the year. Key performance indicators and associated data is submitted quarterly, these, alongside narrative reports, are reviewed at quarterly contract review meetings.

SSQD returns have been submitted quarterly also. St Andrew's also achieved full compliance in submission with regard to its QST self-declaration and annual assessment in 2019. It is noted that compliance with requirements means St Andrew's remain on enhanced surveillance. A number of significant changes have been proposed to NHS England regarding the provision of certain specialised services that will be realised through 20/21.

### Healthwatch

Healthwatch Northamptonshire welcomes the opportunity to comment on the St Andrew's Healthcare 2019/20 Quality Account. We are kept up to date on the progress the organisation is making towards addressing the concerns raised by the Care Quality Commission's 2019 inspection report and ongoing re-inspections by attending the Quality Assurance Board and appreciate St Andrew's candour about their need to improve and desire to be held to account and share progress.

Healthwatch Northamptonshire visited Stowe Ward (Women's Medium Secure Unit) at St Andrew's Northampton site in September 2019 to speak to patients and make observations. During our visit, the ward appeared well-organised, calm and generally positive in regard to patient care and safety (https://www.healthwatchnorthamptonshire.co.uk/report/2020-01-23/visit-st-andrew%E2%80%99s-healthcare). We made some minor recommendations, which St Andrew's responded to, and thank the organisation for facilitating our visit.

We support the 2020/21 quality priorities and plans to continue to focus on co-production of care with patients and the commitment to reducing restrictive practices and the use of seclusion. We also welcome the increasing emphasis on patient and carer engagement and involvement and were impressed by the peer Support and Expert by Experience initiatives we observed during our visit to Stowe Ward.

We look forward to continuing to work with St Andrew's Healthcare over the coming year to support them in making sure the voices of patients, carers and families continue to be heard.

### Nene CCG

Nene CCG have been approached for a statement but this has not yet been received.

### POWHER Advocacy

It has been a challenging year with the pandemic and the need to respond quickly to ensure patients still had access to advocacy albeit remotely. POhWER and St Andrew's worked together and, although not without some issues, these were worked through. Advocacy ensures people's rights are upheld and this is even more critical in the current circumstances. Access was initially difficult but a great deal has been learnt by us all.

St Andrew's respects our Charity's independence and we are able to have open and honest conversations, even when this may be difficult. Issues and safeguarding concerns we have raised have been taken seriously and acted upon. Communication between myself and our direct reporting commissioner, Nicola Lintott, are positive and we feel a valued and integral service to St Andrew's. The role of advocacy is

understood by the majority of staff and we work hard to ensure all staff understand our role and remit. By having an advocacy service that includes IMHA and independent advocacy evidences commitment to patients having their rights upheld and support to voice their wishes and feelings known.

We welcome the focus on reducing restrictive practice and co-production. The focus also on care plans and patient and family members input is welcomed.

## 4. Section 3 – Review of Quality Services

### All Aspects of Care are Co-produced in Partnership with our Patients and Carers

**Why did we choose this priority?**

Co-production forms a key part of the wider Charity strategy, with the aim for all care plans to be co-produced by March 2020.

**What did we achieve?**

In line with this target, the Patient Experience and Co-production Working Group was set-up, for the purpose of increasing awareness of co-production across the Charity.

As part of this initiative, a staff survey was conducted to better understand the experiences of those currently working in the Charity, and identify area/s to target within future campaigns. This update outlines the procedure and findings of the Charity wide staff survey.

**The Survey and Preliminary Results**
A 12-item questionnaire was developed by a multidisciplinary team to explore knowledge and understanding, experience, abilities and organisational barriers to co-production. Patient feedback on the questionnaire was also sought during its development.

The questionnaire was launched in an electronic or paper format for four weeks. All staff were encouraged to complete the survey, regardless of job role.

The total number of complete responses received at the end of the four week period was 108, and included staff from across 21 departments/IPUs. Just over 50% of the respondents had not heard of co-production, prior to taking the survey, mostly Healthcare Assistants, Administrators, and staff/Manager/Lead Nurse. The most common job roles of those who had heard of co-production were Assistant/Trainee Psychologist (30.0%), Psychologist (14.0%), and Manager (10.0%), often working in Dementia & Huntington's, Birmingham units and Men's Mental Health.

Most respondents felt that co-production was very relevant to their role (85%) and for patients (96%). The majority of clinical staff (85%) and just over half (55%) of non-clinical staff felt that they would be able to co-produce care with patients. On average, confidence in co-producing care was higher for clinical than non-clinical staff.

A third of respondents (31.1%) were unsure whether patients are involved in producing their care plans.

Responses were also gathered on a number of qualitative questions, and these continue to be analysed.

**The RiO Based Care Plan**
A RiO accessible care plan has been produced to allow St Andrew's to monitor and collect the data across the Charity to evidence the rated level of co-production within each individual care plan in line with the co-production ladder.

This Care Plan has been produced in co-production with our patients and ensures family and carer involvement within the care planning process.

The new format and process of care planning embeds co-production within Care Plan Update Meetings. The patient is at the centre of these meetings and each section of the care plan is reviewed in turn and updated within this meeting.

Classroom based training has been updated and implemented for all clinical staff to reflect the changes to process and provide people with the knowledge to ensure that the emphasis of co-production is embedded within the care planning process. This is set as mandatory.

The new care plan process and format has been piloted within two wards; Medium and Low Secure. It has now also been embedded within our Neuro IPU and Men's Medium secure. This is now in the process of being rolled out across the Charity.

### Clinical Effectiveness will be Embedded in the Charity

**Why did we choose this priority?**

Embedding clinical effectiveness ensures that treatments and interventions based on the best evidence derived from research, clinical experience and patient preferences are delivered to achieve optimum care and outcomes for patients. It involves a framework of informing, changing and monitoring practice

**What did we achieve?**

We have been working through the domains of our Clinical Effectiveness strategy:

- Ensuring that we are focused on systematically measuring and monitoring outcomes that matter to our patients.
- Reducing restrictive practices.
- Using data and technology to improve patient experience and the way we deliver care.
- Benchmarking our treatments against national standards.
- Introducing a programme of continuous quality improvement.

**Outcomes:**
We continue to systematically measure mental health outcomes using tools such as the HoNOS (Health of the Nation Outcome Scales) and the CGI (Clinical Global Improvement) scale. We also use a patient reported outcome measure, the Recovering Quality of Life (ReQoL) that helps clinicians better understand patient experience of care. We use these outcome measurements and other data in key patient meetings and discussions to inform clinical decision making thus supporting patient centred, outcome focused care.

**Data and Technology:**
The Charity has developed a suite of data driven dashboards using Statistical Process Control (SPC) methodology to track and monitor key parameters across the organisation. The information is available to all clinicians who use this real time high quality data to monitor and manage clinical services and processes. We have invested in our electronic patient record systems to support better integration, and this, along with innovative ward boards, allows our clinicians to have the right information available to them at all times. We have improved patient access to technology through reducing restrictions, thereby improving patient experience.

**Benchmarking**:
We introduced a rigourous programme of benchmarking our treatments against NICE and other national guidelines, with 23 audits being undertaken by our clinicians, as well as clinical peer review system. Our Brain Injury Services were recently accredited by Headway, the National Brain Injury Association in recognition of the quality of the care we provide on these wards.

**Continuous Quality Improvement:**
St Andrew's has embarked on a programme of continuous quality improvement (CQI). We have supported our frontline staff and clinicians with the tools and resources to harness their ideas and develop them through iterative PDSA (Plan Do See Act) cycles resulting in a grounds up process of clinical innovation and improvement. Some examples of this include the introduction of mobile devices on a men's medium secure service through a collaborative project between staff and patients and using body worn cameras in our PICUs to promote and improve safety. The next year will see our clinical teams working on a number of other projects to improve quality in different areas.

## To Further Reduce the Use of Unnecessary Restrictive Practices

In 2019-20, we continued the focus on reductions in restrictive practices. In particular, our focus was on reducing the frequency and length of the most restrictive intervention, namely seclusion, and addressing the broader issue of reducing 'blanket' restrictions on patients as part of their day-to-day care. These latter restrictions, when not necessary, can have significant impacts on quality of patient experience and recovery, as well as acting as points of conflict that escalate risk behaviour.

In order to comprehensively address this issue, a specific project was established and a Board approved Reducing Restrictive Practice Plan was signed off in October 2019. The primary target was a reduction in both the frequency and length of seclusion by a third by September 2020.

This plan was based on the national and international evidence base, including the work of Huckshorn *(NASMHPD, 2008)*, which is cited by the UK Restraint Reduction Network:


**Creating a Safety and Prevention Culture**

*Objective:* to have a culture in which we always proactively assess and support patients to be safe and continuously learn and improve.

**Co-Production of Care**

*Objective:* for staff, patients and carers to improve the problem together.

**Workforce Development**

*Objective:* to have a motivated, skilled and consistent workforce.

**Using Data to Inform Practice**

*Objective:* to use data and visual management for continuous improvement.

**Evidence Based Clinical Models and Environments**

*Objective:* to provide our patients with the best care and environments that we know works to improve recovery.

**Why we chose this priority?**

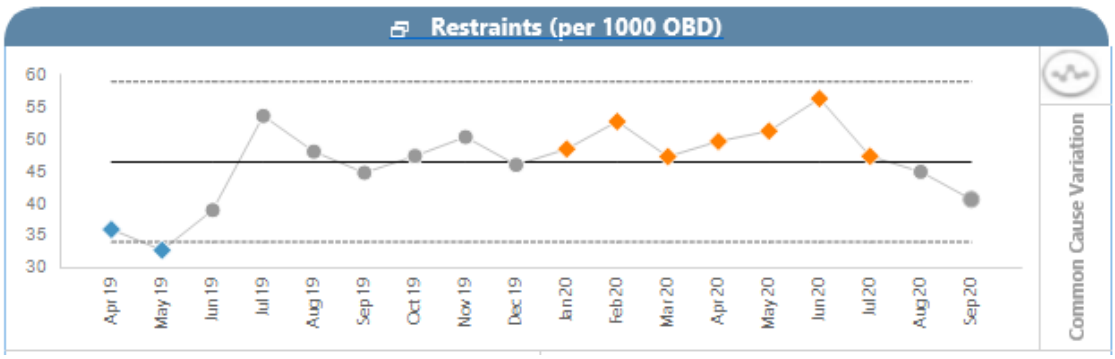
The principle of least restriction is one of the guiding principles of the Mental Health Act Code of Practice, is an area of national quality improvement focus via the National Collaborating Centre for Mental Health and Royal College of Psychiatrists, and is fundamental to patient safety and experience in our services.

Our ultimate aim is to be a recognised leader in mental healthcare for managing challenging behaviour, whilst using a minimal amount of restrictive practice needed for safety or to promote patient recovery

**What have we achieved?**

- Least Restrictive Practice Leads & Champions have been nominated by each IPU who can influence and support the change of culture needed to drive the reduction in restrictive practice.
- Ward level Least Restrictive Practice logs have been issued to Nurse Managers to be shared and co-produced in patient meetings to change the culture of using blanket restrictions. This is by both providing a clear justification for when such restrictions are being applied, and to identify areas where the staff and patients can work together to safely remove restrictions. For example, almost all wards will no longer have blanket rules around access to snacks and hot drinks, which some have achieved through the creation of a hot drinks station or improved patient storage space.
- E-learning packages for Seclusion, Long Term Segregation and Least Restrictive Practice have been developed for all patient facing staff to complete as mandatory training.
- A patient/staff seclusion questionnaire has been distributed to IPUs and Peer Support Workers to inform cultural, practice, training and development changes needed to drive reduction in use of restrictive practice.
- Several IPUs are trialling evidence based interventions (using our new Continuous Quality Improvement approach) known to be associated with reducing the use of restrictive practice.
- We have performed an audit of all our seclusion rooms and completed the priority actions to assure that all these environments are safe and fit for purpose.
- We have continued to develop the Restrictive Practice section of the Patient Safety Framework with sub sections on average length of seclusion by patient and by episode.

**High Level Summary of Restrictive Practice Data (aggregated Charity data)**

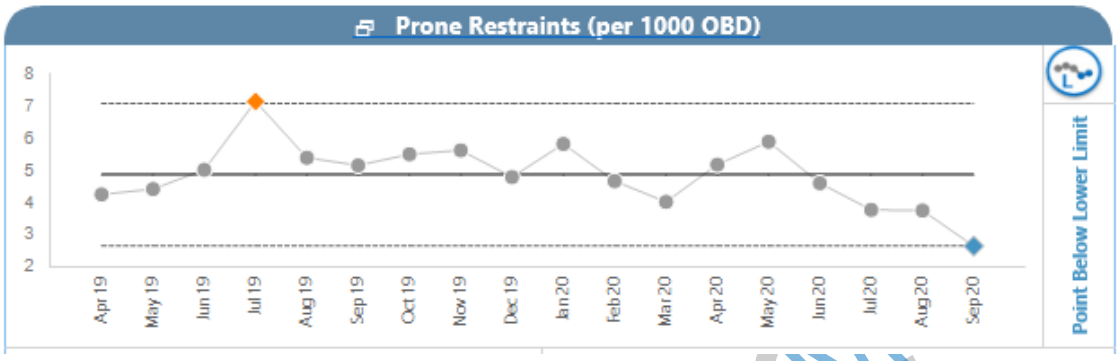



(Data presented in all these charts covers a longer time period than the year being reported, as this is a necessary function of the use of Statistical Process Control which allows variance in data over time to be considered against past performance.)

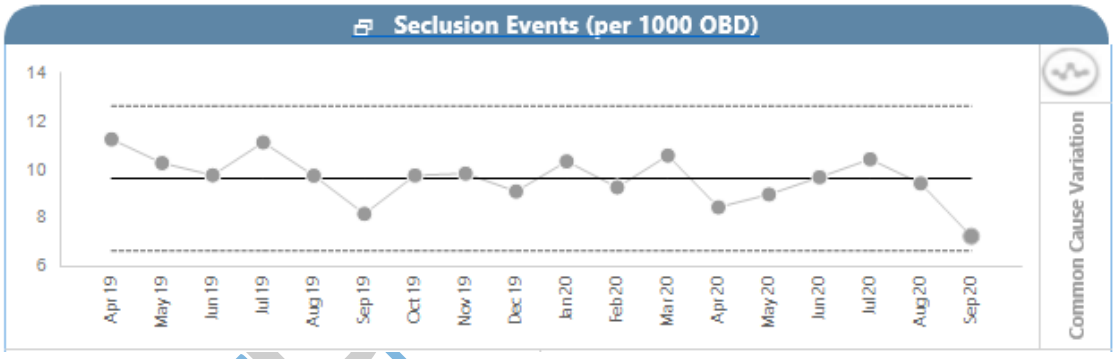
There has been a trend above the mean for restraints in the latter half of 2019. This has been accounted for by three of the 15 IPUs, namely our CAMHS services and Women's Medium Secure Service.

There has been a significant reduction in restraints in our Men's Medium Secure and LD service in Northampton.

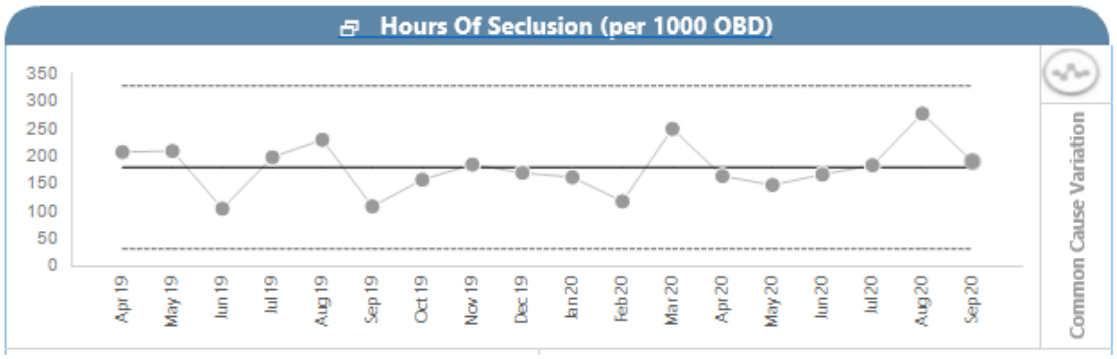
Both the CAMHS and WMS services were redesigned in terms of size, clinical model and environment, as well as both implementing SAFEWARDS, supported by our CQI team. We are confident these changes will support a reduction of restraints in these services. We are seeing reductions in this trend on weekly charts in both services.

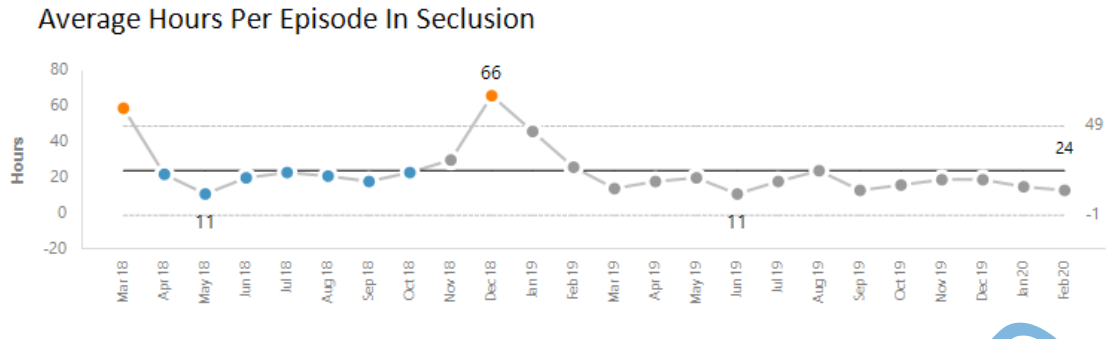


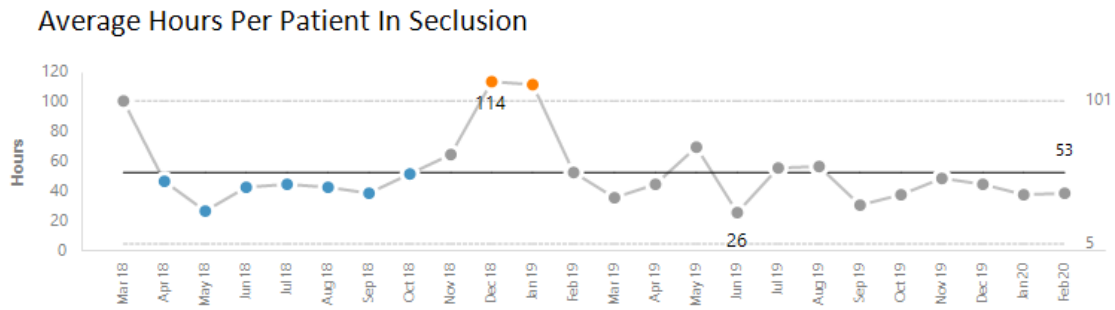

Prone restraints have, with the exception of one month, remained with common cause variation by occupied bed day.




Seclusion episodes tracked around the mean between April 2019 and March 2020



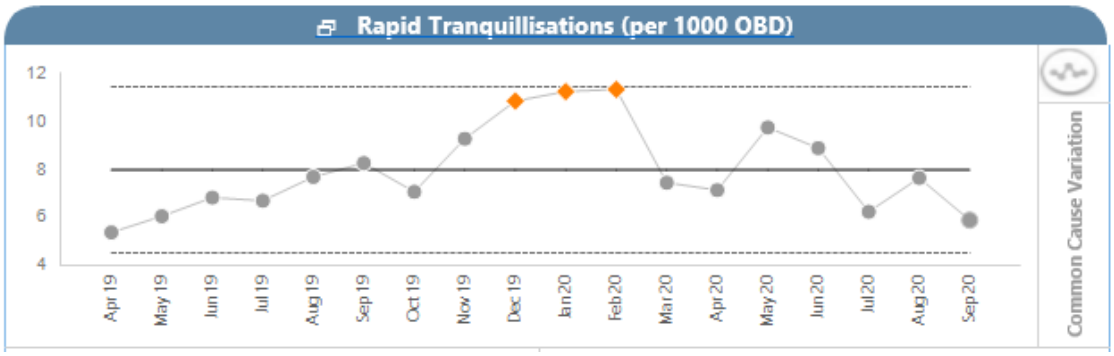



In the first part of 2019, there was a trend above the mean in seclusion episodes that directed our focus on the development of the Reducing Restrictive practice project and plan. This has come back to within common cause variation, which amounts to around a 25% reduction in the six months to Jan 20 compared to the previous six months.

The total hours of all seclusion episodes by month, by episode and by patient is reducing.

Long Term Segregation use has remained within expected variation but we have seen reduction in days spent in LTS, meaning patients are experiencing significantly less time segregated from peers.




Between April 2019 and March 2020, we did see a rise in use of RT, peaking in Feb 20 and decreasing in March 20.

**Next Steps**

- Update our Clinical Risk Management policy to include stronger emphasis on Positive Behaviour Support and Co-production.
- Incorporation of key objectives related to Zero tolerance group, which has developed these in order to reduce violence and support staff wellbeing when exposed to violence and trauma.

- Development and implementation of bespoke training on PBS/ violence management, in line with new CRM policy, and recommendations of Zero tolerance group.
- Follow-up actions identified from the patient/staff seclusion questionnaire.
- Consistent embedding of a culture of debriefing and reflective practice.
- Develop a new least restrictive practice policy into an easy read format for our patients and carers.
- Continue to support our staff in trialling evidence based interventions, in particular implementing SAFEWARDS model in CAMHS and WMS.
- Replace seclusion paperwork by trialling the use of tablet devices to effectively capture seclusion data in a timely manner
- Further develop our restrictive practice dataset for more detailed reporting and analysis of incidents of restrictive practice.
- Continue to decommission seclusion rooms when not required and expand space for de-escalation and the use of sensory interventions.

## 5. Section 4 – St Andrew's Showcase

### Diversity and Inclusion

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

St Andrew's has made great strides in inclusive leadership over the past couple of years. We appointed our first female Chief Executive Officer (CEO), Katie Fisher, and first female Chief Finance Officer (CFO), Alex Owen. Of four internal candidates appointed to the Board, two are female and one is a male from an ethnic minority background. In fact, 30% of Senior Leadership at St Andrew's are from Black, Asian and Minority Ethnic (BAME) backgrounds. We have also achieved a median gender pay gap of zero, which is something of which we are very proud.

We are actively seeking ways to become even more inclusive and cohesive. The creation of our Inclusion Steering Committee was an important part of our Diversity and Inclusion Strategy. Formed in November 2018, we invited self-nominations from across the Charity to steer the strategy and be involved in shaping our future, making sure that everyone feels welcome and valued here: whether they are a patient, a visitor or a member of staff. The committee meets quarterly, and is chaired by Katie Fisher, CEO.

We take an equally inclusive approach to patient care. We are recognised as "Thought Leaders" and have the UK's only Medium Secure ward exclusively for deaf patients. We have also developed our Trans inclusive practice and have been supporting more and more patients who are transitioning, Patients are encouraged to take part in diversity-related events, celebrate national days of interest and develop an awareness of inclusion across all protected characteristics.

A selection of other inclusion initiatives currently in place at St Andrew's, include:

- A successful BAME Network designed to provide peer support and networking for people of all ethnicities.
- The promotion of key events throughout the year, such as Black History Month.
- Cross organisation mentoring and coaching programmes supporting the development of a pipeline of future BAME leaders.
- A reverse mentoring programme pairing BAME network members with leaders from the Charity Executive Committee.
- Unconscious bias training, which is currently being rolled out across the Charity.

- A new Women's network – WiSH (Women in St Andrew's Healthcare)– which is open to everyone and focuses on how we can ensure everyone is heard, supported, represented and be given equality of opportunity.
- An active ABLE networking group, which promotes equality of opportunity and positive attitudes towards people with disabilities.
- A successful LGBT group which aims to ensure that lesbian, gay, bisexual and transgender (LGBT+) staff are given equal recognition, status and treatment. The group also works to raise awareness and eliminate homophobia, lesbophobia, biphobia and transphobia.

### Education

The charitable objective of St Andrew's Healthcare is to 'relieve suffering, give hope and promote recovery.' Education is vastly important within this – not just in the training of our staff, but for the patients in our care too. Education can mean better understanding of mental health issues; it can be learning to cope with the demands of life in the community, or gaining qualifications or work experience to get a job upon discharge from hospital.

At St Andrew's, every patient has the opportunity to access education: enabling them to be happy, healthy and achieve their fullest potential; supporting them to participate in and contribute to all aspects of life.

Our younger patients have access to St Andrew's College, which is the school at the heart of our service for young people.

- The college is rated Outstanding by Ofsted.
- 121 students studied at our college last year, achieving a total of 414 qualifications.
- Core subjects include Art, Business, English, ICT, Maths, PE, Science and Vocational topics.
- Pupils have the opportunity to take part in various enrichment opportunities, including the Duke of Edinburgh Award Scheme, themed events including Harry Potter Day, World Book Day and their very own panto.
- The college has its own Sports Day, and other sporting pursuits including wheelchair rugby and basketball.

Many of our adult patients have had poor experiences of learning in the past. Our professional staff help people learn in ways that meet their particular needs, often leading to awards or qualifications. Over the past year, we held 21,378 teaching sessions for our patients, and they achieved 202 separate qualifications.

### REDS Academy

In June 2018, we launched the Recovery & Every Day Skills (REDS) Academy, which consists of the Recovery College and Peer Support Worker Programme. REDS Academy promotes co-production in mental healthcare and comprises a diverse team in which 75% have their own personal experience of mental health challenges.

The Recovery College offers a uniquely inclusive environment in which patients, staff and carers are all welcomed to attend courses equally as 'students'. Its aim is to increase hope and help students better manage their mental health and wellbeing, through courses that are co-produced by people with professional and personal experience of mental illness. Various patients and staff from across the Charity have contributed to writing these courses that have been attended by over 500 students.

### Peer Support Workers

The Peer Support Worker Programme launched last year in the Northampton site. Six Peer Support Workers, individuals with lived experience of mental health challenges, were trained and recruited to work directly on wards supporting the recovery of patients. As the first mental health provider in the country to employ Peers in this setting, St Andrew's are leading the way. Peers use their lived experiences to provide patients with hope and to help them to identify personal recovery goals. They offer a valuable insight into a patient's perspective, which has also shown to be invaluable for the multi-disciplinary teams during meetings and discussions. Due to the success of the current team, more wards have requested Peer Support Workers, so the project expects to expand during 2020.

### Staff learning

We actively encourage continuous learning and development in all parts and levels of the Charity. We invest significant time and resource in equipping each person for their role with us, to maintain and improve the quality of the care we provide.

On average staff complete 23,000 days of learning each year, with numerous opportunities for face to face study, e-learning and further education available to people of all role levels and career paths.

### ASPIRE

Our ASPIRE initiative, which provides financial and pastoral support to staff as they complete their Nursing degree, is going from strength to strength. The programme is open to individuals who are either starting their career in mental health or learning disability nursing, or for those who are already part way through their nurse training.

ASPIRE gives staff the opportunity to complete a nursing degree in two, rather than three years, while receiving salary support from St Andrew's of over £15,000 per annum. In addition to financial assistance, students in the programme are supported throughout their education with mentorship, pastoral care and regular contact events where they can meet fellow students and peers from the Charity.

There are currently 90 people across St Andrew's Healthcare who are at various stages of their ASPIRE journey. Thirteen graduates received their certificates in March, during the University of Northampton's winter graduation ceremonies.

| Paper for Board of Directors |
|---|
| **Topic:** Integrated Performance Report |
| **Date of Meeting:** 26 November 2021 |
| **Agenda Item: 09** |
| **Author:** Alastair Clegg |
| **Responsible Executives:** Alastair Clegg, Chief Operating Officer and Sanjith Kamath, Executive Medical Director |
| **Discussed/Approved at Previous Board Meeting(s):**<br>Nor discussed previously |
| **Discussed/Reviewed by Patients and/or Carers and/or Staff:**<br>Significant involvement from managers across the organisation in identifying data needs and data sources. Not discussed with patients as this relates to potentially sensitive management data. |
| **Report Purpose/s:**<br>For information and discussion |
| **Key Lines Of Enquiry:**<br>**S ☐ E ☐ C ☐ R ☐ W ☒** |
| **Strategic Focus Area:**<br>Quality / People / Delivering Value |
| **Charity group or committee meetings where this item has been considered (specify date):**<br>Charity Executive Committee have been kept informed with development. Integrated Performance Report data will come to the Board via sub-committees, as set out below. |
| Report Summary and Key Points to Note:<br><br>This item provides the Board of Directors with an update on the Integrated Performance Report. |

The Charity's integrated performance reporting (IPR) tool is now live. The tool brings together data from a range of sources to give a detailed insight into the Charity's performance in relation to:

- Clinical effectiveness and quality (a wide range of data relating to safety, restrictive practice, patient satisfaction, outcome measures and so on)
- Staffing and people measures (including fill rates, turnover, sickness and so on)
- New partnerships (including data relating to referrals, occupancy, and discharges)
- Finance (this section is still under development)

Much of the data, particularly that relating to clinical matters, is in real time, allowing managers to react and respond to issues as they arise, and, increasingly, to spot trends as they develop. Critically, as more data is available, the IPR will enable management to triangulate across a range of metrics to assess overall ward, Division, Hospital and Charity-level performance. The IPR is therefore a core tool for clinical and operational governance.

The IPR will also provide board members, and board sub-committees with information on the Charity's performance. This will require moving the IPR to the Cloud in order that it can be accessed by non-St Andrew's laptops, which we had hoped to achieve in November, but the technical challenge means it is now likely to be delayed until December. The intention is that the clinical elements of the IPR will be reported to QSAC, the staffing elements to the Patient, Carer and Staff Engagement Committee, and the Partnership and Finance elements to the Finance Committee, and this will provide much of the raw data to enable each of these committees to provide their assurance report to the Board.

External feedback from NHSE/I is that the IPR provides significantly better data than is available to the majority of NHS Mental Health Trusts, which is encouraging. However, it is very much a work in progress. In the short term, the priority is to provide finance data, and to ensure the staffing and partnerships data is sufficiently granular to enable an assessment of ward performance (for example to show shift fill rates). In the longer term the plan is to adapt the IPR so it provides the means to report on progress against each of the Charity's strategic objectives.

Most Non-Executive Directors have had sight of the IPR. However, the Board has not had the opportunity to discuss together how effectively it

can provide assurance, the extent to which IPR data should be reported directly to the Board rather than through sub-Committees, nor the priorities for its future development.

Alastair Clegg (COO) and Sanjith Kamath (EMD) will therefore provide a short demonstration of the IPR in order to enable the Board to consider these points.

**Appendices:**

*N/A*

| Paper for Board of Directors |
|---|
| **Topic: Proposal for the External Governance Review** |
| **Date of Meeting:** 26 November 2020 |
| **Agenda Item: 10** |
| **Authors:** Paul Burstow, Chair and Katie Fisher, Chief Executive |
| **Responsible Executive:** Katie Fisher |
| **Discussed/Approved at Previous Board Meeting(s):** Drafts have been shared with both Non-Executives and Executives |
| **Discussed/Reviewed by Patients and/or Carers and/or Staff:** Findings from the CQC Well Led Review have been shared widely across the organisation. One of the actions from this review was the commissioning of an external governance review |
| **Report Purpose/s:** For approval |
| **Key Lines Of Enquiry:** **W** ☒ |
| **Strategic Focus Area:** Governance and assurance |
| **Charity group or committee meetings where this item has been considered: n/a** |
| **Report Summary and Key Points to Note:** In January 2020 the CQC undertook a well-led inspection of St Andrews Healthcare ("the Charity'). The inspection found a number of concerns about the arrangements the Charity had in place to ensure appropriate levels of check, challenge and assurance at the Board.<br><br>Since the inspection the Charity has initiated a number of changes to its governance processes. The Charity is also embarked upon a major change programme culturally, commercially and organisationally to equip it to respond to the changing needs and expectations of our patients, carers and our commissioners. |

| |
|---|
| The Board is currently seeking to commission an external governance review and the paper outlines the proposed terms of reference for this piece of work.<br><br>The Board is asked to approve the terms of reference and the commencement of the procurement work to ensure this work is undertaken in a timely fashion. |
| **Appendices:**<br>*n/a* |

**Proposed terms of reference for the Charity External Governance Review**

## Background

In January 2020 the CQC undertook a well-led inspection of St Andrews Healthcare ("the Charity'). The inspection found a number of concerns about the arrangements the Charity had in place to ensure appropriate levels of check, challenge and assurance at the Board.

Since the inspection the Charity has initiated a number of changes to its governance processes. The Charity is also embarked upon a major change programme culturally, commercially and organisationally to equip it to respond to the changing needs and expectations of our patients, carers and our commissioners.

During 2020 the Non-Executive membership of the Board has been refreshed and a new Chair has been appointed.

The Board has concluded that further amendment and adaptation of the current governance arrangements of the Charity will not prove sufficient to support its ambition to become an outstanding provider of recovery orientated specialist mental health services for patients with complex needs. A reset of all aspects of the Charity's governance arrangements will best support the transformation that is required.



## Purpose

The Board is seeking an independent, external (the "supplier") provider to support to design and implement a new set of governance arrangements covering its corporate, regulatory and clinical governance responsibilities (the "project").

## Sponsors

The project will be sponsored by the Chairman and Chief Executive with support from the Company Secretary.

**Scope**

The supplier will develop proposals that clarify, simplify and streamline all aspects of governance taking account of the complex regulatory environment and commissioning landscape in which the charity operates.

The proposals should:

1. Enable the Board to discharge its statutory duties, set and oversee strategy and fulfil the Objects of the Charity;
2. Provide the Board with the necessary lines of sight and reporting to ensure follow through on its decisions, to offer timely challenge and be assured on all aspects of the Charity's work and in particular to ensure service quality and safety and financial sustainability;
3. Ensure there is a clear demarcation of responsibilities between the Board and the Executive, including a statement of matters reserved to the Board and those delegated to the Chief Executive and the Executive;
4. Establish the necessary Board Committees to support the Board to ensure that an integrated assessment of the Charity's performance can be presented to the Board;
5. Ensure that the Executive has the appropriate sub-committee and other arrangements such that it can discharge its responsibilities to manage all aspects of the Charity's activities;
6. Ensure that the Board is able to make informed judgements about material risks and has in place a robust set of arrangements for identifying, holding and mitigating risk at every level and is able to set its risk appetite policy accordingly;
7. Provide the Board with an annual business cycle and standardised reporting including the appropriate level and style of information for each layer of the Charity's governance;
8. Ensure that the role of the Court of Governors and its relationship with the Board are clear;
9. Enable Non-Executive Directors and Governors to discharge their respective roles;
10. Provide the Board with a suite of self-assessment tools and training to support the Charity become an 'outstanding' well led organisation;
11. Support the Board and its Directors to model the seven principles of public life in all aspects of the Charity's work.

## Method

In developing their proposals the supplier will:

1. Undertake a desk-top assessment of the current governance arrangements to identify those aspects that could be incorporated into the new governance model;
2. Have regard for the findings of the CQC well led inspection and its well led framework;
3. Seek suitable comparator healthcare organisations against which to benchmark its emerging proposals;
4. Interview members of the Board and Court of Governors and such other persons as are necessary to develop and test the new governance model;
5. Consider the order of priority in which the new governance model is implemented and establish a risk register for the change programme including how risks caused by the introduction of a new model are monitored and mitigated.

## Output and Reporting

The supplier will present their emerging findings and proposals to the sponsors in the first instance. The supplier's proposals should include

1. An assessment of the current state of the Charity's governance;
2. A clear and accessible description of each element of the new governance model and which aspects of current arrangements are retained;
3. Costed proposals for the management and administrative support necessary for the day to day operation of the new model
4. A costed implementation plan to support the transition from the current to new governance model, including the necessary organisation and Board development programme to embed the new model.

# Sub Committee Updates

**Quality and Safety Assurance Committee**
Professor David Sallah

**People Committee**
Tansi Harper

**Pensions Committee**
Martin Kersey

**Research Committee**
Dr Sanjith Kamath

# Escalation Report to the Board of Directors

## Committee:

Quality and Safety Assurance Committee (QSAC)

## Date of Meeting:

5 November 2020

## Chair of Meeting:

Professor David Sallah

## Significant Risks/Issues for Escalation:

- **Safeguarding**
  Safeguarding remains an area of continued focus, with the number of incidents reducing to within the control limits. This is likely due to improved management of the safeguarding processes within each division and an increased emphasis of nursing ownership of the process at ward and divisional level with central oversight. Safeguarding training has been refreshed and the process itself has been simplified with clear allocation of roles and responsibilities. Given the importance of safeguarding and that the new processes are still being embedded, safeguarding remains an area that requires ongoing focus and monitoring to ensure sustained improvement.
- **Infection Prevention and Control (IPC) capacity and process**
  The second outbreak of Covid 19 has exacerbated the challenges with capacity in the IPC team. The restructure and recruitment plan to address these is underway but there is a current national shortage of experts in IPC that is impacting our efforts. NHS England/Improvement (NHSE/I) are supporting the Charity through a series of weekly meetings with members of the Charity Executive Committee and the Director of Infection Prevention and Control (DIPC) and are rolling out a series of Quality Improvement workshops for a range of clinical and non-clinical staff to improve our IPC capabilities across al levels in the Charity. While there are mitigating plans in place, it is likely that IPC will remain an area of risk for the duration of the pandemic.
- **Physical healthcare delivery**
  The Charity has made some progress in this area with a refreshed programme of training commencing in this quarter, approval of plans to recruit a geriatrician to improve capabilities in frailty management, the commencement of a funded two year pilot of providing specialist dentistry and more robust oversight of physical healthcare related incidents this is an area of risk given the Covid pandemic and the likely impact and pressures on the general NHS system and availability of resources for patients in a timely manner.

## Key issues/matters discussed:

- **Covid 19**

  The Committee was updated on the Charity's plans to manage the Covid pandemic including support from NHSE/I. It was noted that there had been two outbreaks on wards (two or more positive patients) which were managed. There has been even more emphasis and focus on the need to use appropriate PPE given that the country is in the second wave and this has been supported by an effective communication campaign.

The updated Covid Board Assurance Framework will be presented at the next QSAC meeting for review and approval and submitted to the next Board meeting.

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

  The Quality and Safety Group report was received and discussed with items relating to patient safety and the quality of care were discussed noting the areas of challenge and improvement and the actions being undertaken to manage these. The QSG report noted areas of improvement with a significant reduction in incidents of self harm, incidents of violence and rapid tranquilisation. Safeguarding incidents are returning to within control limits following the refresh of the procedures and assurance mechanisms in the divisions. Acuity remains high in some areas with relatively high numbers of incidents associated with ward moves but these are reducing.

- **Lessons Learned**

  The Charity's new process for sharing lessons learned under the name "Make it Count" was discussed. This involves a process through which lessons identified from incidents, complaints, near misses, safeguarding etc. are communicated through different channels to staff with a process of follow up to ensure that these are discussed at governance meetings and staff at all levels are aware of these.

- **Physical Healthcare**

  The Charity Executive Committee (CEC) has authorised an investment in refreshing the training programme for the assessment and escalation of deteriorating patients as a priority. This will bring the training offered in line with the new policies and procedures that were signed off. The CEC has also approved the recruitment of a 0.4 WTE Consultant Geriatrician and Frailty Lead to support the delivery of physical healthcare to our older adult wards.

- **Integrated Performance Report (IPR)**

  The Integrated Performance Report was presented for the first time in its new format and it is anticipated that the dashboards will shortly become available to both Executive and Non Executive Directors in real time. The IPR demonstrated some areas of improvement with a reduction in numbers of incidents, serious incidents, seclusion use and restraint were noted.

- **Report of the Mental Health Law Steering Group (MHLSG)**

  The work of the MHLSG was noted including the development of two audit tools, the publication of the bi-monthly bulletins and the approval received by St Andrew's to deliver an accredited Approved Clinician (AC) refresher courses. The group has developed training videos and workshops have been undertaken on the subject of capacity assessments

- **Quality Improvement Plan**

  The Committee reviewed the Quality Improvement plan which was presented highlighting actions in progress, overdue actions and those that were completed and closed in the reporting period. It was noted that 26 actions were completed with 4 outstanding actions but there were no overdue actions.

## Decisions made by the Committee:

- The QSAC Terms of Reference were approved and will be submitted to the Board
- QSAC approved the Quality Accounts for 2019-20

## Implications for the Charity Risk Register or Board Assurance Framework:

- R224 – Integrated Patient Healthcare Management – the Residual risk score remains 28
- R1271 – Covid 19 Infection &Pandemic – the Residual risk score remains 23
- R1011 – Unwarranted Clinical Practice Variation – the Residual risk score remains 31

## Issues/Items for referral to other Committees:

- Matters relating to the assurance process for the professional regulation of doctors and other registered professionals to be moved from QSAC to the Patient Staff and Carer Engagement (People) Committee.

## Issues Escalated to Board for decision

- Board to formalise the process through which relevant information is channelled between the sub committees namely QSAC, ARC and Patient Staff and Carer Engagement (People) Committee to avoid duplication of assurance processes without creating assurance gaps.
- Board to consider the renaming of the QSAC to QSC i.e. the Quality and Safety Committee aligned to other board Sub Committees that provide assurance.

## Appendices:

Revised Terms of Reference

# Quality and Safety Committee

## TERMS OF REFERENCE

### 1. Purpose

1.1 The function of the Quality and Safety Committee (the "Committee") is to provide effective governance over all aspects of quality and clinical safety in relation to the Charity's Objects (as laid out in the Articles of Association) of promote the healing of sickness, the relief of suffering and the relief of need of those experiencing mental disorder. It will do this by:

1.1.1. defining the Quality Strategy for the Charity;
1.1.2. monitoring and measuring the implementation and effectiveness of the Quality Strategy; and
1.1.3. identifying, and recommending the implementation of controls of associated risks

In order to provide assurance and make appropriate reports and/or recommendations to the Board.

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

### 2. Constitution and Authority

The Committee shall be accountable to the Board and is authorised by the Board to:

2.1 investigate any activity within its duties under these Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request by the Committee;
2.2 obtain outside legal, financial, healthcare, or other independent professional advice and to secure the attendance at Committee meetings of outsiders with relevant experience and expertise if it considers this necessary at the cost of the Charity;
2.3 establish any new sub-committee or group as deemed appropriate in order to discharge their duties.
2.4 attend any meeting of the Charity or visit any part of the Charity in order to discharge their duties.

### 3. Membership

3.1. Membership of the Committee will be appointed by the Board and shall consist of three Non-Executive Directors, one of whom will be a Clinical Non-Executive Director appointed by the Board to be the Chair, and the following:

Executive Medical Director

Chief Nurse

Chief Operating Officer

In Attendance:

Chief Executive Officer

Company Secretary

3.2. All members shall be required to confirm their independence upon appointment and annually thereafter.

3.3. Appointments of Non-Executive Directors to the Committee shall be for a period of up to 3 years, which may be extended for further periods of up to 3 years, provided that the relevant criteria for membership are met.

3.4. Membership of the Committee will be reviewed annually by the Nominations and Remuneration Committee.

3.5. The Chair of the Committee shall have the relevant qualifications.

## 4. Meetings

4.1 Meetings of the Committee shall be convened by the Company Secretary at the request of the Committee Chair and shall be held not less than six times a year. Notice of the meeting confirming venue, time and date, together with the agenda will be sent to each member of the Committee and any other party required to attend, with supporting information, as appropriate at least 7 days before the meeting or in a timely manner to allow full and proper consideration to be given to the issues.

4.2 Extraordinary meetings may be convened at the request of the Committee Chair in addition to the scheduled meetings.

4.3 The Company Secretary or his or her nominee shall act as the Secretary of the Committee.

4.4 Any Executive Director may be invited to attend all or part of any meeting as and when appropriate and necessary. The Committee may also invite any other Governors of, or employees of, St Andrew's Healthcare or any professional adviser to St Andrew's Healthcare, or patients and/or carers, to attend meetings.

4.5 A quorum shall be at least three members, comprising at least two Non-Executive Directors and one Executive Director. At least one Non-Executive Director and the one Executive Director must have the relevant qualifications for the meeting to be quorate.

4.6 Meetings of the Committee may be conducted when the members are physically present together, or in the form of audio or video conferences.

## 5. Duties

The duties of the Committee shall be:

5.1 To maintain strategic oversight of the quality governance environment and context in which the Charity operates, together with associated risks.

5.2 To inform the Board of the level of assessed assurance with regard to quality governance arrangements across the Charity.

5.3 To monitor and review the Charity's Quality Strategy, and Quality Priorities, implementation thereof and the production of the Charity's Annual Quality Account, providing assurance to the Board.

5.4 To monitor, review and assess the level of assurance received on the quality risks, control and governance processes, providing reports to the Board of Directors.

5.5 To monitor and review the Charity's strategies associated with the relevant accountable committees. To maintain an ongoing review of those risks included in the Charity's Risk Register for which the Committee is the designated responsible committee.

5.6 To monitor ongoing compliance with the CQC compliance framework and how patient care is delivered in line with each of the CQC Quality Domains of Caring, Responsive, Effective, Well-led, Safe (CREWS) and ensure the implementation of agreed actions following CQC inspections/visits.

5.7 To monitor, review and assess the level of assurance received on the implementation of the Charity's Quality Improvement Plan.

5.8 To monitor, review and assess the level of assurance received in relation to the Charity's strategies, policies and procedures associated with Safeguarding,

5.9 To promote learning and sharing for all areas of activity, both from within and outside of the Charity, including benchmarking with areas of recognised best practice.

5.10 To review the reporting sub-committee structure to ensure both efficiency and effectiveness of reporting, including the establishment of new committees or working groups as required.

5.11 To direct relevant sub-committees to undertake deep dive reviews of specific issues in order to gain appropriate assurance. Output of deep dive reviews to be formally presented to the Committee in accordance with agreed timescales.

5.12 To develop and maintain an annual work-plan to reflect and enable scrutiny and assurance in relation to matters within the committee's remit.

5.13 Through the Chair, Non-Executive and Executive members, to ensure that appropriate communications are maintained with regard to the activity of the other Board committees.

5.14 To escalate issues of concern requiring Board awareness and/or attention.

5.15 To undertake tasks assigned to the committee by the Board.

## 6. Reporting Procedures and Other Matters

6.1 The Minutes of the meetings of the Committee shall be taken by the Company Secretary or his/her nominee and circulated to the Committee Chair for approval or amendment within 5 working days of the meeting, before circulation to members. Members can make corrections at the next meeting. Once approved minutes will be circulated to all other members of the Board.

6.2 The Chair of the Committee shall report to the Board on its proceedings after each of its meetings on all matters within its duties and responsibilities and shall also formally report annually to the Board on how it has discharged its responsibilities.

6.3 The Committee shall arrange for annual reviews of its own performance and review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board. The results of the annual review is to be reported within the Committee's annual Board report. At least once every three years, these reviews may be externally facilitated.

6.4 The Chairman of the Committee shall provide an annual report to the Court of Governors on its proceedings and how it has discharged its duties. Further reports will be provided to the Court of Governors on specific discussion topics, as determined by the Governors, in line with the schedule of Court meetings.

6.5 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

## 7. Standing Agenda items and key items for discussion

| Agenda Topic | Frequency / Month |
|---|---|
| | |
| Divisional Deep Dive (including Lessons Learnt) | Each meeting* |
| Executive Medical Director's Report | Each meeting |
| Chief Nurse's Report | Each meeting |
| Covid-19 Update | Each meeting |
| Quality Improvement Plan | Each meeting |
| Cost Improvement Programme – Quality Impact Assessment | Each meeting |
| Serious Incident investigation Reports | Each meeting |
| Risk Register Review | Each meeting |
| Integrated Performance Report | Each meeting |
| Sub-Committee / Group Updates - Quality and Safety Group (Escalation Report) | In line with groups schedule |
| Sub-Committee / Group updates – Mental Health Law Group | In line with groups schedule |
| Quality Account – draft review | February meeting |
| Quality Account – pre-Board approval | April meeting |
| Safeguarding Annual Report – draft review | April meeting |
| Safeguarding Annual Report – pre-Board approval | June meeting |
| Annual Health and Safety Report | April meeting |
| | |

*Indicative schedule of Divisional Deep Dives as follows

| Month / meeting | Division |
|---|---|
| | |
| November 2020 | Locked and Specialist Rehab Division (LSSR) |
| December 2020 | Medium Secure |
| February 2021 | Neuro and Birmingham |
| April 2021 | Essex and ASD & LD |
| June 2021 | CAMHS and Community Partnerships |
| August 2021 | LSSR and Medium Secure |
| October 2021 | Neuro and Birmingham |
| December 2021 | Essex and ASD & LD |
| February 2022 | CAMHS and Community Partnerships |



November 2020

# Committee Update Report to the Board of Directors

## Name of Committee: People Committee

## Date of Meeting:
18 November 2020

## Chair of Meeting:
Tansi Harper

## Significant Risks/Issues for Escalation:
- Patient Survey – poor response rate and declining scores
- Risk Register – template to be reviewed and updated by January 2021
- Patient Involvement Strategy to be updated by March 2021

## Key issues/matters discussed:
- Risk Register
- Patient Involvement Strategy
- Co-Production Progress
- Patient Survey Results
- Health & Safety
- Carers Commitment
- HR KPI's
- Updates from BENN's Group, Carer Advisory Group, Employee Forum, Learning & Development Group, Inclusion Steering Committee

## Decisions made by the Committee:
- Risk Register – template and report to be reviewed and updated and presented at next meeting
- Patient Involvement Strategy to be updated by March 2021 with draft in January
- Patient Survey – Divisions to present Actions to People Committee during 2021
- Health & Safety – John Clarke to meet with Tansi Harper to review reporting and review which topics People Committee to review in 2021

## Implications for the Charity Risk Register or Board Assurance Framework:
- Review of Risk Register Template and Reporting

## Issues/Items for referral to other Committees:
- Tansi Harper to join BENNS Group to replace Peter Carter

## Issues Escalated to the Board of Directors for Decision:
- Patient Survey – decline in response rate and patient scores

# Committee Update Report to the Board of Directors

## Name of Committee:

Meeting of the Directors of St Andrew's Pension Trustees Limited

## Date of Meeting:

09 October 2020

## Chair of Meeting:

Martin Gaskell

## Significant Risks/Issues for Escalation:

- None

## Key issues/matters discussed:

- Barnett Waddingham, Actuarial Services update
- GMP (Guaranteed Minimum Pension) reconciliation, rectification and equalisation
- It was noted that the Pension Scheme annual report and accounts had been circulated and approved by the Pension Trustees prior to the meeting
- Investment update:
    - Fiduciary management update
    - Isio fees (Investment Advisor)
    - Scheme funding update
    - ESG (Environmental, Social and Governance) Criteria
    - It was noted that the updated Statement of Investment Principles had been circulated and approved by the Pension Trustees prior to the meeting
- Long-term objectives
- Trustee indemnity insurance
- Pension Annual General Meeting

## Decisions made by the Committee:

- Following a recommendation from the Pension Scheme Actuary, the Pension Trustees agreed changes to the Pension Scheme's actuarial technical factors.
- It was agreed that Barnett Waddingham would provide a GMP project proposal including costs and timescales.
- Following a recommendation from the investment committee, the Pension Trustees agreed with the proposal to move forward with the shortlist of fiduciary management managers.
- The Pension Trustees agreed to an additional Pension Trustee meeting where Barnett Waddingham and the Pensions manager would provide training and discuss long-term objective proposals.
- It was agreed that the Pension Chair would consult with Pension Trustees members regarding setting up a working party that would consider the development of the Pension Trustee's ESG policy.

- It was agreed that the Pension Chair would consult with the Pension Member Nominated Trustees members regarding the AGM.

## Implications for the Charity Risk Register or Board Assurance Framework:

- No Change for Pension Risk on the Risk Register

## Issues/Items for referral to other Committees:

- Fiduciary Management to be reviewed with Investment Committee

## Issues Escalated to the Board of Directors for Decision:

- None

# Committee Update Report to the Board of Directors

## Name of Committee:

Research Committee

## Date of Meeting:

14 October 2020

## Chair of Meeting:

Sir Peter Ellwood

## Significant Risks/Issues for Escalation:

- The Covid pandemic has caused a delay in a number of projects due to restrictions on researchers from partner organisations visiting and undertaking data collection. These activities had resumed to near normal levels over the summer but are likely to be affected again in the second wave. External researchers are required to abide by the Charity's Infection Prevention and Control policies and procedures including the use of PPE, etc.

## Key issues/matters discussed:

- **New Clinical Leadership**
  Dr Paul Wallang has been appointed as the Associate Medical Director for Research and Innovation marking a change to the department structure with a clear emphasis on clinical leadership and integrating research into the clinical services at St Andrew's.

- **Refresh of the Research Strategy**
  In line with the change in leadership and the progress made against strategic objectives, the Committee discussed and agreed a refresh of the department's strategy, identifying 5 key strands of research to take forwards;

  Trauma strand
  Neurodevelopmental strand
  Mental Health
  Technology, data and systems
  Dementia

  It was agreed that all future research projects should be aligned to these strands and the key benefits to the Charity and patients would need to be articulated as an essential component of the research proposal. The formal updated strategy

- **Research Capacity**
  To further the integration of research into the clinical services and to build sufficient capacity to achieve the department's aims, funding has been secured to ring fence time for clinicians with expertise, ability and an in interest in research to lead and undertake research projects aligned to the strategy following a competitive recruitment process.

- **Project Updates**
  The Research Department presented progress updates on a number of key projects including the NIHR funded CALMED project and the EU -VIORMED study among others. It was noted that a number of projects have experienced through problems with data collection during the Covid pandemic but all projects have now resumed.

- **Terms of Reference**
  The Terms of Reference for the Research Committee as well as the roles and responsibilities of the members and committee membership were discussed and approved.

## Decisions made by the Committee:

- Terms of reference and responsibilities of members were agreed.

## Implications for the Charity Risk Register or Board Assurance Framework:

The Research Department is updating its risk register under the new leadership and will present this at the next Research Committee meeting

## Issues/Items for referral to other Committees:

- None

## Issues Escalated to the Board of Directors for Decision:

- None

# Questions from the Public for the Board

(Paul Burstow - Verbal)

# Any Other Urgent Business

(Paul Burstow - Verbal)

# Date of Next Meeting – 28 January 2021

(Paul Burstow – Verbal)