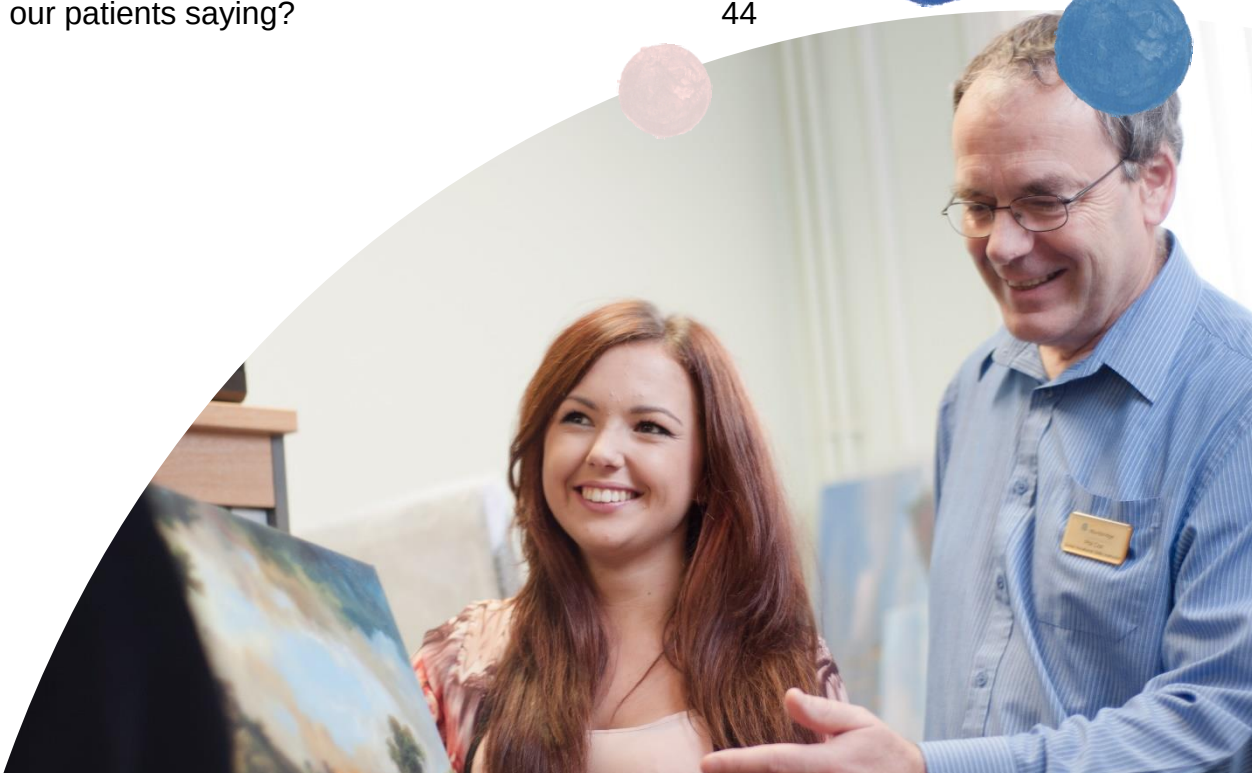
St Andrew's HEALTHCARE

Quality Accounts 2017/18

Contents



Section 1 - Progress and Plans

Transformation

Peter Winslow
Executive Chairman

Throughout St Andrew's 179 year history it has had a reputation for innovation, and 2017/18 was no exception. The year has been one of momentous change for the Charity, but it has been change which will lead to improved outcomes for our patients, and change that has put the Charity in a good position to meet the challenges ahead.

Mid 2017 saw the culmination of two years' work to develop an Outcomes Framework, which for the first time allows the Charity to effectively measure the impact of the treatments and therapies that we offer our patients. The Outcomes Framework was co-created with patients, carers and staff, and reflects the diversity of issues that patients are affected by, including their mental, physical and spiritual wellbeing and the importance that each of those aspects plays in understanding their recovery.

The creation of an Outcomes Framework is part of the model of Value Based Healthcare, developed by Dr Michael Porter. In a world of limited resources, Dr Porter's proposition is healthcare cannot be delivered in a vacuum that does not take into account the cost of that healthcare and that patient value is defined as patient-relevant outcomes, divided by the costs per patient across the full cycle of care in order to achieve these outcomes. Value Based Healthcare therefore focuses on maximising the value of care for patients.

Central to the transformation, and critical to the delivery of care and the understanding of value, is the organisational structure that underpins the model. The creation of Integrated Practice Units (IPUs), which are smaller groups of patients with similar medical conditions, allows more bespoke care for that patient group, and much improved understanding of the costs of delivering the care required.

The first IPUs (Psychiatric Intensive Care Unit and Women's Dialectical Behaviour Therapy) were created in August 2017, and by March 2018, 15 IPUs had been created, including all of the patients and pathways from our previous structure. The IPUs are supported by a central resource for common issues, with only those services required by the IPUs surviving scrutiny. The model not only aims to give more bespoke care to patients, but the efficiencies it will bring through local ownership of care and budgets will lead to more time for staff to spend with patients and more ownership by staff of the value equation.

There is clearly a long way to go to get to a position where we truly understand the cost of care for each individual patient, but we are already seeing real benefits to our patients in some areas, including shorter periods for first granting of leave, and some limited use of mobiles in our PICU wards.

All of this hasn't happened in a vacuum, and the implementation of other projects, such as a new governance model, an electronic time and attendance system that will transform staff scheduling, considerable work on staffing models and a key focus on data gathering and management, are all vital to the success of the move to Value Based Healthcare.

We have also examined where our skills gaps are by understanding where we have challenges with recruitment and retaining people, and how we can make the most of our more experienced staff to develop their careers and reward their loyalty. We are improving our work with staff agencies and ensuring that where new staff join our team they are made welcome and supported to perform at their very best throughout their careers at St Andrews.

As far as I am aware, St Andrew's is the first mental healthcare provider in the world to adopt a Value Based Healthcare approach, which again reinforces the innovation that is at the heart of the Charity.

I am extremely proud to work with such dedicated professionals who have shown incredible enthusiasm and energy to transform the Charity, making it a better place for patients to be, and securing its future. Whilst we still have much to do I would like to thank all of our staff, patients and carers who have been involved so far in this amazing transformation programme and I look forward to continuing to reflect and report upon our success.

Peter Winslow
Executive Chairman

Quality Improvement
Dean Howells
Executive Director of Nursing and Operations

St Andrew's Healthcare recognises and values the unique knowledge and support that carers, families and friends offer and their crucial role in supporting the health and wellbeing of the person they care for. We know that by working in partnership with them we can bring about better outcomes for the people who use our services. We have co-developed a new Carers Strategy that sets the direction for the Charity to achieve tangible and lasting improvements for patients, their families and friends whilst simultaneously providing much greater support to our patients and embracing a culture of openness, honesty and candour.

Our focus on transformation this year has brought about a step change right across the Charity with the creation of 15 Integrated Practice Units (IPUs) and the devolution of some of the central support. Alongside this has been the drive to further improve the services we are offering to our patients, to bring about better, sustainable outcomes.

During the year we have made good progress with the Quality Priorities and this is detailed later in the report. The biggest success has been in the MAPA (Management of Actual or Potential Aggression) training with 97% of our clinical staff now having been trained. The MAPA approach provides staff with clear guidance on promoting an ethical, value-based and consistent approach to supporting people safely by focussing on prevention, deceleration and avoidance.

We are proud to have been working extremely closely with Dr Keith Hurst who is nationally renowned for his work in identifying staffing levels in healthcare environments. All of our wards have now been mapped in terms of nursing staff numbers for safe, optimum and establishment figures, which will provide a real confidence for our staff, patients and carers that the right staff are in place to ensure that patients are kept safe and properly looked after.

The CQC has carried out focussed inspections during the year providing us with further insight into how we can improve our service. Although we were pleased to retain a 'good' rating for 42 of our wards spread across all of our services during the year, we did receive a Warning Notice for our Men's Wards following the inspection in May 2017. Following the inspection we worked incredibly hard to put right the areas identified by the CQC as being inadequate. I'm pleased to report that the Warning Notice was removed following a further inspection in January, and we await the results of the follow-up inspection that the CQC carried out on the Men's service in March. Details of the inspections and our responses can be seen later in the report.

In February 2018 the CQC confirmed the re-registration of our Winslow site based in Bestwood, Nottinghamshire. This is a six bedded unit that is now registered as a residential home with nursing enabling us to provide a bespoke community service to people from the Nottinghamshire area.

The Charity is also continuing to enhance its culture of openness and transparency. We are committed to listening to our staff and making improvements to our internal communications. We now have more opportunities than ever for staff to engage with the culture and future of the Charity. For example we have an internal Facebook page with over 1,100 members, our 'Ask the Exec Live' roadshow, locked screens, intranet communications and stories and our Risk Amnesty campaign.

Our most recent staff survey was undertaken over October and November 2017. There was a response rate of 62% with 2555 people completing the survey. The survey showed that people do feel more involved, are happier with leadership communication and agree that performance management has improved, with areas to work on including pay and benefits, resourcing, bureaucracy and communications.

There are so many areas of real improvement to draw your attention to and many of these are detailed within this Quality Account. Whilst we know we still have more to do I am grateful to all of our staff for their skill and dedication in improving the lives of so many people. I am also grateful to our patients, carers, volunteers, commissioners and stakeholders who have provided so much valuable feedback to enable us to deliver services that meet the needs of all of our patients.

Dean Howells
Executive Director of Nursing and Operations

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 2017/18.

Peter Winslow
Executive Chairman
Date: 15/06/2018

Section 2 - Quality Priorities

Quality Priorities for 2018/19

To support our vision of Transforming Lives with C.A.R.E. (Compassion, Accountability, Respect and Excellence) we have identified Quality Priorities aligned to our strategic priorities. We want to continue the great work already achieved around reducing restrictive interventions; ensuring that we have the right staff in the right place and the right time; really getting parity between physical and mental healthcare and truly empowering carers to make a difference. Our Quality Priorities are designed to further enhance the recovery of our patients through the use of less restrictive practices and the full engagement of carers in that recovery journey.

Our Quality Priorities for 2018/19 are:

1. Empowering patients and Carers to make a difference

- Continue to improve on the immense work that has already commenced around patient and carer engagement and involvement to ensure that both patients and carers are truly empowered to make a difference

2. Outcomes

- To embed outcome driven care throughout the organisation;
- Work towards publishing our outcomes data

3. Further reductions in restrictive practices

- Eradicate the use of Prone Restraints (unless it is patient choice, care planned and risk assessed);
- Minimise the use of Seclusion as a therapeutic intervention;
- Maximise the capability of data and analysis when evaluating quality and value within the patients' outcome measures;
- Ensure staff are trained to deliver positive and safe care and reduce the use of enhanced support and restraint;
- To increase the opportunities for the therapeutic use of leave and other off ward activities for patients in keeping with the principles of least restrictive practice and recovery focussed care

4. Right Staff, Right Place, Right Time

- Implement the staffing models identified through the Hurst Assessments and effectively manage the workforce resource to achieve the best outcomes for the patient;
- Enhance care hours and the therapeutic time and opportunities for patients including leave, therapy and activity;
- Ensure a stable, engaged and skilled workforce working in teams to deliver the highest quality standards and outcomes;
- Appropriate reduction of agency staff use

5. Gain parity of esteem between Physical Healthcare and Mental Health

- Implement the recommendations made by the Physical Healthcare Needs Analysis around the patients' physical health needs, overall governance of the Service; approaches to physical healthcare and the charity-wide operational delivery

Measurement and Monitoring of Progress

The overall responsibility for the monitoring of progress lies with the Quality and Safety Assurance Committee. In order to inform this monitoring and track the progress of implementation we need to ensure that there is a strong set of key performance indicators in place for each of the quality priority areas.

1. Empowering Patients and Carers to Make a Difference

The Patient Involvement Strategy outlines several key areas however our priorities are:

- Listen and respond to feedback
- Co-produce future plans and services
- Demonstrate our impact, share good practice and shape national agendas.

The Carers Strategy defines the *Triangle of Care* as a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing. The Strategy clearly identifies its seven key priorities as:

- Carers and their role are identified at first contact or as soon as possible;
- Staff are trained on carer engagement;
- Policy and practice protocols concerning confidentiality and sharing information are in place;
- Defined post(s) responsible for carers are in place;
- Effectively communicating with carers including an introduction to the service and staff;
- Provide access to support and information;
- Planning, delivery and evaluation of our services.

2. To Embed Outcome Driven Care Throughout the Organisation

We will systematically collect, and measure meaningful clinical outcomes for patients that are monitored at patient, ward and IPU level. These outcomes will be displayed through a real time dashboard that will be used to support clinical decision making and allow clinical teams to monitor the progress of individual patients, assist Clinical and Operational Leads to make responsive decisions regarding resource allocation, support management in tracking therapeutic effectiveness at ward and IPU level and provide external and internal stakeholders with timely and clinically relevant information regarding quality of services. The use of outcomes in this way will drive Value Based Healthcare and improve the care of our patients.

3. Further Reductions in Restrictive Practices

Active monitoring is taking place via the existing Reducing Restrictive Practice data set with a live feed from Datix through PARIS reporting which is well established and monitored by the Restrictive Practice Monitoring Group (RPMG). There is also a process in place to enable Thematic Reviews within IPUs and 'focus-on' reports should a further concentrated effort be needed.

We will implement systems to record and monitor the use of leave and activities that are used to measure patient progress in this domain.

4. Right Staff, Right Skills, Right Place and Time

Following the success to date around commencing workforce planning at St Andrew's, understanding our workforce planning and its subsequent development, the Workforce Planning Programme will now focus upon implementation ensuring sustainability as part of the Therapeutic Day. It will do this through the following:

- To fully implement Level 1 and Level 3 recommendations within IPU's; inclusive of both Enhanced Support and Occupancy flexibility;
- Knowledge transfer to IPUs, Matrons and Business Partners (including models).

Monitoring in the Workforce Planning Group includes occupancy, safe staffing levels, optimum staffing levels, establishment, actual staff, expected staff and available staff. Establishment management, shift planning and changed perception of safe staffing are all being measured against patient outcomes.

5. Gain Parity of Esteem between Physical Healthcare and Mental Health

The very detailed Physical Healthcare Review has identified recommendations on future governance of physical healthcare delivery, approaches to patient care and suggested operating models for the Northampton site and the three main regional sites.

It would therefore seem sensible to include parity of esteem between physical healthcare and mental health as a Quality Priority using the recommendations as the key performance indicators to monitor the progress of implementation. The weekly 'task and finish' group chaired by the Executive Medical Director ensures that actions are implemented and this group reports into the monthly Physical Healthcare Group which is overseen by the Quality and Safety Assurance Committee.

These priorities form the basis of the KPI's for the delivery of this Quality Priority and will be monitored through the Patient and Carer Experience Group and the Carers Strategy Group. The strategy will be monitored by patients, carers and the Quality and Safety Assurance Committee with quarterly updates to the Board of Directors.

Statements of Assurance from the Board

Review of Services

From 1 April 2017 to 31 March 2018 St Andrew's provided services in the field of mental health, learning disability and brain injury to 1454 patients, commissioned by 290 different bodies, of which 96% were NHS services or organisations. The remaining 4% of patients are funded by non-UK organisations, private funders or individuals. St Andrew's has reviewed all the data available on the quality of care in respect of the services for which it provides clinical NHS care. The services reviewed in the Quality Account for 2017/18 represent 100% of St Andrew's income that was generated from the provision of NHS services during the period 2017/18.

Never Events

'Never Events' are described as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (National Patient Safety Agency (NPSA) 2009).

There have been no never events in the Charity during this 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	2016/17	2017/18
The percentage of patients aged: *(i) 0-15 and* *(ii) 16 or over* *Readmitted to a hospital which forms part of the Charity within 28 days of being discharged from a hospital which forms part of the charity during the reporting period.*	Percentage	0% 0.95%	0% 4.70%
Patient safety incidents	Number	23,111	20,708
Patient safety incidents that resulted in severe harm or death	Number (Percentage)	14 (0.06%)	14 (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.

	2016/17	2017/18
Percentage of patients 0-15 years	0%	0%
Percentage of patients 16 years or over	0.95% (6)	4.70% (18)

St Andrew's Healthcare considers that this data is as described for the following reason: The readmission rate has increased for the 16 years or over age group due to the opening of a new female Psychiatric Intensive Care Unit (PICU) ward in Northampton. We now have four PICU wards (2 in Northampton and 2 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 (please see showcase section for further details around Transformation and Integrated Practice Units).

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

	2016/17	2017/18
Patient Safety Incidents	23,111	20,708
Patient safety incidents that resulted in severe harm or death	14	14

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.

Duty of Candour

In the first instance we established a project group to identify what actions needed to be taken to enable us to be compliant with this legislation. The group ensured that all of the identified actions were implemented and continued its work until the action plan had been signed off by the Quality Committee. We reviewed and updated our 'Being Open' policy to include the requirements of this Duty and detailed the process to handle this requirement to colleagues. This was cascaded to all staff through our intranet, through our policy newsletter and by holding Continuous Professional Development (CPD) sessions to which an external speaker put some context around the Duty for our staff. Slides of this event were also cascaded to all staff. We developed a 'Knowledge Nugget' which, on one side of A4 outlined the Duty of Candour, the criteria that makes an incident a Notifiable Safety Incident, details our process and provides a link to the full policy. We have established a Duty of Candour Observation Group that reviews all Notifiable Safety Incidents (NSI's) to ensure that the process is followed correctly. During the year we have confirmed four Duty of Candour incidents.

Mortality Surveillance/Review

For the June 2018 Quality Accounts, providers are expected to report how their investigations and learnings from deaths have informed their quality improvement plans. In February 2018 the Board was presented with the Annual Report on Mortality evaluating the investment that had been made in 2014/15 in building the Managed Clinical Network (MCN) for Neuropalliation. The report also provided for thematic learning drawn from the standardised review of ten deaths occurring in the charity between 1 January and 29 December 2017.

Amongst evidence of personalisation and outstanding care the review also found improvement in holistic End of Life (EoL) care planning with care teams reporting increased confidence in practice, learning and positive coping and family engagement. Colleagues have worked in collaboration with palliative care experts in external partner organisations and there is also better compliance and confidence in meeting the Coroner's requirements.

Improvement opportunities were also detailed including embedding standardised assessment tools, improving the organisation of the patient record, clarifying the use of the EoL register and its operations between the Physical Healthcare Team and the ward and to strengthen and clarify Serious Incident (SI) triage to ensure there is confidence about appropriate classification and review methodology.

Participation in Clinical Audits

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 2017-18 included:

- The use of depot/long acting injectable (LAI) antipsychotic medication for relapse prevention – data was submitted during June 2017. The report has just been received and was presented to the Medicines Management Group in March for review and action planning. Data for 80 patients was included in the report;
- Prescribing Valproate for bipolar disorder – data was submitted during October 2017 - the report has not yet been received;
- Rapid Tranquillisation – data collection will start during March 2018 and be completed by the end of May 2018.

The reports of these national audits are reviewed by the Medicines Management Operational Group and the Quality and Safety Assurance Committee. St Andrew's has now fully implemented (across 66 wards) the electronic Prescribing and Administration system (ePMA) to support medicines optimisation and improve quality related to the use of medication through the use of medication templates within ePMA; links and guidance regarding prescribing and side effects; mandatory review dates and indications for specific medicines.

Participation in Local Clinical Audits

This year the Clinical Audit & Service Evaluation Proposal process was reviewed and updated to improve the benefit of audit activity within St Andrew's. This included additional fields within the on-line proposal form to facilitate the recording of key audit "drivers" such as relevant NICE guidelines and CQC domains. These changes and a higher awareness of audit activities taking place should mean we are better able to evidence how we are improving patient care and learning from the completed audits and evaluations. The new approach was developed in collaboration with the Research Department and in defining key terms and areas of responsibility, provides a wider, more joined up approach to Research, Clinical Audit and Quality Assurance for the Charity.

During 2017/18 17 local clinical audits were completed and 22 are currently in progress following approval via the St Andrew's review process, these are detailed in the following table:

Completed Local Clinical Audits	Approved Local Clinical Audits at various stages of progress
Care for Diabetes in Long-Term Mental Health Care Hospital	Case study in the use of Media
A Needs Analysis for a Male Low Secure Adolescent Mental Health Pathway	Evaluation of CL@S pilot initiative
Combined /High Dose Antipsychotic Monitoring	Case Study of 1:1 music service provision
Weight/Obesity Management (QAT supported)	Transforming Lives - Women with Learning Disabilities in the Criminal Justice System
Evaluation of risk assessment measures in ASD patients	Occupational Therapists Use of Occupation Focused Practice in Secure Services
Sharing good practice, identifying our next steps	Secondary Care Physical Health Access (QAT supported)
Staff and Patient Understanding and the Perceived Usefulness/Effectiveness of PBS Plans	Media Service Review
Effectiveness of Adaptation of ROSS Programme	Arts @ St Andrew's Service Review
Tribunal Medical Report Writing	A Review of the Adherence to S17 Leave Conditions Specified on the Leave Forms
Compliance with Medicines Reconciliation Procedure	Evaluation of the Talking Positive Programme
Impact of Changes made to the Safety Level System on behaviour and quality of life	The Role of Autism Specific Factors in Offending Behaviour
SLT TOMs (QAT supported)	Change in Level of Functioning of Forensic Patients
Consent to treatment and section 58 form completion	Comparison of Patients with ASD and LDD
Review of weight gain within a forensic medium and low secure environments	The Role of a Psychology Graduate Research Forum for Assistant Psychologists Working in a Secure Mental Health Provider
Assessment, Interventions and Outcomes for Adults with ABI	Measuring quality improvement in the clinical documentation produced by occupational therapy within neuropsychiatry
RAID and Positive Behavioural Support plan Evaluation	Assessing the Efficacy of a Newly Developed SPJ Tool
Mortality review	Contribution of functional ability to risk assessment and intervention in forensic care
	Measuring sexualised behaviour within secure psychiatric services
	To understand the difference in offending behaviour with patients who have a diagnosis of ASD
	Staff Perceptions of the Appropriateness of the HCR-20 for patients with ASD
	Section 17 and therapeutic activities
	Comparison of patients with ASD & LD

Quality Assurance Team

A programme of Quality Assurance assignments that incorporates audits and reviews against specified categories/drivers is maintained by the Quality Assurance Team. These audits and reviews are in addition to the audits completed by Clinicians as part of the Clinical Audit proposal process and the audits or compliance checks performed at a Ward level.

During 2017/18, 18 audits were completed by the Quality Assurance & Internal Audit Teams and 7 are currently underway at various stages of completion.

A further 8 were completed by clinicians with support from the Quality Assurance Team, these are detailed in the following table:

Completed & Published Audits by the Quality Assurance & Internal Audit Teams
Seclusion Audit Pre CQC
Seclusion Pack and Vital Signs after RTM
Seclusion Pack and Vital Signs after RTM (Essex)
Consolidated Action Plan Seclusion audits
Falls Outcomes
Section 132 Patient Rights
Care Plan Quality – Patient Care Plan Review programme
MMH Foster - targeted section 17 Patient Leave & Escorting review
Section 17 Patient Leave & Escorting
Seclusion Documentation and Environment MMH Northampton
GASS Assessments
Seclusion Room Environment
Seclusion Documentation MMH Medium Northampton
Safeguarding
Infection Prevention & Control
Patient Carer Records
ASD - Patient Acuity
ASD & LD Formulations
Provided assistance to clinicians and medical staff in supporting with their audits
Patient Transfer and Discharge
QS88 Personality Disorders - Borderline and Antisocial
Psychosis and Schizophrenia
Carer Visits Survey
NEWS observation
ASD Standards - Environment Review
Capacity Assessments
Secondary Care
Ongoing audits and reviews at various stages of completion
Advance Statements & Decisions
Care Programme Approach
Referrals of increasing patient Acuity / Complexity
Meaningful Activity
Consent review
ePMA Follow-up
NHS Wales Required Care Outcomes

Learning from Clinical Audits

The Clinical Audit and Quality Assurance procedures ensure clarity in the use of auditing and embed 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.

Four audits undertaken this year have been detailed below as examples of our learning:

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.

A specific, continuous audit was developed in conjunction with the Care Programme Approach Working Group and the Head of Compliance and takes into account specific CQC and Commissioner Requirements, Health & Social Care Act regulations and the current expectations of the Charity.

The reviews are completed on a monthly basis ensuring a sample of care plans for patients from all Pathways (and incorporating 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 as well as through periodic spot checks on progress. Updates can also be given at the appropriate Quality or Operational Meetings within the IPUs.

The outcome of all Patient Care Plan audits are collated and maintained on a trend analysis with a quarterly summary provided to management (by ward/IPU), highlighting areas of good practice as well as areas that require improvement. Since its introduction, the care plans of over 170 patients from 51 wards have been reviewed.

GASS

The Glasgow Antipsychotic Side-effect Scale (GASS) is a self-reporting questionnaire aimed at identifying the side-effects of antipsychotic medication. An audit was carried out to monitor compliance of St Andrew's policies for the use of high dose antipsychotic medication.

60 patients were reviewed from across the Charity. Measures included completion and review of the form, care planning and on-going monitoring of side effects.

Overall the audit highlighted positive findings with more than three quarters of patients having a GASS, most of which had been updated in the past year. The BNF % was not always complete on the GASS, however was almost always present elsewhere on RiO. Medication was covered by care plan or additional care plan in the majority of cases; however these were sometimes generic and not always updated regularly. Side effects were not always monitored to timescale or clearly recorded in progress notes.

Recommendations included, putting in place structured medicines optimisation reviews, to include completion of GASS on a regular basis, and medication care plans. Reviews should focus on patient outcomes with their involvement alongside the MDT & pharmacy.

Care for Diabetes in Long-Term Mental Health Care Hospital

This audit focussed on four of the recommended processes of care likely to be neglected in mental health hospitals. This is due to care being managed by MH professionals not routinely trained in the treatment of long term conditions such as diabetes, and less frequent visits to the GP surgery. The criteria were;

Diabetic patients should have;

- Weight, height and BMI calculated on admission and 6 monthly
- Smoking status checked and documented at admission and annually
- Offered eye screening for retinopathy on diagnosis and annually
- Foot examination on admission and reviewed annually

A standard of 90% was set for each criterion. Sample included 24 patients in the older adult wards admitted more than a year and diagnosed for at least a year. Results revealed all standards were met or passed, and exceeded the National audit reports.

Although standards were met, there is a need for further modification of lifestyle risks to reduce impacts of diabetes, such as weight gain and feet problems.

Recommendations included

- Increase physical activities, refer to OT and dietician.
- Availability of smoking cessation techniques
- Referrals for podiatry treatment where appropriate
- Reminders to improve eye screening appointment attendance.
- Re-audit should focus on the actions and interventions identified during annual reviews

Compliance with Medicines Reconciliation Procedure

The audit was designed to ascertain whether the procedure is currently implemented by admitting Duty/Ward Doctors, in-line with the Medicines Reconciliation Procedures. It was completed on 40 patients across Naseby, Upper Harlestone & Sherwood (then Heygate).

No cases had the MRP applied & no record of the source of information on the prescribed medication. Recommendations to raise awareness of MRP, alerted doctors to comply with procedure, work out feasible prompt for doctors to consider MRP.

A re-audit on 34 patients four months later, highlighted small improvements and showed increased awareness of MRP. Agree actions included, adding Medicines Reconciliation to ePMA for doctors to record relevant information. A further re-audit is planned once ePMA is fully implemented and embedded within the Charity.

Participation in Clinical Research

Knowledge and technology do not stand still and if St Andrew's is to improve and innovate in the years ahead and provide world class hospitals it will need to invest, adapt and evolve to take advantage of the latest thinking, knowledge and technological advance.

During the year a strategic review of research activity was carried out and as a result of this work a new research framework was developed. The framework identified three key themes to guide our research in the future, these are:

- Personalisation: building a patient-centred knowledge base to change individual care and outcomes
- Mental and physical health: developing treatments for the whole person, exploring the interplay between mental and physical conditions
- Transition: enhancing event prediction and care precision to improve patient flow across mental and physical health systems and settings

This places patients at the centre of everything we do. It also puts a focus on utilising technology to enable assessment and care, with translation into practice the goal for every research project. Being a research active hospital means encouraging patients to participate in research and creating high quality research opportunities for future innovators and researchers who are an essential to progress. Familiarity with research and translating it into evidence based practice should be part of everyday clinical practice and we aim to build capacity so that there is an opportunity for our clinicians to get involved.

The number of NHS patients receiving care provided by St Andrew's in the 2017/18 reporting period that were recruited to take part in approved research studies was 133.

Academic data for the Quality Account 1 April 2017 – 31 March 2018:

Articles and Book Chapters		
Published Articles	**Accepted for Publication**	**Book Chapters**
12	1	4

Conference Attendance				
Oral Presentation	**Poster Presentation**	**Symposium**	**Workshop**	**E Poster**
3	5	-	13	-

Patient Participation in Research Studies				
MMH	**WMH**	**NPS**	**CAMHS**	**LD/ASD**
17	18	15	5	78

Affiliations:

- Institute of Psychiatry, Psychology and Neuroscience (IoPPN)
- London South Bank University
- Loughborough University
- University of Birmingham
- University of Buckingham
- University of Cambridge
- University of Kent
- University of Northampton
- University of Oxford

Goals Agreed with the 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. Despite increasingly challenging requirements, St Andrew's has maintained 100% achievement since their inception.

The current CQUINs are relevant to the specialist care provided by the Charity and are summarised below along with our achievement scores:

CQUIN Title	Q1	Q2	Q3	Q4
Recovery Colleges for Medium and Low Secure Patients	100%	100%	100%	Tbc*
Reducing Restrictive Practices within Low & Medium Adults Secure Services	100%	100%	100%	Tbc*
Improving CAMHS Care Pathway Journeys by Enhancing the Experience of the Family/Carer	100%	100%	100%	Tbc*
Mental Health Discharge Planning and Care Planning	100%	100%	100%	Tbc*

*at the time of writing the results were still to be confirmed (Tbc) for Q4

What Others Say About St Andrew's

The 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.

The CQC issued a warning notice in July 2017 in respect of six of our wards within the Men's pathway on the basis of environmental and cleanliness issues, training, record keeping and governance. The CQC re-inspected the wards in January 2018 and found improvements had been made resulting in a lifting of the warning notice.

During the year the CQC carried out five inspections with regard to the fundamental standards. The first of these was in May 2017 to our Northampton site and included our Child and Adolescent Mental Health Service (CAMHS), Women's services, Men's services, Learning Disability (LD) and Autistic Spectrum Disorder (ASD) services, and our Neuropsychiatry services. The second of these visits was to Essex in June 2017. Our Nottinghamshire site was inspected in September 2017, our Men's service in Northampton in January 2018 and finally our Men's service in March 2018. The current ratings across the charity are detailed in the tables below:

Birmingham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Birmingham	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

CAMHS

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and Adolescent Mental Health Wards	N/A	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	N/A	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Essex

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient/Secure wards	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Men's Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient/Secure wards	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate
Long Stay/ Rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate
Wards for older people with mental health problems	N/A	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Overall	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate

Neuropsychiatry

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

Nottinghamshire

	Safe	Effective	Caring	Responsive	Well-led	Overall
Nottingham	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Women's Services

	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

Our staff were able to demonstrate many areas of good practice to the CQC and these were noted in the reports. These included comprehensive and holistic care plans, access to the physical healthcare team, reporting and investigation of incidents and complaints, up to date care records, technology and equipment used to enhance care, specialist training for staff, participation in clinical audits, supportive management, emphasis on positive behaviour support and reducing restraint, comprehensive patient assessments and patient involvement in care planning.

With the new senior team in place in the Men's service and staff that willingly embrace change, a commitment to outstanding care now runs deep within the service. The roll-out of the MAPA training was accelerated and has resulted in 95% of the clinical staff in this service being trained; the consideration of cleanliness and environmental issues has been transformed, a senior member of the housekeeping team attends the weekly governance meeting which includes cleanliness as an agenda item, additional more stringent cleanliness checks are also now in place and a monthly meeting now occurs with the Estates team to drive improvement in environmental issues. We have introduced weekly audits of all seclusion paperwork to improve record keeping, feedback to nurse managers is immediate and this has resulted in a marked improvement in the quality of these records. The CQC re-inspected this service in January 2018 and lifted the warning notice as a result of the improvements that have been made.

The CQC also carried out a full inspection of our Men's wards in March 2018. Initial feedback from this review described significant improvements since May 2017 with evidence of a change in culture to a more open and empowering approach. Improvements were also noted in the areas of management supervision, record keeping and governance. Staff demonstrated responsive and person centred care and the involvement of carers in planning care and services had been improved.

Further work is to be undertaken in providing greater clarity to staff around the changes that are currently being undertaken to transform our services alongside some minor operational changes that are needed including improving cleanliness in the kitchen of one ward.

The final report is due to be published early June 2018.

The CQC inspected our Essex hospital in June 2017 for which they noted that the wards were clean and well maintained, equipment was well maintained and safety tested, patients were given a welcome pack on the PICU wards which contained essential items, there were sufficient numbers of staff, morale was vastly improved, staff were open and transparent with patients and explained to patients when things went wrong. Further work was required in reducing restraint and this has now been completed through holding a Least Restrictive Practice Awareness week covering such topics as restraint, Positive Behaviour Support (PBS) plans, seclusion and the recording of restrictive practices. The use of restraint is also closely monitored through the Restrictive Practice Monitoring Group which is attended by members of the Multi-Disciplinary Team (MDT) from across the Charity and keeps a very close eye on progress in this area, providing timely information and advice and guidance on further reductions.

We were really pleased to welcome the CQC back to our Nottinghamshire hospital in September of last year. The report confirmed areas of good practice including adherence to infection control principles, staffing levels, physical health monitoring and the employment of technical instructors to support patients with special interests and occupational activities. Areas for improvement included seclusion reviews, management of ligature risks, maintenance of equipment and reducing restraints. All associated actions have now been completed.

In addition to the fundamental standards inspections described above, the CQC undertook 61 unannounced inspections under the Mental Health Act across the Charity during this year. Overall our position with regard to findings in these reports is very positive, where action plans have been required, 100% of these have been returned to the CQC within the defined timescales.

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 MHSDS dataset in line with national requirements. Codes are checked and validated on a regular basis against national lists.

Information Governance Toolkit

St Andrew's Information Governance Assessment for this period is a level 2 green rating. St Andrew's is required to reach at least a level 2 in all required standards. We can confirm that this was achieved, with a level 3 also being attained in some areas. The Charity's compliance with the requirements at level 2 has been achieved by working with Standard Leads across the organisation to gather the required evidence.

Auditing of the evidence within the IG Toolkit has been introduced. This helps us ensure that the evidence that we submit is of the level required to achieve the standard.

Improvements were made in the area of Information Governance (IG) in 2017/18 in terms of processes and procedures. A Charity-wide governance review took place which included a review of IG policies and training. There is also a project team working with Standard Leads in order to ensure the Charity can meet the updated General Data Protection Regulation (GDPR) requirements which come into force on the 25th May 2018.

The IG team is based within the Charity's Legal and Audit Directorate and forms part of its compliance and assurance function. The Charity's network of Information Governance Champions continues to increase, covering a mix of clinical and non-clinical areas. The focus of the IG team during the past year has been on improving staff awareness and working to ensure GDPR compliance.

Clinical Coding Error Rate

SNOMED CT is the fundamental standard for healthcare terminology. SNOMED CT provides the vocabulary for recording structured data in relation to the health and care of an individual in electronic records; as such its use in systems is wide ranging. SNOMED CT also provides features that enable powerful analytics and a high level of expressivity of information about the health and care of the individual. Implementation of SNOMED CT is part of the national requirement for electronic patient records. St Andrew's is working towards implementing the SNOMED coding change, in line with the national requirement for compliance by 2020.

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.

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 2017) full compliance was declared.

Staff Survey Summary

Our engagement score this year is 64% remaining the same as for 2016. Of the 56 questions we asked the result of 53 of these have either improved or remained the same year on year. Our engagement score is made up of:

- ✓ Pride – 56% are proud of their workplace
- ✓ Optimism – 61% are optimistic about our future
- ✓ Energy – 75% are excited about how their work contributes to our success

Our biggest improvements from 2016 were:

- ✓ +7 (57%) have a clear understanding of how their performance is evaluated
- ✓ +7 (48%) agree that sufficient effort is made to get people's opinions
- ✓ +5 (77%) agree that we consider what is important to our patients when making decisions
- ✓ +5 (62%) receive ongoing feedback that helps improve their performance
- ✓ +5 (53%) agree that senior leadership effectively communicate what we are trying to achieve

The things that we do well are:

- ✓ 88% agree that we look after our patients with compassion
- ✓ 85% are willing to give extra effort to help meet our goals
- ✓ 83% agree that their team constantly look for ways to do their jobs better
- ✓ 81% agree that expectations about doing high quality work are clear
- ✓ 77% agree that we consider what is important to our patients when making decisions

We know that we still need to do more in the following areas:

- ✓ 43% believe they should be paid more fairly for the work they do
- ✓ 36% have said there is a need for more resources
- ✓ 34% agree we could do more to reduce bureaucracy
- ✓ 30% would like an improved benefits package
- ✓ 28% think communication can be more open and honest

However since 2015 we have improved in the following areas:

- ✓ +10% points improving senior leadership communications
- ✓ +10% points developing processes and procedures to meet patient needs
- ✓ +11% points minimising or eliminating bureaucracy
- ✓ +10% points making communications more open and honest

Our next steps are:

- ✓ Online training sessions for all report owners
- ✓ Local review and communication of results
- ✓ Agree priority areas to address within teams
- ✓ Create action plans
- ✓ Address the issues raised in 2018 and beyond

Complaints

The Charity received a total of 215 complaints during the current year compared to 121 complaints in total last year. These are broken down by pathway in the following table:

Pathway	No.	% of total
Adolescents (now CAMHS)	27	13
Autistic Spectrum Disorder	25	11
Learning Disability	21	10
Men's Mental Health	58	27
Neuropsychiatry	18	8
Women's Mental Health	58	27
Other	8	4

The total number of complaints upheld for the year was 38 (17.6%), compared to a total of 33 (27.3%) in 2016/2017 and 80 (20%) upheld in 2015/2016. Our response rate within the 30 working day deadline fluctuated during the year due to staffing changes and an increase in volume. We have further improved our processes and the year ended at 80.25% of complaints being responded to within this time period. We continue to be focussed on making improvements in this response rate still further.

The top themes for complaints in this period were Clinical Treatment and Staff Attitude and Behaviour which received an equal number of complaints. In terms of complaints received for Clinical Treatment, the move away from Pathways to IPUs has created a Clinical Lead Role and Operational Lead Role. These roles are responsible for a smaller number of wards and patients which will allow time to be spent on improving Clinical Treatment. This will also form part of the IPU Quality Assurance Meeting agenda. Staff Attitude and Behaviour Compassion Focus Care is now part of the Induction for all staff. Existing staff are being trained on this also, to create an awareness and expectation on the staff culture within the hospital.

All complaints received give us the opportunity to improve and we use these to help us to identify when and how we can make changes. Our key improvements following complaints during the year have included:

- ✓ Active involvement of medical staff in the formulation of responses, benefitting both doctor and patient in seeking ways to do things better;
- ✓ Additional meal time options introduced to enable patient privacy when eating;
- ✓ A staff focus around proportionate escalation levels when responding to an incident;
- ✓ ASD awareness and development sessions for staff to enable better communication;
- ✓ Better recording systems to enable greater patient independence in looking after their personal items;
- ✓ Proactive engagement with patients to communicate plans to improve staffing levels.

During the year we have improved the complaints reporting system by including it on our Datix system. Aside making complaints data more accessible across our services this also enables better triangulation between complaints, incidents and safeguarding alerts.

During 2018/19 our focus will be to work together with the patient experience team to produce joint reporting to reflect a more informed and rounded picture of the experiences of our patients and to explore opportunities with IPU Operational Leads to consider how ward teams can reflect and learn from complaints and seek continuous improvement.

Health, Adult Care and Wellbeing Scrutiny Committee

Northamptonshire County Council are thanked for the feedback provided by the Health, Adult Care and Wellbeing Scrutiny Committee. The feedback contained some areas for inclusion and amendment for which the Quality Account has been updated and congratulated St Andrew's on making a marked improvement in its CQC rating reflecting the hard work undertaken to review structures.

POhWER

POhWER's local Manager and Regional Manager have developed strong working relationships with all levels of management at St Andrews. This is a collaborative working relationship which also recognises the needs and boundaries of an independent advocacy service for the good of our mutual clients/patients.

As part of this collaborative approach, we have together made significant improvements to processes which were in place with the previous provider of advocacy services. These improvements are designed to re-enforce the independent nature of the service and include moving away from using the St Andrews mail and IT systems along with taking over the organisation and facilitation of the patient forums.

Another significant improvement has been the way in which we work together on safeguarding issues. The process now ensures safeguarding concerns are raised appropriately, without possible duplication to the local council, but with independent escalation where required. The emphasis is on safety for the individuals, not just tick box record keeping. Our local manager sits on the Safeguarding Board with St Andrews leads and other agencies.

POhWER has worked closely with colleagues in St Andrews on awareness raising of the service. As well as informally on the wards, we have also had presence at awareness raising events such as the Garden Party and two carers events.

POhWER's view is that we have a strong and continually developing relationship with St Andrews.

Nene

The St Andrew's Healthcare annual quality account for 2017/18 has been reviewed by NHS Corby and NHS Nene Clinical Commissioning Groups (CCGs). It is noted that the report was reviewed whilst in draft format. Core quality account indicators are included within the report. There is no mention of the number of national audits that the Charity could have participated in and the reasons why you have not. There is also no mention of whether the charity have been routinely publishing the number of avoidable deaths.

Commissioning for Quality and Innovation (CQUIN) schemes for 2017-18 are included within the report. The trust should update the final report to reflect the achievement of the year-end position of all CQUINs. It is to be noted that these CQUIN are subject to NHSE Specialist Commissioning and not CCG.

The annual quality account has sought and included the views of patients. The 2018-19 quality improvement priorities in relation to patient safety, clinical effectiveness and patient experience are supported by NHS Corby and NHS Nene CCGs.

Commissioners will continue to work closely with the trust and support their aspiration to progress from a 'Good' to an 'Outstanding' provider delivering safe, quality care.

NHSE

NHS England recognise the development of the Outcome Framework and the creation of IPUs and the potential for these to further strengthen the service. The focus on carers is welcomed and NHS England colleagues have joined carer events which were well attended and were positive and also provided an appropriate level of challenge. NHS England works closely with St Andrews Healthcare in order to seek the necessary assurances. In particular we have focused on staffing levels. All providers face a challenge of recruiting and retaining staff and we welcome their adoption of the Hurst staff modelling tool which has provided a comprehensive understanding of staffing requirements on a ward by ward and day to day level. St Andrew's Healthcare face a number of challenges with changes in demand and expectations; for example the expected reduction in learning disability beds as a result of Transforming Care. They have shown a commitment to work closely and transparently with NHS England in order to deliver this reduction.

NHS England will continue to work closely with St Andrew's Healthcare and recognise and welcome the areas that have been identified for further focus in 2018/19 such as reducing restrictive practice and a particular focus on long term segregation.

Healthwatch

Very sorry to have missed your deadline and unfortunately we do not have the capacity to respond to your Quality Account this year.

Section 3 – Review of Quality Services

The Quality Account for 2016/17 defined the Quality Priorities for 2017/18. These are areas of real focus for the Charity to further improve the services we are offering to our patients and bring about better, sustainable outcomes. Progress on the delivery of these priorities is detailed in this section.

Quality Priority 1 – Reduce the Number of DSH incidents by 20%

Deliberate Self Harm (DSH) can be described as an expression of personal distress in which the person directly intends to injure him/herself. The National Institute for Health and Care Excellence (NICE) has stated that it is important to acknowledge that for some people, especially those who have been subject to abuse, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like' or dissociative states. For the purposes of this document we will therefore use the term 'self-harm'.

Why did we choose this priority?

Self-harm continues to be one of the key themes across our serious incidents. We wanted to improve the safety of our patients by making a concerted effort to reduce the number of this type of event.

What did we achieve?

This priority has been partially achieved.

- At year end the data showed an apparent variance with some months evidencing a significant reduction in incidents of self-harm and others not. Although this remains inconsistent and influenced by patient admissions, a further factor is the clinical presentation and complexities of individual patients;
- In November 2017 a focus on self-harm within pathways was undertaken following the thematic review, this was shared through the Modern Matrons and the clinical team were able to benchmark and consider strategies to reduce the incidents of DSH;
- The greatest reduction has been seen in our Learning Disabilities pathway in which there was a 37% drop in self-harm between April 2017 and March 2018;
- The charity is now able to identify the different types of DSH within data, enabling greater analysis and focus. Of note, ligatures accounted for the highest number of reported self-harm incidents across the charity (33%) whilst 'Other' category (which consists of re-opening wounds, hair pulling, punching and scratching) accounted for 21% of incidents across the charity;
- The Reducing Restrictive Practice dataset has been further enhanced to ensure greater detail in relation to self-harm at ward level to improve practice through analysis.

What next?

The RPMG will continue to maintain oversight of self-harm charity wide through continued scrutiny of the Restrictive Practice data set.

- Further `focus on` self-harm to be completed twice a year, review and monitoring of intervention to reduce self-injury to be led by Modern Matrons in supporting IPU leads.

Quality Priority 2 – Reduce Restrictive Practice to ensure the least restrictive principle is applied for all patients

In accordance with the Mental Health Act 1983: Code of Practice, St Andrew's focusses on a positive and therapeutic culture and has in place a restrictive intervention reduction programme.

This priority has been partially achieved.

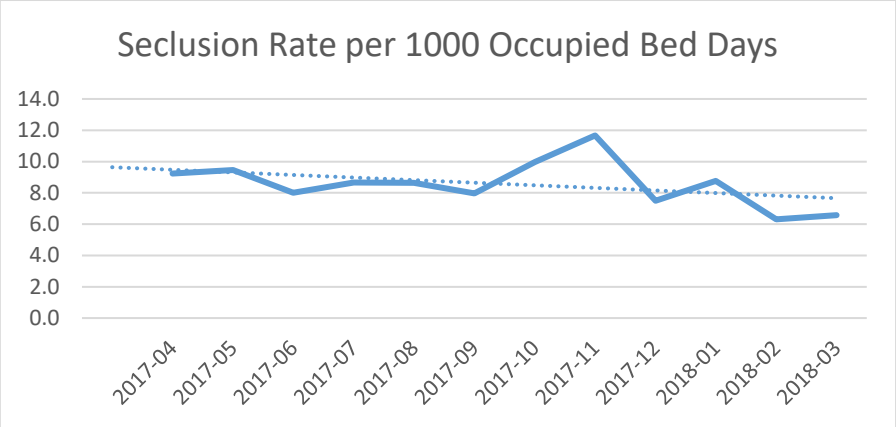
Why did we choose this priority?

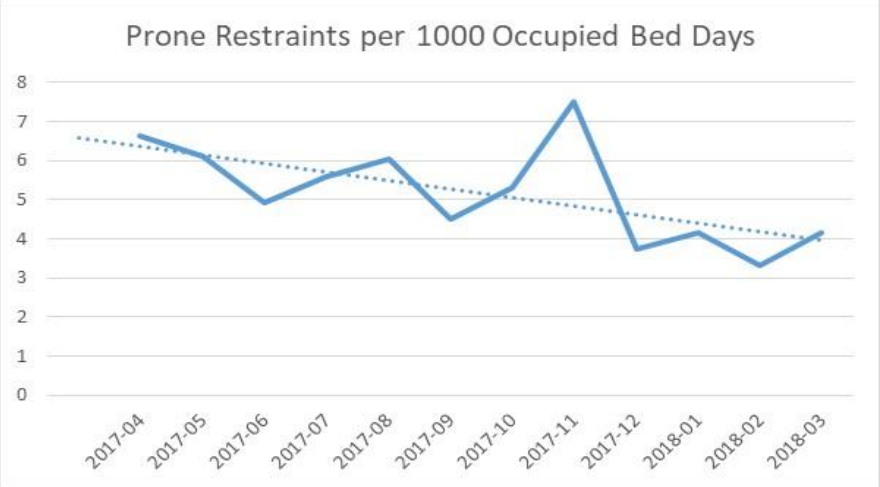
Safewards has been piloted in 18 wards and has had some fantastic results in helping to reduce restrictive interventions. On this basis Safewards will be rolled out across the wider Charity.

What did we achieve?

- Reducing Restrictive Practice dataset enhanced and now includes Restraints, Prone Restraint, Self-Harm, Seclusion, LTS, and Enhanced Observations. This is a Live data feed from Datix and provides a granular report for analysis and thematic focus review;
- There has been focussed communication and education on Reducing Restrictive Practice including screen shots, scenarios and signposting for advice and support;
- Reducing Restrictive Practices workshop weeks have been held in Essex and Men's Mental Health in 2018. Further Seclusion workshops took place in Men's Mental Health (MMH);
- MAPA training progressed and achieved 96%; In addition to this alternative (to prone) Injection training is now in place with a total of 171 qualified nurses trained;
- All patients now have a personalised Positive Behaviour Support (PBS) plan, the previous Professional Management of Aggression and Violence (PMAV) care plans being archived;
- The Safewards model of practice featured in training workshops delivered both in Essex and Men's Mental Health in Northampton. Advanced Nurse Practitioners and now Modern Matrons lead on rolling out the Safewards programme to appropriate areas namely Birmingham, Essex and the Women's services in Northampton.

The following charts demonstrate the rates (solid line) and downward trend (dotted line) seen in Seclusion and Prone Restraint rates per 1000 occupied bed days across the charity.





The rate of seclusion has fallen from 9.2 to 6.6 per 1,000 OBD and the rate of prone restraint has fallen from 6.6 to 4.1 per 1,000 OBD over the course of the year. This is due in part to the Safewards programme but also to the additional investment the Charity has made in working to reduce restrictive interventions such as MAPA training, the closer monitoring by the Senior Management Teams in the pathways and the scrutiny of the Restrictive Practice Monitoring Group. The Charity did experience a spike in both seclusion and prone restraint in November 2017 this was due to two patients that were admitted to our CAMHS service who were extremely unsettled when they first arrived. Both of these patients have now settled and are doing well.

What next?

- Following recent attendance by service users the RPMG has extended invitations to two patients within the charity. Both will be supported to feedback on the key points from the meeting within the charity wide BENNS meeting;
- All policies relating to Reducing Restrictive Practices and models of practice are to be reviewed within the RPMG, an annual schedule of review being formulated.

Quality Priority 3 – Reduce the use of LTS by 50%

The Mental Health Act Code of Practice defines Long Term Segregation as a situation in which a patient is not allowed to mix freely with other patients on a long-term basis on the ward due to the risk of harm posed by that patient to others.

This priority has been partially achieved.

Why did we choose this priority?

Long-Term Segregation (LTS) is very resource intensive and costly. Through the work on reducing restrictive interventions and the further roll out of MAPA training we can reduce this type of patient management.

What did we achieve?

- The Reducing Restrictive Practice dataset also enables a granulated illustration of the use of LTS per Ward/IPU which can be consolidated to give an overview within current pathways. Greater oversight of the use of LTS is now achieved, this informing a review of practice and specific interventions;
- The Reducing Restrictive Practice Monitoring Group (RPMG) now maintains oversight of incidents of LTS charity wide;
- Patients currently in LTS who are access assessed as requiring transfer to an increased level of security or bespoke care package are being checked for transfer progress;
- We now have arrangements in place with NHFT for the independent review of LTS exceeding 3 months.

What next?

- RPMG to continue to maintain oversight of the use of LTS Charitywide, as informed by the Restrictive Practice data set.
- Further `focus on` LTS to be completed twice a year, review and monitoring of intervention to reduce the use of LTS.

Quality Priority 4 – Ensure closer engagement with carers, through newsletter events and better face to face communication

Good leadership that generates a positive and inclusive culture can lead to genuinely person-centred care. In high-quality services, staff really get to know people's likes and dislikes. This supports relationships where staff and people who use services work together to set and achieve meaningful and realistic goals. The way these services engaged with and supported carers and family members also showed an inclusive approach to care. (*The State of Healthcare and Adult Social Care in England 2016/17,* CQC).

This priority has been achieved.

Why did we choose this?

- Carer feedback on communication;
- Poor attendance at carer events;
- Lack of carer awareness about St. Andrew's.

What did we achieve?

- Co-produced carers information booklet, distributed by social work;
- Carer input on Internet site;
- Carers self-support group initiated in CAMHs;
- Carers strategy developed and approved by Board – aligned to Triangle of Care principles;
- Carers lead recruited and in post;
- Carer database update underway;
- Our new Carers Centre opens in May 2018 and is a dedicated private space for carers to get together, share experiences and relax.

What next?

Our focus will be on the implementation of our Carers Strategy which includes:

- Annual carers event booked for June 16th – the planning group includes carers;
- Develop carer engagement training for staff;
- Establish Carer Champions for IPUs;
- Opening of Carers Centre;
- Completion of first phase of carers database;
- Introduce different methods of carer communication, which for the first time will include a text service;
- Update carers section of internet site.

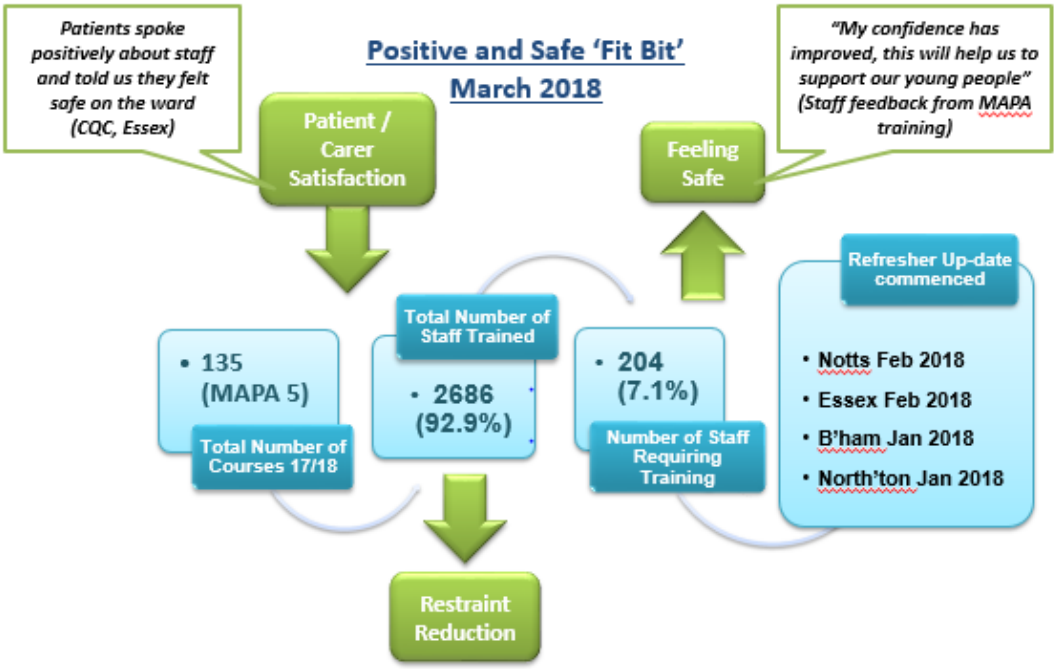
Quality Priority 5 – 90% of Clinical and Ward Based Staff to be MAPA trained

This priority has been achieved.

Why did we choose this?

The MAPA training roll-out was a key element of the Charity's Positive and Safe initiative and its drive towards implementing least restrictive practice across the organisation. The challenge was to design and implement a culture change programme focused on embedding the values of care, welfare and the safety and security of all members of St Andrew's community. Following an extensive search, St Andrew's entered into partnership with the Crisis Prevention Institute (CPI) to develop the MAPA development programme.

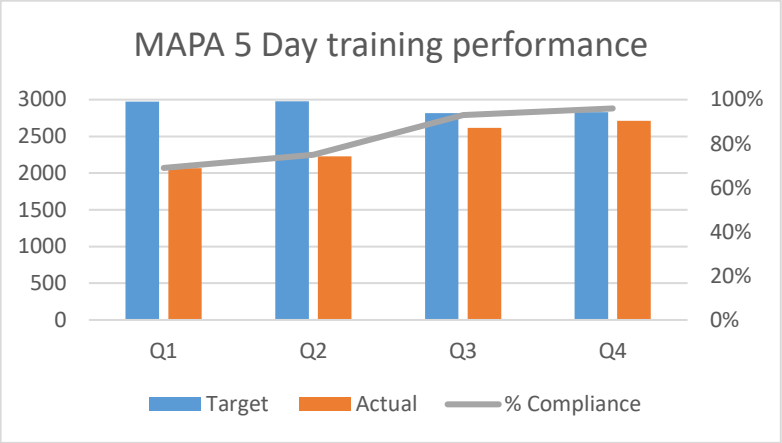
What did we achieve?



Over 240 (124 in 2017/18) MAPA courses have taken place with over 3,300 (1,602 in 2017/18) delegates. To ensure consistency of approach to these skills in all areas of the Charity the deadline for completion of the roll-out was brought forward from the end of January 2018 to the end of December 2017. Following the completion of the roll-out, compliance levels are high with 92.9% staff (clinical and non-clinical) having completed training. As well as delivering the training roll-out, the team of Positive and Safe Facilitators have been providing practical coaching and mentoring support across the Charity's wards. This initiative has helped ward staff and managers to embed their MAPA skills in the clinical environment, and increased confidence in managing situations to meet patients' needs safely.

A 2-day refresher training course was launched in January 2018. This consists of all the essential skills required to ensure staff keep up to date with their MAPA skills. This course is blended in design, using digital learning and situational application of the theories and models in the programme in response to a varied level of aggression. All MAPA trained staff will need to complete a refresher course annually. Since the introduction of MAPA training there are key measures that indicate that the programme is having a major impact on the way clinicians are managing aggression and violence.

Our MAPA training performance is detailed in the following chart:



In the 2017 Patient Survey, patients spoke positively about staff and told us they felt safe on the wards. Staff feedback from MAPA training indicates that clinicians are skilled, able and confident to manage situations "The skills I have allow me to make informed decisions in clinical situations".

To complement MAPA skills, an increase in the roll-out of RAID (Reinforce Appropriate, Implode Disruptive) training has taken place. RAID training is a 3-day course delivered by St Andrew's clinical professionals in partnership with The Association of Psychological Therapies (APT). The course aims to promote proactive management of risk behaviours which focusses on positive communication techniques which incorporate the principles of positive behavioural support.

Working in Partnership with CPI to develop, structure and facilitate MAPA has given St Andrew's access to extensive, world-wide expertise in crisis prevention and intervention. CPI are thought leaders in this field and have founded the Crisis Prevention Network to bring leading organisations like St Andrew's together to explore ground-breaking initiatives in this area. This partnership has enabled St Andrew's to develop learning outcomes that meet the needs of BILD accreditation, The Department of Health Positive and Proactive Care guidance and the Care Quality Commission (CQC) Brief Guide on Restraint.

What next?

An on-going schedule of the annual 2-day MAPA refresher programme will continue throughout 2018/19 to ensure skills are updated and assessed regularly. A particular area of focus will be to support the decision making and problem solving skills that are utilised in emergency situations. This is an intensive and innovative, programme that includes theory updates via e-learning and practice-based assessments using practical scenarios. Feedback from delegates as well as performance and impact measures will be monitored to ensure the programme is as effective as possible.

The initiative to measuring the impact and return on investment from the MAPA programme will continue throughout 2018/19. In particular, analysis of the volume, type and time of restraints will be assessed on an ongoing basis. Also, serious incident reports will be assessed to gauge how MAPA has influenced these. Feedback from staff including evaluation from courses and the Charity's staff survey will be used to better understand the impact MAPA has had. Most importantly, patient feedback will be collated from surveys, staff contact and ongoing Facilitator support in clinical areas to determine how MAPA is supporting the Charity in meeting patient needs

Quality Priority 6 – Improved Physical Health monitoring, recording and awareness

This priority has been partially achieved.

Why did we choose this priority?

A thematic review of our physical healthcare monitoring identified some areas for improvement. The areas that we decided to focus on were to carry out an annual audit of physical healthcare NEWS (National Early Warning Score) chart completion and to monitor training figures for Healthcare Assistants (HCAs) for both NEWS and physical observation skills.

What did we achieve?

We have delivered core skills training framework on physical observations and NEWS training to well over 100 HCAs across the Charity. This full day session is supported by a workbook that needs completing within 6 weeks of the session to embed the skills. The training is also being cascaded by identified staff in high use areas to increase the pace of the training and improve the skillset. This will continue across the HCA staff within the Charity and then progress to refresh qualified mental health nursing staff.

The audit tool for the NEWS audit is complete. This audit identifies the current activity and competence of the use of the form. This enables the team working alongside the Learning and Development department to target those areas that require more training with the tool. This will complement the training that has begun across the Charity in teaching staff to be able to take a full set of basic physical observations, chart the results and take appropriate action.

This will assist staff in

- Understanding and accurately recording and analysing numerical data to improve patient care;
- Accurately measuring and recording baseline vital signs;
- Accurately recording and acting upon the NEWS.

What Next?

The competency of staff is being collated and will enable us to carry out a comprehensive re-audit of the NEWS chart. The overall plan runs through until March 2019 with two skills lab drop in days to enable further improvement in practice.

Quality Priority 7 – Ensure that the Charity continues to enhance its culture of openness and transparency and encourages staff to have the freedom to speak up

This priority has been achieved.

Why did we choose this priority?

To transform lives and do the very best for patients in our care, we need motivated and engaged staff who feel comfortable in speaking up and sharing their views. That's why we're so committed to listening to our people and making improvements across our charity. Over the past year the St Andrew's Communications Team have developed internal content and messaging that can be easily shared, and have built more effective channels of communication.

What did we achieve?

- The successful roll-out of an internal brand campaign, called My St Andrew's, that wraps up and delivers our people messages
- The internal My St Andrew's Facebook page reaching over 1,200 members, providing a key channel for staff to connect with each other and share good news
- A newly launched Monthly Executive Update newsletter to share the latest messages from our Executive Leadership Team about recent developments in our charity
- Our 2017 Your Voice survey told us that our employee engagement score is 64% - the same as it was in 2016 - and of the 56 questions we asked, the results of 53 of these have either improved or remained the same year on year
- The survey response rate was 62% and a total of 2,557 people responded to the survey – 100 more compared with 2016
- The survey received over 2,000 comments from staff, which has given us a great insight into how people feel within their roles
- Overall the survey showed us that people feel more involved (a 7 percentage point gain on 2016), are happier with leadership communication (a 5 percentage point gain on 2016), and agree that performance management has improved (a 7 percentage point gain on 2016)
- Our 'Ask the Exec Live' roadshows have been attended by a record number of staff across all sites, giving staff the opportunity to ask our Executive Leadership Team questions
- Our internal communications channel audit received over 700 responses from staff, which highlighted our most popular channels (locked screens and the intranet) and ideas for channel development
- The survey told us that 63% of staff had seen an improvement in our communications in the past year
- 532 members of staff said the communications they receive are interesting and informative
- Our Risk Amnesty campaign provided colleagues with an opportunity to anonymously report issues - resulting in 36 items of feedback
- Our intranet views are at a record high since June 2016, meaning that more people read and engage with our stories month on month.

What next?

We'll continue to develop our communications throughout 2018 and beyond, including continuing to improve cascade packs from leadership events (aiming to have them distributed within 24 hours of the event), and increasing the frequency of our 'Ask the Exec Live' roadshows - these will now be quarterly across the charity. We'll also continue to develop our content, including from our newly formed Integrated Practice Units to help us to inspire our people to transform lives.

Section 4 – St Andrew's Showcase

Transformation Programme

During the year the Charity as a whole has been focussed on putting the foundations in place to enable the delivery of 'Value Based Healthcare' to provide the best patient outcomes for the best investment, to give ward teams more ownership and to reduce bureaucracy.
In order to bring about this change we have been running the following projects:

IPUs – The central and biggest part of the Transformation Programme is the creation of Integrated Practice Units, or IPUs. IPUs are a group of wards that offer the best possible outcomes for patients with similar clinical needs – for the best possible investment. As from 1 April 2018 we have 15 IPUs up and running.

IPU Dashboard – An important part of effectively managing our outcomes for every patient is to build a way of recording and displaying all of our outcome data alongside how those results are achieved. Our Management Information team have built a system in which each IPU can capture and access information about every single patient and how we are supporting them.

Workforce Planning – To ensure that our workforce is organised around what patients need. The focus is to make sure that the right staff with the right skills are in the right place at the right time. In order to do this we are working with Dr Keith Hurst who is an independent expert in healthcare staffing, using a tool that is accredited by the National Quality Board.

Support Function Realignment – The success of our new IPUs and the Transformation programme is underpinned by how well they are supported by core functions such as HR, Finance, IT, Sales and Marketing and Estates and Facilities. We are looking at ways that each support function is best able to boost IPUs to deliver the best possible care for our patients.

Success Factors Improvement – This software was introduced across the Charity in 2015 and helps us to manage a wide range of processes from purchasing to training, appraisals to payslips. We are making further improvements to capture expertise, streamline processes and resolve system issues.

Time and Attendance – Our Workforce Planning project will rely on the successful implementation of our time and attendance system (Kronos). This is already underway across all of our sites.

Physical Healthcare – A vital part of how we measure our patient outcomes. Our holistic approach blends mental healthcare with physical and spiritual wellbeing. Making sure that we integrate physical healthcare into our work with patients is an important part of the Transformation Programme.

Change and Culture – In order to deliver Value Based Healthcare we are changing as an organisation. Our IPUs are gaining more control to improve patient outcomes and support functions are adapting how they work to deliver what IPUs want and need. Successfully adapting to these changes means that the culture of St Andrew's is evolving too.

Governance – Over the years our wards, pathways and support functions have created hundreds of policies, rules, processes and guidelines which can get in the way of personalised care and improving patient outcomes. We are now reviewing which of these we need to keep to remain safe and effective and which we can remove to reduce bureaucracy. We are also reviewing and streamlining the many committees that operate across the Charity as part of the development of our new Governance Framework.

IPUs

The transformation of the Charity to a value based, outcomes driven organisation has been an exciting journey. IPUs have been designed as the vehicles through which outcomes that are both meaningful to patients and clinicians and measurable will be delivered. The new IPUs will mean that care is organised much more closely around what patients need, and emphasise the accountability for both outcomes and costs to be held by the teams responsible for the delivery of care. This brings decision making processes much closer to the patient and allows the differences in patients' needs and requirements to be managed in a more individualised way. The process of setting up the IPUs involved a significant amount of staff engagement and the coproduction of outcome measures with patients. Each IPU went through a carefully planned and managed programme of activities that delivered improvements that staff and patients wanted to see. Often there were simple changes that made a big difference to how people felt. Some of these simple changes to date include giving patients more choice at mealtimes, trialling access to mobile phones, giving wider access to patients to have televisions in their own rooms, new social events, greater involvement of non-qualified staff, more meaningful training opportunities for staff in skills, increasing opportunities for leave and therapeutic activities and more.

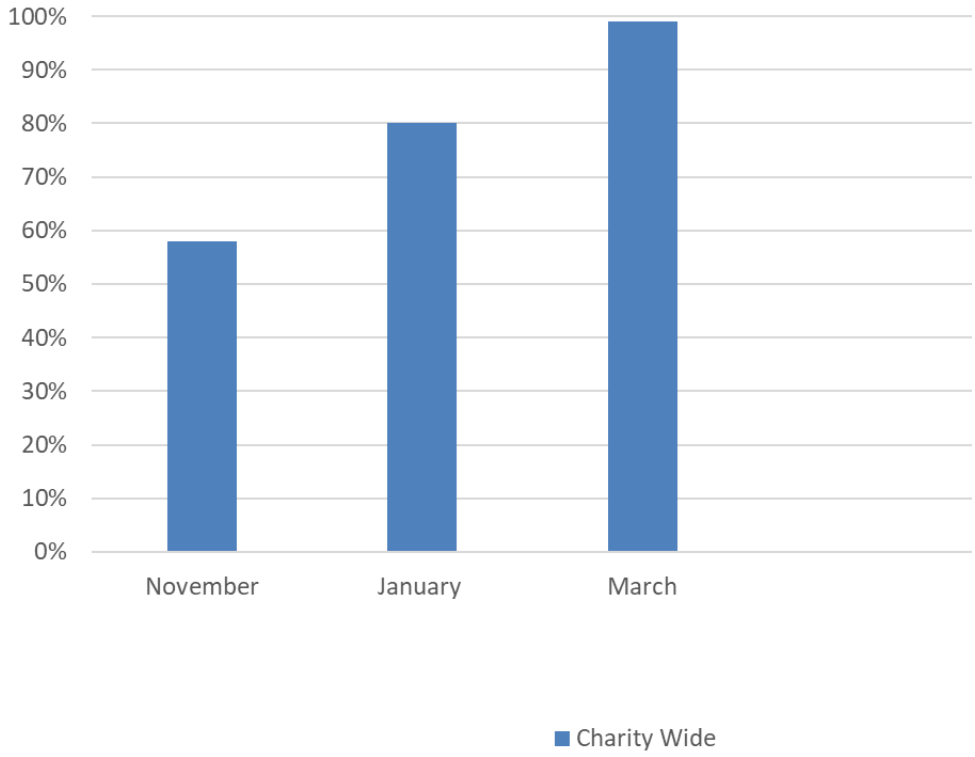
Our DBT IPU has now been live since July 2017. It brought three women's wards together: Spencer South, Hereward Wake and Spring Hill House. Many changes and improvements have occurred since this time, the highlights of which are listed below:

- ✓ Outcomes are now measured for every patient to see how their mental and physical health is improving and how well their care is personalised to them;
- ✓ Teams work in partnership across the three wards to cover absence and emergencies;
- ✓ New colleagues have been appointed: DBT assistants, Events Co-ordinator, Assistant Psychologist and the Clinical and Operational leads;
- ✓ The Care Programme Approach (CPA) process has been streamlined and improved;
- ✓ Ward rounds have a new template which was designed by patients;
- ✓ The Occupational Therapy timetable has been modified to become more responsive to patient need;
- ✓ Parking management has been improved at Spring Hill House.

An important tool to support the progress of our patients is having useful data involving measuring outcomes for every patient. The outcome measures show how people are progressing in terms of their mental health, physical health and their experience of care. In order for our IPU staff to understand and analyse those measurements an Outcomes Dashboard has been developed to support decision making. This Dashboard displays Health of the Nation Outcome Scales (HoNOS) data (a national scoring system asking 12 questions of the patient which can be tracked over time); ReQoL (The Recovering Quality of Life scale), the CGI (Clinical Global Impressions) scale used by clinicians to assess how much the patient's illness has improved, the Friends and Family test which asks patients if they would recommend St Andrew's to friends and family should they need mental health care and a patient satisfaction score which reflects the patient's own views on how they are being cared for. An example of how this data is displayed is detailed below:

Management Supervision

The Charity has introduced a comprehensive Management Supervision process. Management supervision can also be described as one-to-ones or review meetings. They are ongoing and regular meetings between an employee and their manager to explore the day to day work issues such as workload, priorities, challenges and performance. Management supervision takes place four times a year equally spaced across the year in addition to our mid-year and annual IPDR (appraisal). All employees are required to have these ongoing performance review meetings. The system was introduced in November 2017 and the chart below illustrates the progress made in this short time:



Physical Healthcare

We are very pleased to be able to report the improvements within our physical healthcare provision. Over the last year there has been a substantial shift within the physical healthcare service, the team structure and skill set. The service now has a range of RGN nursing intervention levels and a wider complement of clinical experience knowledge and ability. This has rebalanced the service and is now evenly distributed between preventative and responsive care, in line with national drivers (The Kings Fund, 2016 & NHSE, 2017).

The Physical Healthcare Team has new members that are focused on the delivery of high quality care with a clear vision. The service structure now reflects the patient needs and has a more consistent, patient need focused provision across the Charity.

We have made significant changes to the staffing of our Physical Healthcare Team by employing additional physical healthcare nurses and providing improved leadership in that team in order that we can better meet the physical healthcare needs of our patients. This has facilitated the service to shift the focus from a reactive service to a proactive and responsive one. The current staffing structure is now broader with a range of nursing levels and competencies that will complement the physical care needs of our patients. We also have a paramedic within the team.

For each shift 08.00 -20.00 we have allocated a 'nurse in charge' who can coordinate the team and respond to urgent requests and ensure prioritisation of care for our patients throughout the day. To improve communication between the PH team and medics we have introduced a nurse and medic handover.

Within the Physical Healthcare Team we have begun to deliver specific female, minor surgery, and Long Term Condition Clinics. We have increased the triage from once a day to three times a day and are currently planning a rapid access clinic for tissue viability and pressure ulcer prevention.

Further clarity around the roles, responsibilities and processes will be defined as part of the Health Needs Assessment. Work has begun to define how we` will work together to ensure that the systems are processes are suitable and communication between the physical healthcare team and the IPU is paramount.

We have an electronic blood result system in place (ICE), EMIS health is now used efficiently and we have access to Consultant Connect, the system that provides direct and immediate telephone calls to local speciality consultants. These consultants can advise the Physical Healthcare Team nurses, GP's and medics in providing the right physical care and avoid unnecessary admissions to acute care and swifter admission if required.

The team now has three non-medical prescribers with another due to join us once they have completed their course. This will assist in reducing acute care requirements and enable the Charity to look after patients who need more specialist interventions. Other training within the team has been on Diabetes, Naso-gastric feeding, compression bandaging, Sepsis, vaccinations, ear syringing, syringe-drivers and managing long term conditions (LTC).

The team has begun to deliver regular training on tissue viability and venepuncture. Other more bespoke training is delivered to specific wards with a specific patient or clinical need. We have recently arranged new-born life support training for a bespoke group of staff to meet the changing patient group and this will continue so that we are prepared and clinically competent within our unpredictable patient group.

Our New Governance Framework

The new structure was developed by the Governance Steering Group and went through extensive consultation with IPUs and key stakeholders across the Charity, including it being piloted by a number of IPUs. The structure is supported by approved Terms of Reference (ToR), templates (including agendas and action/decision logs) and a guidance note for all meetings. A key addition to the ToRs over previous ones, is the clarification of key meeting inputs and outputs that assist in highlighting how information and decisions are escalated or disseminated through the structure.

The structure is presented in two formats: Summarised and Detailed. The summarised version contains only the Charity internal meetings and groups where decisions are made. The detailed version provides more information about topics discussed in the main IPU meetings and Quality and Safety Assurance Committee. The structure has been designed to allow for a degree of flexibility at an IPU Level:

Creation of Meetings at an IPU / Ward Level - Clinical Lead and Operational Lead have authority to approve creation of an IPU / Ward meeting if there is a need for it.

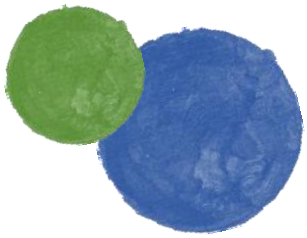
Meeting Membership. All meetings' ToRs contain a list of core members; however non-members may attend at the Chair's discretion.

IPU Cluster Meeting. The Cluster meeting format will depend on the needs of the individual IPU Cluster and IPUs within it and therefore will be organised at the Chair's discretion i.e. individual IPUs may attend a part of the meeting or have separate meetings per IPU in addition to meeting as a cluster.

Monthly IPU Meetings. Not all topics will be applicable to all IPUs; therefore the IPUs should only discuss topics relevant to them. If a topic is not on the list it can be added for discussion.

Daily and Weekly IPU Meetings. The ToR suggests a number of areas that should be covered in daily / weekly meetings; however the nature of discussion will depend on what happened over the last 24 hours / week.

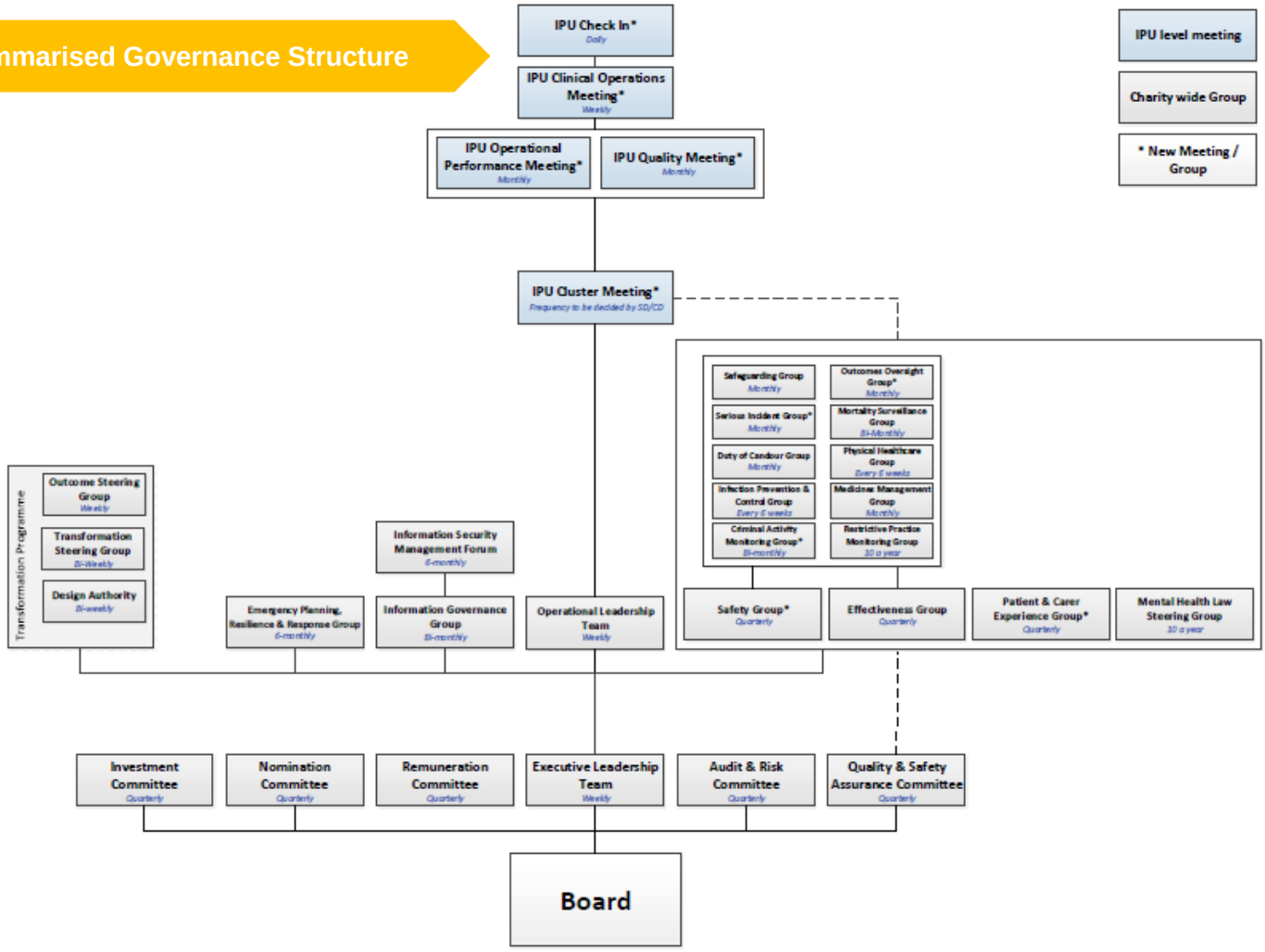
Meeting Information - A central Meetings information area on the Charity Intranet is under development and will enable actions, decisions and key meeting information to be available across IPUs and Support Functions, further improving the communication between them and increasing the transparency of meetings. The necessary access levels will be put in place in relation to the meetings and content.



In addition to the Meeting information area we are proposing that Key messages from the Charity-wide Groups are sent to the IPU Leadership and any other key individuals via email (similar to existing Executive Leadership Team (ELT) key messages). The email may have a link to the applicable papers – giving an option to view more information.

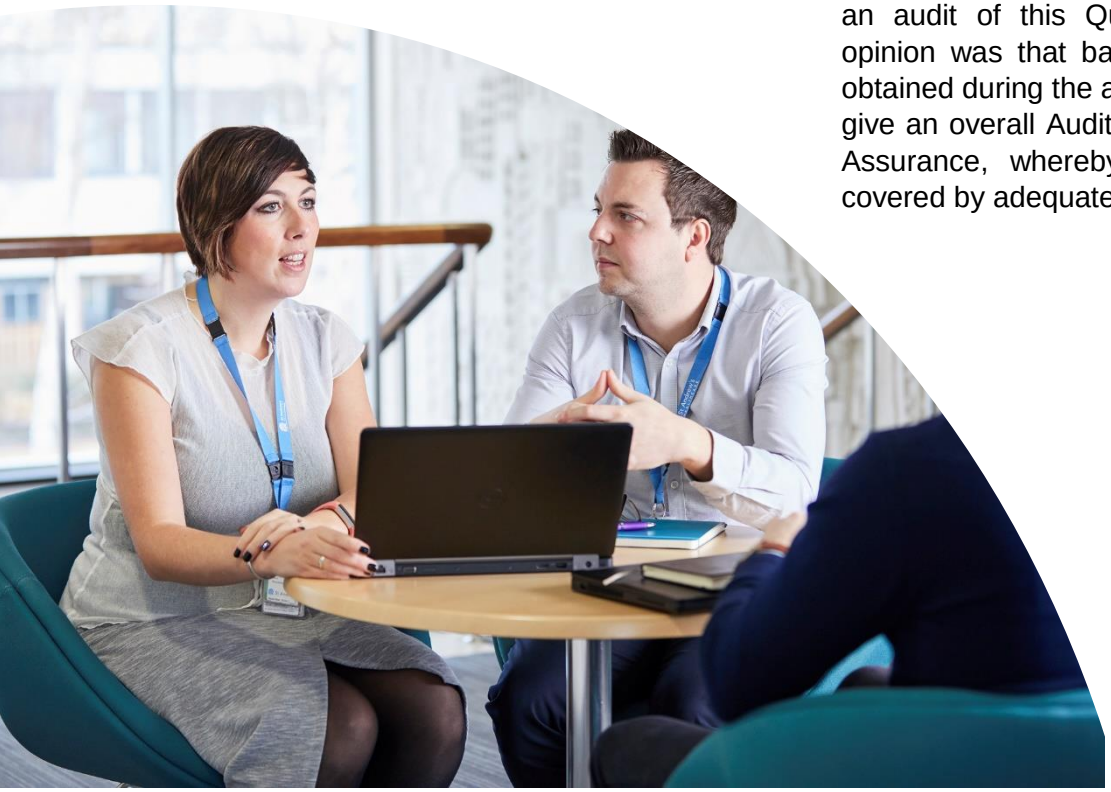
In order to monitor and maintain the integrity of the new Governance structure, the General Counsel & Company Secretary will have an overall oversight. The plan is for the structure to go live on 1 April 2018, with a formal review planned in 6 months in October 2018.

Summarised Governance Structure



Independent Auditor Assurance

Our Internal Audit Department carried out an audit of this Quality Account. Their opinion was that based on the evidence obtained during the audit they were able to give an overall Audit Opinion of Adequate Assurance, whereby the key risks are covered by adequate levels of control.



What our Patients are saying

‘I have been here two years. The care here is good. Staff help me a lot. I wouldn’t change a thing about my care here. There are lots of things to do on the ward.’

‘Good about care: Helpful staff always there to help me; correct medication given when needed; night staff are especially good’

‘The psychology sessions are really helpful to me.’

‘I was sent here from somewhere else, they are very caring and compassionate, they have helped me on many occasions when I needed them, they have saved me once or twice, they are always there when I need them.’

‘I have been here for three and a half years, I have seen myself get better it is up and down. The staff are good – by talking with us, having a good attitude. I would recommend St Andrew’s as a hospital.’

’However hard St Andrews is for me, I would recommend it as it has been life saving for me.’

‘The physical health side of things has improved dramatically over the past 18 months.’

St Andrew's HEALTHCARE

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MINDFUL EMPLOYER
Great Green Star Award 2015/2016
Stonewall TOP 100 EMPLOYERS 2017
INVESTORS IN PEOPLE
food for life CATERING SILVER
Excellence in Diversity Awards
BRITISH SAFETY COUNCIL Five Star Occupational Health and Safety Audit 2015
POSITIVE ABOUT DISABLED PEOPLE

Individuals pictured are models and are used for illustrative purposes only.