# St Andrews Healthcare

## Quality Report

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Date of inspection visit: 23 and 24 Octoer 2019
Date of publication: 07/01/2020

| Core services inspected | CQC registered location | CQC location ID |
|---|---|---|
| Reactive Provider Well Led Assessment | St Andrew's Healthcare – Men's Service | 1-121538205 |
| | St Andrew's Healthcare – Women's Service | 1-121538225 |
| | St Andrew's Healthcare - Neuropsychiatry Service | 1-121538260 |
| | St Andrew's Healthcare - Adolescents Service | 1-121538276 |
| | St Andrew's Healthcare - Birmingham | 1-121538294 |
| | St Andrew's Healthcare - Essex | 1-121538312 |
| | St Andrew's Healthcare - Nottinghamshire | 1-233736027 |
| | Winslow | 1-2731592703 |
| | St Andrew's Healthcare - Consultancy Service | 1-586476807 |
| | Broom Cottage | 1-6482830869 |

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

# Summary of findings

### Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

# Summary of findings

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# Summary of findings

## Overall summary

- The provider's leadership team had a comprehensive knowledge of current priorities and plans were in place to address these. Many of these were in their infancy.
- The provider had not always responded to concerns raised by CQC in a timely manner. Despite board meeting minutes acknowledging inspection findings, we were told of a two-year backlog to address some issues. Board meeting minutes also contained statements which demonstrated senior leaders had not fully accepted the serious nature of concerns raised, or ratings applied, following some inspections.
- The provider's systems for sharing learning within and across the organisation were variable and inconsistent. The provider did not have fully effective systems to share learning across different pathways and services. Senior leaders recognised this need.
- The provider's recent changes and improvements to the governance structures did not equate to a fully integrated approach at the time of inspection. Staff were able to detail how it would be and when they expected to have an integrated governance dashboard in place. There was minimal evidence of scrutiny or challenge, to either corporate or clinical governance, being delivered by the non-executive directors at governance committees.
- There was a lack of clarity regarding operations and governance processes taking place in the same committees and whilst the staff believed it worked currently, there was a potential risk of conflict of interest, as best practice and policy development could be influenced by operations managers. The provider may wish to consider separating governance and operations at the highest level to mitigate the risk for potential conflict.
- The link between the risk register and strategic assurance framework (SAF) was unclear from those we spoke to during the well led review. The escalation process between ward and integrated practice units (IPU) and then IPU to clinical governance, and upwards to the charity executive committee, were also unclear. Ongoing development of these structures was noted.
- The provider had robust systems and processes for monitoring compliance with the Mental Health Act.
- The board reviewed performance reports that included data about the services, which included an integrated clinical governance report. An integrated performance report was under development and near completion.
- The provider had made improvements in IT systems and infrastructures which lay the foundations to fulfil larger plans.
- The provider was actively engaged in collaborative work with external partners, to share and learn, network, and work in partnerships with a focus on looking at gaps in treatment pathways for people struggling with their mental health.
- There were various mechanisms for staff to feedback and engage. As the culture evolved staff were using these more.
- The provider was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
- The provider had invested in a research team with an allocated budget and a focus on research projects that were practical and meaningful to care, and services provided.
- Staff did not consistently feel confident to raise concerns without fear of reprisals. The provider had not afforded the appropriate protection to one staff member under The Protected Disclosures Act 2014.
- The mortality report did not evidence a robust and comprehensive analysis of mortality and lessons learned.
- Mental Health Act governance did not include regular reporting to the board. This was only done through exception and was not a routine report.

# Summary of findings

Therefore, there was a risk the board may not be fully sighted of all concerns identified, for example from Mental Health Act review reports. The Chief Nurse provided information and allocated responsibility to relevant teams, in-line with processes for CQC actions. The assurance and appraisal of Hospital Managers needed to align to the Mental Health Act requirements.

- The provider had not yet embedded a formal and consistent approach to quality improvement. Audit activity was undertaken by both a quality team and clinical audit. There appeared to be confusion between audit and quality improvement. A formal and consistent approach to quality improvement was yet to be embedded. It was recognised that revised governance structures required further development prior to launching formal quality improvement. Innovations were still encouraged following a plan-do-study-act (PDSA) methodology including body worn cameras, reducing restrictive interventions, and admission projects.

However:

- The provider had a newly formed leadership team with many of the skills, abilities, and commitment to provide high-quality services. There was now a clearer focus on clinical leadership, alongside an identified need to further define and develop the assurance function within a non-executive director/ governor role.
- We recognised that the appointment of a chair, through a robust external process, had paved the way for future non-executive director recruitment and engagement.
- Senior leaders were visible and approachable. The provider had a programme of visits to all services.
- The board and senior leadership team had a clear vision and set of values that were at the heart of all the work across services. They were working hard to make sure staff at all levels understood them in relation to their daily roles. There was an authentic desire to live the values and embed these within the recruitment process to build a robust and consistent culture.
- The provider's work around staff wellbeing, development, and recruitment and retention were recognised as strengths and were having a positive impact. Examples included opportunities for support workers to complete nurse training, vicarious trauma teams, and recruitment assessment centers were recognised as strengths and were having a positive impact.
- The provider promoted equality and diversity in their day to day work and when looking at opportunities for career progression.
- The provider had developed and embedded data systems, which were showing early promise to give greater oversight of issues facing the provider. The safety framework dashboard was underpinned by a good process and ability to illustrate trends and graphs by facility and by group.
- Incidents of staff use of physical restraint of patients were increasing. The provider had a reducing physical interventions plan but, at the time of inspection, this had not led to a reduction in restraint incidents.
- The provider's process for recording and monitoring duty of candour requirements was not fully effective. We found some discrepancies between the duty of candour register and the details in the quality report. We were aware of plans for review of policy and process.

# Summary of findings

## Our inspection team

The team included two heads of hospital inspection, two inspection managers, one inspector, one Mental Health Act reviewer, and two specialist advisers with expertise in assessment of governance procedures.

## Why we carried out this inspection

St Andrews Healthcare has been inspected by the Care Quality Commission (CQC) on ten occasions between September 2013 and October 2019. These inspections were part of the CQC's planned inspection methodology in England.

The provider's services had been inspected as both a location and as core services, in line with the terms of their registration. More recently inspections have focused specifically on men's, women's, adolescents and neuropsychiatry services. Whilst the inspections identified a few positive factors, they also identified some concerns linked to the provider's leadership and governance arrangements. Further details are below.

During our inspections several examples of positive care were observed. For example:

- outstanding support for patients with lesbian, gay, bi-sexual and transgender needs
- an impressive range of therapies within excellent facilities
- comprehensive mental health assessments and care plans for patients
- effective multidisciplinary teams providing a range of specialist care to meet patients' needs
- support for patients to access spiritual support.

However, our onsite activity and analysis highlighted a few significant concerns around level of compliance with The Health and Social Care Act 2008 (Regulated Activities) 2014 regulations. The key concerns include:

- staff not always treating patients with dignity and respect
- staff practices in relation to restrictive practices not adhering to the Mental Health Act Code of Practice
- managers not ensuring safe environments
- governance systems failing to identify and address issues
- repeated and systematic failings across locations.

**Inspection History**

As at 1 August 2019, there were seven locations with a breach of regulation under the Health and Social Care Act 2008 (Regulated Activities) 2014. There was a total of 13 breaches.

Detailed below are the specific inspections that contributed to the decision to undertake a reactive provider well led assessment at the administrative offices at Cliftonville Rd, Northampton NN1 5DG.

**St Andrews Healthcare Nottinghamshire:**

Between 2 and 4 October 2018, and 8 and 9 October, the Care Quality Commission completed a planned comprehensive inspection at the Nottinghamshire service. This inspection was a routine inspection under our methodology. The provider was found to be in breach of the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirement notices were issued in respect of:

- Regulation 11 – need for consent
- Regulation 18 – staffing

CQC also issued a warning notice for breaches of

- Regulation 10 – dignity and respect
- Regulation 12 – safe care and treatment
- Regulation 13 - safeguarding service users from abuse and improper treatment
- Regulation 17 – good governance

# Summary of findings

The service was subsequently rated inadequate and placed into special measures.

Between 11 and 13 June 2019, and 26 June 2019, CQC inspected this service to check on improvements made following it being rated inadequate and placed into special measures. The provider was found to be in breach of the following regulations:

- Regulation 9 – person centred care
- Regulation 12 – safe care and treatment
- Regulation 13 - safeguarding service users from abuse and improper treatment
- Regulation 18 – staffing

Requirement notices were issued for these breaches. The service was rated as requires improvement overall. We found that the provider had addressed some, but not all, of the issues from the previous inspection and further work was required relating to the 'safe' and 'effective' domains. Caring, responsive and well led received 'good' ratings. The service was taken out of special measures following this inspection

**St Andrews Healthcare - Adolescents Service**

St Andrews Healthcare provides their adolescents service at the Northamptonshire site.

Between 31 October 2018, 6 and 7 November and 17 January 2019, the Care Quality Commission completed a series of focused inspection visits of the adolescent service at Northampton. These visits were in response to concerns raised to CQC relating to safe care and treatment of patients. The provider was found to be in breach of the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A requirement notice was issued in respect of:

- Regulation 17 - good governance.

Between 19 March and 18 April 2019, the CQC again inspected the adolescent services provided at the Northampton site. This inspection was pre-planned and still undertaken as an opportunity to review progress against the requirement notices issued following the previous inspection and to allow an opportunity to review the service as a whole. The CQC took enforcement action following this inspection and issued warning notices for the following breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014:

- Regulation 10 - dignity and respect,
- Regulation 12 - safe care and treatment
- Regulation 13 - safeguarding service users from abuse and improper treatment
- Regulation 17 - good governance.

The adolescent service was rated inadequate overall and placed into special measures. CQC will complete a follow up inspection within six months of the service being placed into special measures.

**St Andrews Healthcare – Men's Service**

St Andrews Healthcare provides its men's service at the Northampton site.

Between 17 and 24 July 2019, the CQC completed a focused inspection of St Andrew's Healthcare, men's service at the Northampton site. This was a focused inspection of Foster Ward, a locked rehabilitation ward for older people with mental health problems. The provider was found to be in breach of the following regulations under the Health and Social Care Act 2008 (Regulated Activities) 2014. Requirement notices were issued in respect of:

- Regulation 12 - safe care and treatment
- Regulation 15 – premises and equipment
- Regulation 17 – good governance

The adult social care directorate inspected Winslow, a service to transition from secure settings to community, in September 2019.

The CQC visited the provider's headquarters in Northampton to complete the reactive provider well led review on 23 and 24 October 2019.

## How we carried out this inspection

**Letter from the Chief Inspector of Hospitals**

# Summary of findings

The Care Quality Commission (CQC) carried out a short notice reactive provider well-led assessment of St Andrews Healthcare, on 23 and 24 October 2019. This review was completed at the provider's offices in Northampton.

The St Andrews' Healthcare charity has ten locations registered with CQC: seven inpatient mental health units based at four different sites, two care homes and a consultancy service.

During our assessment we:

- interviewed the leadership team and reviewed evidence at the provider's head office at Northampton
- carried out focus groups with the clinical team leaders, modern matrons, operational leads, non-executive directors, council of governors, Mental Health Act hospital managers, clinical directors, carers and patients
- reviewed an analysis of data sources available to CQC, between October 2018 and October 2019.

CQC has not published a rating as part of this provider well led assessment.

## Information about the provider

St Andrew's Healthcare is a charity providing specialist mental healthcare for people with complex mental health needs. The registered charity number is 1104951. The provider has its headquarters on its largest site in Northampton. The provider employs over 3,500 permanent staff and has 1,000 temporary staff employed on their internal bank system. Over 90% of staff are directly involved in clinical care for patients.

St Andrews Healthcare history as a charity began in 1838 with the opening of a hospital at Northampton offering 'humane' care to the mentally ill. St Andrew's Healthcare was one of four registered psychiatric hospitals that chose not to join the National Health Service in 1948, maintaining a charitable status.

St Andrew's provides services for men, women, children and adolescents, offering secure provision, locked and open rehabilitation, and community-based solutions. Most patients are referred via the NHS and are from all parts of the United Kingdom. Through inpatient and outpatient services, the provider supports individuals at varying stages of their treatment. Treatments are offered for trauma, personality disorder, psychosis, autism, learning disability, brain injury, complex dementia and Huntington's Disease.

Most patients are detained under the Mental Health Act (90%) and 50% of those are referred via the criminal justice system.

Northampton is St Andrew's Healthcare headquarters. They also have sites in Essex, Birmingham and Nottinghamshire providing care for people with a range of mental health conditions.

The charity provides the following services:

- Mental health services for men
- Mental health services for women
- Child and adolescent mental health services
- Neuropsychiatry
- Autistic spectrum disorder services
- Learning disability services

St Andrews Healthcare provides a total of 859 inpatient beds at the following locations:

- Northampton - 57 wards and 600 beds.
- Birmingham, Essex and Nottinghamshire – 18 wards and 273 beds.

St Andrew's Healthcare receives almost all its income from NHS commissioners. The biggest source of funding is NHS England. The provider also receives funding to support education from the education funding authority and local authorities and some income is received from donations. The provider does not actively seek donations from the public. The 2018/19 annual report states the total funding received for charitable activities was £182.8m. A further £21.8m was secured from trading activities and £0.4m was received from investments, an increase of 33% on the previous year. The annual report states a total income for 2019 of £205m. The provider's expenditure for the same period totalled £209.5m; resulting in a loss for the year of £5.1m. However, the provider remains in a strong financial position with total reserves of £203.4m (a decrease of £4.8m on the previous year).

# Summary of findings

The St Andrews' Healthcare brand has ten locations registered with CQC: seven inpatient mental health units based at four different sites, two care homes and a community partnerships service.

The provider's inpatient services are managed as integrated practice units (IPUs). The provider has 17 IPU divisions, each led by an operational lead and a clinical lead.

## Areas for improvement

### Action the provider MUST take to improve

- ensure that effective governance systems and processes are embedded across all services to support the delivery of sustainable and high-quality care.
- review the arrangements for the independent challenge of decisions made by the executive team.
- ensure all breaches of regulation are actioned and completed in a timely manner.
- ensure all concerns identified by Mental Health Act reviews are actioned and completed in a timely manner.
- ensure all staff who raise concerns are afforded protection in accordance with The Protected Disclosures Act 2014 and the provider's policies and procedures are adhered to.
- ensure systems and processes are embedded for shared learning across all locations. ensure that restrictive practices, including physical restraint, continue to be reviewed across all services and that action is taken to reduce the use of restrictive practices in line with current good practice guidance.

### Action the provider SHOULD take to improve

- ensure systems and processes to support understanding and learning from deaths are embedded.
- review the assurance and appraisal process for hospital managers.

# St Andrews Healthcare

**Detailed findings**

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

## Summary of findings

Our summary of this inspection is included earlier in the report.

## Our findings

Our findings

**Vision and strategy to deliver high-quality care and support, and promote a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people**

The provider had a vision, underpinned by strategies to enable the delivery of high-quality care. However, the embedding of a culture that promoted open, inclusive and person-centred care was in its very early stages.

The board and senior leadership team had a clear vision and set of values that were at the heart of all the work across services.

The provider had concise vision that was based on a refresh of its original charitable purpose; To relieve suffering, give hope and promote recovery. The vision featured through the provider's strategy (2018/2022) which was broken into deliverable objectives with a single executive owner for each area. These were:

- the quality of care we provide
- developing our workforce
- working in partnership
- our clinical environments and use of technology
- promoting innovation and research
- delivering value

The provider had four core values, known as CARE values: compassion, accountability, respect, excellence. The new leadership team was working hard to make sure staff at all levels understood them in relation to their daily roles. There was an authentic desire to live the values and embed these within the recruitment process to build a robust and consistent culture.

All staff appointments, inductions, appraisals and supervisions were directly linked to the provider's vision and values; to ensure staff not only demonstrated the required values on appointment, but also that this was maintained throughout. The provider had a code of conduct, distributed at employee induction days and available on the intranet. We saw evidence of staff having been performance managed out of the organisation at senior management level (13 individuals at executive level and just below) when values were not aligned.

Senior leaders were able to give a clear explanation of St Andrew's Healthcare's strategy and referred to the vision and desire to effect real change across all services. There was an acknowledgement that work was needed to raise the profile of the organisation. Senior staff spoke of a desire for the organisation to be regarded as a market leader for effective and evidenced based treatment for patients with complex and challenging conditions.

The provider's board of trustees (directors) met twice a year for specific days to review strategy. Progress against strategy was measured as an agenda item in board meetings.

The board minutes for March 2019, May 2019 and July 2019 and the current strategic assurance framework (SAF) reported that patients, carers and staff had been consulted by leaders through focus groups to influence organisational values and strategy. Board minutes discussed goals to involve all patients and carers in the co-production of care plans. However, an analysis of themes emerging from qualitative analysis of provider action statements, share your experience documents and complaints (including whistle-blowers) from patients, staff and relatives suggested that patients and relatives who contacted the CQC did not feel involved in care planning.

**Culture**

# Are services well-led?

The new senior leadership team acknowledged there was work to do to improve the culture in their services. We heard reports from many sources alluding to a historical culture that had not been conducive to good quality patient care and, by association, low morale and a sense of 'being done to' by local staff teams. Senior leaders now promoted an inclusive, open and transparent culture at the top of their agenda. All senior staff we spoke with were overwhelmingly positive about the focus on improving culture and were particularly praising of the changes being implemented following the appointment of the new chief executive officer in July 2018.

However, some phrases and language documented within board meeting minutes, dated 30 May 2019, suggested the provider had not fully acknowledged the serious failings identified in CQC inspection reports for the adolescent service. For example, one comment suggested "if the report is actually read without seeing the ratings, then it would not be seen as an inadequate report" and "it should also be noted that the CQC had faced intense criticism following the Panorama programme a few weeks ago and this may have had an influence on their decision making for the CAMHS (adolescents) report". "We could also have been more aware of the pressures on the CQC to produce a highly critical report". The audit and risk committee meeting minutes dated July 2019 state "there is a different bar for the charity to meet in terms of quality because the space it sits in is uncomfortable for the NHS".

The quality and safety assurance committee meeting minutes dated 13 December 2018 referred to concerns raised related to recurring themes from CQC inspections. These included long term segregation, record keeping, Mental Health Act compliance, environment, physical healthcare, blanket restrictions, staffing and learning lessons from serious incidents and complaints. There was no record within these meeting minutes that the committee acknowledged this observation, except for improvements to staffing, or had plans to review these practices. CQC continued to highlight failings in these areas in subsequent inspection reports; particularly in relation to the adolescents' service. There was a lack of evidence that issues highlighted by CQC over a significant period were adequately addressed or acted upon in a timely manner to provide safe care and treatment for patients.

The provider had a robust inclusion strategy; approved by the board in September 2018, designed to embrace diversity and promote equality of opportunity. From January 2019, a steering committee, led by the chief executive officer had monitored the implementation of the workforce race equality standards action plan 2018-19 and encouraged the implementation of a range of support networks, including BAME, able network, LGBT+ and WiSH (women in St Andrews). All networks had an executive sponsor.

The provider had run a few events throughout the year:

- Trans-inclusive Healthcare Conference
- Pride
- Carers Week
- LGBT History month
- Black History Month
- National Inclusion week
- Mental Health Awareness Week
- Pride week
- Wellbeing week

The provider had a specific action to support greater understanding of diversity and inclusion for staff, patients and carers. A few key actions had been completed, including the delivery of stonewall train the trainer training, gendered intelligence trans awareness, LGBT awareness workshops and patient 1:1s, and unconscious bias for leaders. The provider was introducing reverse mentoring for the five members of the executive team and had five BAME staff who had agreed to be mentors.

The provider's inclusion and diversity report 2018/19 identified approximately 20% of staff and 30% of senior staff from a BAME background. This compares favourably with the national average of 12.4% and 20% within the NHS.

**Enquiries and Notifications to the Care Quality Commission**

The Care Quality Commission receives information directly from a few sources, including patients, staff, families, carers and outside agencies. The CQC reviews all information and, where required, seeks clarification from providers, including evidence of investigation, outcomes and learning.

Prior to the inspection the CQC completed a detailed analysis of this data for the year to 30 June 2019. Sources included complaints made by patients (48) complaints from patients related to the Mental Health Act (81) Share

your experience contacts, including whistleblowing, from staff (40) and whistle-blower contacts via phone/web (13). From analysis, CQC identified some themes occurring across a variety of sources.

Provider level qualitative analysis of complaints data (including whistleblowing) highlighted St Andrews Healthcare, Nottinghamshire was of concern due to the frequency with which the CQC received complaints about this service, especially from staff. A key theme from staff comments related to the existence of a cover-up culture in which allegations of abusive behaviour and poor care were covered up by falsifying records to prevent poor and abusive practices from coming to light. A few comments pointed to a culture in which management sought to actively manage how their service was perceived by CQC. We heard similar concerns surrounding the active deception of the CQC from patients and from their relatives' complaints. Whilst this issue was prevalent in comments received about Nottinghamshire, it was also discussed in relation to other St Andrew's locations.

Staff working in the Nottinghamshire service told us, via share your experience and complaints (including whistleblowing) that employees who had previously been dismissed following disciplinary action (for threatening patients in one case, and abusive interactions with a patient in another) were being invited back to work. Senior managers did not provide records of when this had occurred during the inspection but provided information on two examples, which related to these themes, post inspection.

Share your experience, complaints (including whistle-blowers), notifications (Nottinghamshire service only) and provider action statements data raised questions about the embedding of a person-centred culture. These sources referred to multiple incidents which may indicate a lack of person-centred care. The volume of notifications in which similar incidents were reported across the whole period indicated a poor learning culture. There were 31 reports of patient-patient assault and the same two patients assaulted one another in four separate incidents. This may suggest that even in notification reporting, where reference was made to plans for preventing incidents from re-occurring, these plans may have been inadequate, or not being actioned.

Share your experience and complaints (including whistle-blowers) from patients, staff and relatives raised concerns that management may either not be aware of or are not responding to issues including poor and selective reporting, falsifying records, intimidation of staff, and active deception of CQC. Staff, patients and relatives attributed these behaviours to management. However, it was not always clear from comments whether 'management' referred to senior leaders, or ward level management.

Most of the whistleblowing contacts received between June 2018 and June 2019 were received from the Nottinghamshire service following the inspection (rated inadequate) in October 2018. The whistleblowing's were mostly anonymous and very brief information was provided.

Complaints received from patients raised concerns that when they raised issues in the service, staff and management did not believe them, or accused them of lying.

Complaints (including whistleblowing) from staff included references to whistle-blowers being bullied by managers. Staff expressed fear about retaliatory action, based on having seen previous punitive action against whistle-blowers at their service, for example the outcome of an employment tribunal that supported staff concerns. The provider was judged to have acted unfairly at the conclusion of an employment tribunal case in August 2019, where an employee was subject to automatic unfair dismissal for having made protected disclosures. The Protected Disclosures Act 2014 exists to encourage people to report serious wrongdoing in their workplace by providing protection for employees who want to 'blow the whistle'. This applies to public and private sector workplaces. The tribunal expressed concerns about the failure of the provider to disclose unredacted versions of important and relevant documents.This would not be consistent with the provider's responsibilities and did not support an open and transparent culture.

There was evidence of low staff morale caused by clashes of personality on wards, understaffing, and concerns about staff safety. The staff who got in touch with the CQC through share your experience suggested that staff were leaving to avoid endangering their professional reputation by association with poor and unsafe care. However, the provider's exit interviews did not support this.

Recent enquiries (July to October 2019) from the Adolescent's Service were prioritised due to specific

concerns about the recent quality at that service. This showed there were 22 enquiries about this location. They included nine safeguarding concerns, five complaints (Mental Health Act related), five complaints about provider, two follow-ups, and one whistle-blower complaint. Understaffing, inappropriate staff behaviour and staff competence were key areas of concern. These issues were linked to risks to both patient and staff safety, including physical assault, patient observations not being in line with their care plans, and poor patient care.

All providers registered with the Care Quality Commission are required by law to submit notifications about certain changes, events and incidents that affect the service or the people who use it. These include the death of a person or unauthorised absence of a person detained under the Mental Health Act, the outcome of a deprivation of liberty safeguards application, abuse or allegations of abuse, serious injury, and incidents reported to the police.

Between 1 August 2016 and 31 July 2019, St Andrew's submitted a total of 2,140 notifications across eight locations. Most notifications were submitted by the mental health locations (2,121 submitted – 99% of all notifications). The social care organisations have submitted a total of 19 notifications (seven deprivation of liberty safeguard applications, seven abuse notifications and five police incidents). Most notifications submitted were where abuse or suspected abuse had occurred (1,838) representing 86% of all notifications.

The volume of notifications (284) for January 2019 to August 2019 was lower compared to the same time in previous years. This may be an indicator that the new leadership team was achieving a level of effectiveness in reducing the number of incidents reportable to CQC.

Notifications (from the Nottinghamshire service only), share your experience and complaints received from staff and patients indicated that services saw the same incidents (relating to safety, acquired injuries, bullying, and claims of abuse) repeating multiple times. Where incidents occurred, patients, staff and relatives told us through share your experience and complaints data that 'management' had failed to address complaints made by staff about these incidents. It was not always clear from comments whether 'management' refers to senior leaders, or ward level management.

It was worthy to note that notifications analysed from the Nottinghamshire service were of high quality, sufficiently detailed and in general were examples of good reporting.

**Freedom to Speak Up Guardian**

The provider had recently appointed freedom to speak up guardians. These roles were required as part of NHS standard contracts. The freedom to speak up guardian acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation. The provider appointed four freedom to speak up guardians on 18 October 2019, their substantive job roles included, operational lead, nurse manager and senior HR project manager. These roles were not yet fully operational; therefore, no reports or data could be reviewed. The guardians met for an introductory meeting on Monday 21st September 2019 and discussed the role including ways they would work together. Their initial discussions indicated that the number of days that would need to be protected for each person was 2 days per month or as required to cover each other. The guardians will cover all the sites and were contactable via a secure email address.

The provider had several other routes for staff to raise concerns. These included a confidential whistleblowing line (SAFECALL) available 24 hours per day 365 days a year, provided by an external organisation. All whistleblowing raised were reviewed by the executive director of human resources and further reviewed at the charity executive committee. The most common reported incidents were unfair treatment and incidents of general safety. The provider had received 23 concerns over the past year. Incidents had declined since 2014 and 2015 where there were 31 and 30 concerns raised respectively. In 2017, 54% of concerns raised were upheld or partially upheld. In 2018, this number had reduced to 20%. Staff were also able to raise concerns and questions to the executive team. Since the beginning of 2016 there had been 744 questions raised. We were not provided with themes or actions for concerns via this route.

Senior leaders, including governors, were improving their visibility in services. Senior leaders undertook regular visits to services. Between January 2019 and August 2019, 17 governors completed ten visits to nine services. The executive and non-executive directors had a timetable of visits across all services between 5 August 2019 and 14

# Are services well-led?

October 2019; which defined which executives, individually or in teams, visited sites. There were gaps where some wards had not received visits during this time. However, this timetable was ongoing to January 2020. References to improving executive visibility on wards were discussed in the July 2019 board meeting minutes.

**Duty of Candour**

The provider's compliance with duty of candour requirements was found to be inconsistent. Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain incidents.

Duty of candour was part of incident reporting and review processes. The provider held a register of all incidents meeting the threshold. However, we found discrepancies between the duty of candour register and those incidents reported in the quality report 2018/19. The duty of candour register identified 17 incidents meeting the threshold, whilst the quality report identified three. The provider reviewed this discrepancy and advised that amendments would be made at the next governance meeting.

The quality report also said there was a duty of candour group, that reviewed duty of candour requirements. However, staff were not aware of one and no minutes could be found. Duty of candour incidents were monitored as part of the report on serious incidents presented to the patient safety group, quality and safety assurance committee and charity executive committee.

**Safeguarding**

The provider had a head of safeguarding. Each integrated practice unit (IPU) had a specified safeguarding lead (usually a social worker). Staff were in receipt of safeguarding training. At 30 September 2019, 99% percent of eligible staff had completed level 1 and 2 training and 92% had completed level 3. The provider encouraged front line staff to report all safeguarding concerns directly to the local authority, in line with their professional requirements. CQC had seen evidence of this during routine monitoring.

**Staffing levels and sickness absence rates**

The provider reported sickness rates ranged between 4% and 8% across all sites with Nottinghamshire reporting the highest rate at 8%, specifically mental health wards for people with learning disabilities or autism. All other locations were below the provider average for sickness rates (6%).

The provider reported staff vacancy rates ranged between 2.5% and 8.5% with Northampton reporting the highest rates at 8.5%, specifically the mental health acute wards for adults of working age and psychiatric intensive care units based at Northampton.

The provider's annual average turnover rate for all staff was 13%. Essex, Nottinghamshire, and Derbyshire all had a high number of staff leavers over the last 12 months. The Winslow service, a community mental health service for people with learning disabilities or autism, reported no vacancies.

The provider used bank or agency staff to cover staff absence and vacancies. Bank and agency staff were familiar with the wards and patients they cared for, they also received the same induction and training as substantive staff. Between July 2019 and September 2019, 11,492 shifts were filled by bank or agency staff, representing 15% of total shifts. Agency staff covered 1,121 shifts (10%). Agency staff worked an average of 21 shifts during this period.

The Northampton site had the highest use of bank and agency staff, and the highest number of unfilled shifts across the provider (2,862). Four of the wards with the highest number of unfilled shifts, also had the highest number of staff vacancies (Meadow, Prichard, Seacole, and Sunley).

The Derbyshire site (Broom Cottage) did not have any shifts unfilled, or any shifts filled by bank and agency.

Board meeting minutes contained discussions of challenges, concerns and risks. Staffing and staff absenteeism received attention during board meetings. The provider's strategic assurance framework discussed development opportunities and flexibility regarding working patterns for employees.

The provider had a rolling staff recruitment programme and held 26 recruitment assessment centres between October 2018 and October 2019, employing 141 new staff. The average time to hire from recruitment assessment centres was eight to nine weeks and 11-12 weeks for routine appointments.

# Are services well-led?

Staff told us of consideration being given to amending the shift patterns for staff to ensure all staff worked across a 24-hour shift pattern. Patients had told us that often their care co-ordinator or named nurse worked permanent night shifts. This had made access to one to one session difficult.

The provider undertook exit interviews for staff leaving employment. These are carried out face to face or via written feedback. Following a recent analysis of leavers, the following themes were identified as the main reasons for leaving:

- Work life balance,
- Better package
- Promotion/ opportunity

The provider used feedback received through exit interviews to inform organisation wide and locally targeted initiatives to address concerns raised.

**Staff suspended and/or under supervised practice:**

The provider reported 20 staff suspensions across the Northampton, Birmingham and Essex sites. Of these, 14 related to health care assistants. The highest number related to the adolescent service in Northampton (8) with four reported for Meadow ward. The most common reported outcome was dismissal or resignation.

**Leadership capacity and capability to deliver high-quality, sustainable care**

The newly formed leadership team had the capacity and capability to work towards the delivery of high-quality sustainable care for patients. The leadership team had many of the skills, abilities, and commitment to provide high-quality services. There was a clearer focus on clinical leadership and a need to further define and develop the assurance function within a non-executive director and governor role. The provider's leadership team had a comprehensive knowledge of current priorities and plans were in place to address these. However, many of these were in their infancy.

The senior leadership team had undergone some significant changes over the past two years. In July 2018, the provider appointed a new chief executive officer and in April 2019, a deputy chief executive officer and chief financial officer were appointed. A new role of chief information officer was established in March 2019 and in June 2019 the provider appointed a chief nurse and chief operating officer. In July 2019, the provider appointed a new chair, with extensive experience of working within the NHS mental health sector and Royal College of Nursing.

The executive team understood their portfolio's and had a knowledge of the current priorities and challenges to quality and sustainability. However, actions identified by senior leaders were not always effective in addressing the challenges to quality and sustainability. Inspection and monitoring activity by the CQC found repeated issues across locations resulting in enforcement action being taken.

The current board structure did not currently offer enough challenge and/or support to the executive team. Both non-executive directors and governors required training and development around the assurance function of their role. There was an induction and welcome pack, but there has been little evidence of investment and development to the role to date. Current transformation plans did not appear to be fully connected with little evidence of review. The provider should ensure these roles are better defined to ensure the challenge/ support processes are fully embedded and understood. We recognised that the appointment of a chair, through a robust external process, had paved the way for future non-executive director recruitment and engagement. We were told the chair was reviewing the skills within the existing board and non-executive directors with a view to further developing the expertise of the board of trustees.

The provider ensured there were registered managers appointed. Registered managers had been in place for all required locations for the last 12 months prior to inspection, with only one vacancy in May 2019. The current chief operating officer was also the registered manager for the men's, neuropsychiatry and Nottinghamshire locations. The current chief nurse was also the registered manager for the adolescents and women's locations. It was unclear how enough oversight of all these services could be maintained, alongside an executive role. The provider has advised that they have no plans to change these arrangements.

Clinical and operational leads spoke highly of the senior leadership team and were particularly praising of the chief executive officer. Clinical and operational leads were responsible for service delivery within their individual integrated practice units (IPU). Leaders spoke of 'going back to basics' but were positive about improvements in

shared learning, lines of responsibility and governance processes. The new appointment of six modern matrons had added a clear nursing voice to governance meetings; identified as a significant recent improvement, and leaders told us they felt they now had a voice, were listened to, and were encouraged to make local improvements to benefit patient care. There were clear lines of reporting from ward to board; aligned across all the integrated practice units, although these were not yet fully embedded.

The provider had processes in place for succession planning, linked to its strategy, with a formal review once a year to the charity executive committee. The provider took a healthy view to a 'grow your own' agenda to ensure staff were successfully developed towards more senior roles, where appropriate. To October 2019, there had been 336 internal promotions, representing 11% of the workforce. Roles included four board appointments, five clinical directors, 27 clinical and operational leads which head up the IPU's plus 46 registered nurses, 50 senior nurses, 17 ward/nurse managers and 16 clinical nurse leaders.

There was a clear focus on succession planning for critical posts, with coaching and mentoring in progress. Staff who were identified as being potential successors for senior leaders put in place a development plan and were offered appropriate training and support to suit their needs. There were clear examples of staff being promoted within the organisation, to reach senior roles. For example, the chief nurse who started with the provider in 2000 as a healthcare assistant.

**Responsibilities, roles and systems of accountability to support good governance and management.**

The responsibilities, roles and systems of accountability to support good governance and management required further attention in order to become consistent and embedded.

The provider used a cross functional project team to complete a review of its governance processes in the months leading up to the start of the 2018/19 financial year. The new structure was likened to the 'seven pillars' of clinical governance. We were advised this structure had suited best as it aligned medically and was a methodology widely agreed upon to drive change. However, there was not yet a fully integrated approach to governance and staff spoken to had differing understanding.

The provider was governed by a court of governors and a board of trustees. All trustees were also directors of the company. At the time of inspection, there were 30 member governors and nine honorary governors. The court of governors met three times a year, including the annual general meeting, where the governors received the annual report and accounts and re-elected trustees.

The board was made up of 11 trustees, including six non-executive and five executive trustees. The board was responsible for the overall leadership and monitoring of the provider's vision, values, purpose, long term objectives and strategy. The board met six times a year for formal meetings and twice a year to review the strategy.

The board was supported by seven sub committees. However, there were gaps in the reporting lines. For example, a few committees appeared to discuss the same issues, with no evidence the issue was owned by a specific committee.

The provider's key committee for governance was the charity executive committee. The charity executive committee was made up of 20 senior leaders, the majority of which were in clinical roles. Governance processes sat under the general counsel who had a very large remit and therefore did not have a detailed view. This was due to the fact that responsibility for clinical and corporate governance was disseminated to senior managers who chaired relevant committees and who were knowledgeable in their respective subject matters.

The charity executive committee met weekly. The meetings were structured so in each month there was a meeting focussed on performance, a meeting focussed on strategy, and two meetings dealing with business as usual matters.

There was minimal evidence of external scrutiny or challenge to either the corporate or clinical governance being delivered by the non-executive directors or external parties and governance committees. However, there was evidence of good discussions about how that would take place.

Some senior staff told us governance processes were working well and meetings and terms of reference were available in the intranet. Meeting terms of reference were explained, however there were very few meeting minutes available. This process was still in its infancy.

# Are services well-led?

Staff were able to detail when they expected to have an integrated governance dashboard in place and leaders were fully committed to the process. The clinical directors and matrons were very enthusiastic and keen to make it work. It was clear that clinical care had risen to the top of the provider's agenda. This was a positive improvement.

The board had recently agreed to the appointment of four "constituency governors", who would represent carers and staff at the governors' meetings for the first time in the provider's history. The first appointments would be for three years, and the individuals would be appointed, subject to board approval, at the board meeting on 10 October 2019.

Although board minutes showed discussion and recognition of challenges, concerns and risks, analysis of other qualitative sources suggested this was not shared at management levels or with staff in services. Board meeting minutes reference cooperation and collaboration with NHSE and commissioners for approving the 2019/20 budget, NHSE contract and the recording of restraints.

The provider had a taxonomy of policies with an executive sponsor and subject matter expert for each. These were managed formally by general counsel and by the head of audit**.** We reviewed a sample and found these to be robust and in date.

St Andrews Healthcare provided care and treatment for patients detained under the Mental Health Act 1983. Over 90% of patients were detained under the Act and of those, 50% were detained under Part 3 of the Mental Health Act, referred via the criminal justice system.

The provider had robust systems and processes in place to support compliance with the Mental Health Act Code of Practice. The senior Mental Health Act administrator attended bi-monthly meetings with the independent advocacy service manager. The process of administration and scrutiny of section papers was recently subject to an internal audit, for which a substantial assurance rating was provided over its controls, activities and accuracy. The provider maintained up to date policies and procedures for the Mental Health Act Code of Practice and supported these with e-learning packages as part of induction and the employee mandatory training programme. Staff received training in the Mental Health Act and Mental Capacity Act. Overall, 94% of staff were compliant with training.

The provider had a Mental Health Act law steering group who oversaw any changes to the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. Subject matter experts were involved in policy reviews, for example, a Mental Capacity Act assessor was involved in the review of Mental Capacity Act.

The Mental Health Act law steering group reported to the charity executive committee and quality and safety group before going to board. However, the provider advised there was no standard Mental Health Act reporting to the board, only exceptions or concerns. Senior staff were not aware of any occasions when an exception report had been submitted. Although MHA Reviewer reports being treated in the same way as CQC reports, there was inconsistent oversight of Mental Health Act compliance issues raised from CQC inspections and Mental Health Act reviewer visits. Senior staff told us reports went to the Mental Health Act senior administration team who passed these to clinical directors; however senior administrators told us they had not received them. There was inconsistent oversight of Mental Health Act compliance issues raised from CQC inspections and Mental Health Act reviewer visits.

The CQC is responsible for ensuring Mental Health Act reviewers completed monitoring visits to locations where patients are detained. Where breaches to the Mental Health Act Code of Practice are found, providers are required to issue a 'provider action statement' detailing how these issues will be addressed. Analysis of provider action statement data showed that out of 35 ward visits between July 2018 and July 2019, 32 visits highlighted that the provider needed to take actions to protect patients' rights and autonomy. Issues included action needed to maximise patient independence and involvement in their care, evidence of blanket restrictions and examples of absence of dignified and respectful treatment. However, recent Mental Health Act reviewer visits have been more positive, with a reduction in action points issued.

The provider's oversight of the hospital managers was not robust. The provider had 65 hospital managers across all sites. Hospital managers attended the provider's induction and received training on induction, annual training on site, and a bi-annual training day for all managers at the Northampton site. Ad-hoc training was also available. This was supplemented by a twice-yearly newsletter from the chair of MHA managers. The provider advised that managers were appointed for a three-year term, and their

performance was reviewed prior to re-appointment, in compliance with s.38.9 of the Mental Health Act Code of Practice. However, it did not detail how performance was reviewed or recorded (s.37.10) and the Mental Health Act chair of hospital managers annual report 2018/19 did not provide clarity. Hospital managers only received peer reviews every three years. There was no clear process for hospital managers to raise or escalate concerns. We were told some hospital managers found it hard to criticise peers. Hospital managers were not provided with a hard copy of the Mental Health Act Code of Practice.

**Complaints**

St Andrew's Healthcare submitted summary information about complaints it had received. Between 1 October 2018 to 30 September 2019, 244 complaints were received, of which 166 (66%) of those complaints related to Northampton services, covering women, men's, and child and adolescent services. There was a peak in the number of complaints received in February 2019 (35) of which 31 were attributed to Northampton and related to four wards, Meadow, Tavener, Seacole and Naseby.Tavener and Meadow wards received a substantially larger number of complaints than any other ward associated with Northampton. Analysis of Meadow ward complaints data identified two key themes: staff behaviour/ conduct and errors/ competency.

During the same period the provider received 365 compliments (October 2018 and September 2019); 28% were from patients, 42% from relatives and the remainder from external professionals.

72% of compliments were about staff, 13% about clinical treatment and the remainder were about communication and access to services

80% of compliments were for Northampton IPUs, 9% for Essex, 5% for Nottinghamshire and 2% for Birmingham.

At the Essex, Nottinghamshire and Birmingham sites, where data was available, no trends of note were identified in the pattern of reporting.

Of the total complaints received, four complaints were forwarded to the ombudsmen. None were upheld.

**Is appropriate and accurate information being processed, challenged and acted on**.

The provider had a process and plan for clinical audit. Clinicians completed audits in line with an agreed proposal and review process overseen by the effectiveness group and executive medical director which covered clinical governance, National Institute for Health and Care Excellence guidelines, clinical records, Mental Health Act and Mental Capacity Act. Each subject was assigned a subject matter expert to work alongside the audit team. Actions from audits were tracked using an audit action tool, monitored and overseen by the effectiveness group and quality safety & assurance committee, with follow-up audits completed on most assignments.

Internal Audit was delivered by a team managed by the Head of Audit who has a direct functional reporting line to the chair of the audit and risk committee and day-to-day line management from the general counsel and company secretary. Audits were delivered in line with an approved audit plan, reviewed on a quarterly basis. Audit actions were agreed with management and monitored and overseen by the charity executive committee and audit and risk committee.

We reviewed the 2018-19 internal audit annual report. The head of audit recorded 'partial assurance' that arrangements to maintain the charity's internal control environment were suitably designed and applied effectively. However, the auditor also commented that it was clear that there had been an overall improvement in management's implementing and on-going handling of agreed internal audit actions, and this was most noticeable in the second half of the year. The provider linked this improvement to the introduction of clear ownership and oversight of audit actions being assigned to the charity executive committee.

The provider completed an internal audit of the data security and protection toolkit in January 2019, as part of the internal audit periodic plan for 2018/19. The data security and protection toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's ten data security standards. All NHS patient data and systems must use this toolkit to provide assurance they are practising good data security and that personal information is handled correctly. The provider's review concluded an opinion of 'adequate assurance' but highlighted a few areas for improvement. All actions were completed by March 2019.

# Are services well-led?

There were a few information systems present within the organisation These included patient records, staff records and incident and risk reporting.

A lead was identified for the general data protection regulation (GDPR). There was a Caldicott guardian and senior information risk owner in place at executive level

The Mental Health Services Data Set (MHSDS) is a patient level data set, which aims to provide robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with mental health services. It is mandatory for all providers of NHS-funded specialist mental health services to submit data about people using these services to the MHSDS, including independent providers of NHS commissioned services. NHS Digital publishes key information by provider each month and CQC also has access to a full extract of MHSDS data. Review of these sources indicated that for those measures where the provider was submitting data, the provider compared well in relation to the national averages on most of the data quality measures. The items where it compared less well were:

- Postcode of Usual Address,
- General Medical Practice Code,
- Source of referral,
- Delayed discharge attributable to and
- Referral request received time.

The Data Quality Maturity Index (DQMI) is a quarterly publication intended to highlight the importance of data quality. The first publication focused on the quality of a set of core data items identified by the national information board working group as being important to commissioners and regulators. Subsequent versions of the DQMI have been refined based on stakeholder feedback and to reflect changes to the national patient level data set.

St Andrews had a fairly high DQMI score when compared against a peer group of other Independent Health providers. Over time, their DQMI has ranged from a highest score of 96.20% in January to March 2016 to a lowest DQMI score of 80.20% in April to June 2017. Although their DQMI scores compared favorably with other independent health providers, their scores have tended to be lower than those typical for NHS providers. The score for July 2019 showed 91.9%.

The provider had developed three key performance indicators, service, education and research, to measure performance against the provider's charitable purpose. Three specific measures were used to measure progress with delivery of care and support to patients. The clinical global impressions outcome tool had been adopted to measure whether treatments delivered to patients were leading to improvements in patient health. The provider reported their latest assessment indicated 57% (out of 1,068 patients) had seen an overall improvement in their condition.

The provider had ten key performance indicators for the research Centre. In 2018/19, 19 research papers and conference abstracts were produced and published against this target. The research Centre has a target of 30 papers published by 2022. The provider expects to meet this target.

The provider conducted a patient survey. The survey was comprised of various themes, including care planning, staff support and interaction, environment, physical health, treatment and care. The provider collaborated with patients in developing a new set of questions to ensure patients could feedback on issues important to them. Therefore, we were unable to compare results with previous years.

The provider produced questionnaires, distributed via advocacy who supported patients in the completion of the survey. The provider reported a 66% response rate. Positive feedback related to clean wards, knowing how to make a complaint, involvement in meetings, physical health care and support to communicate. However, involvement with care planning and interactions with care co-ordinators required attention alongside improving introduction to services, access to leave and activities and implementing changes as a result of complaints. Each IPU had received their own individual report and action plans were implemented to address concerns. The provider had plans to ensure progress against actions would be a standing agenda item at operational meetings and a deep dive would be conducted quarterly.

The latest friends and family test assessment showed 54% (out of 539) were 'likely' or 'extremely likely' to recommend St Andrews.

**How the service continuously learns, improves and innovates to ensure sustainability**

# Are services well-led?

The provider had newly introduced processes to support continuous learning and improvement. However, this required further review to ensure the cascade of information reached all areas.

The provider acknowledged that quality improvement was in its early stages and required development. However, the principles of quality improvement had begun with examples being projects including the use of body cameras to reduce violence and aggression, and the programme of reducing restrictive interventions. Statistical process control methodology had been used, in consultation with NHSI for the implementation of the safety framework.

Systems were in place to identify complaints, serious incidents and unexpected deaths in the organisation. The provider reported 64 serious incidents in the six months to October 2019. The top three incidents, by theme, were physical health (13) physical aggression and violence (11) and self-harm (10). Incidents were investigated, and learning identified. Staff received information on lessons learned from a variety of sources, to including 'red top alerts. Where appropriate, red top alerts contained photographs of items of concern for staff reference. Alerts were on one page, easy to read and had links to policy guidance for staff reference. Staff also discussed lessons learned from incidents and complaints in team meetings.

The provider did not consistently respond in a timely manner when significant concerns, related to patient safety and compliance with the Mental Health Act, were identified by CQC. The board meeting minutes acknowledged that CQC had highlighted issues on numerous occasions via a number of inspections for which the provider had not taken appropriate action. Minutes acknowledged that work was now being undertaken to address all concerns raised; however, there was a two-year backlog to address some issues.

Some senior staff told us there had been a history of poor recognition or acknowledgement of the failings identified and a failure to act promptly. The provider had also failed to consider whether concerns found in one service might be replicated in another, Therefore, the same issues were highlighted on numerous inspections across different services. This had placed both staff and patients at risk. We were, however, assured that the new leadership team were taking a more proactive and systemic approach towards addressing concerns and sharing learning.

The provider's adolescent service was rated inadequate in June 2019 and placed into special measures. The provider was required to submit an action plan to show how urgent improvements would be made. In conjunction, the provider sought an independent review of their service. An NHS trust rated outstanding were on site during our well led review to undertake this quality improvement work. The provider had secured an improvement director to work alongside this trust for six months.

The provider had improved compliance with the Metal Health Act Code of Practice for patients in long term segregation. The CQC had reported the provider's failure to comply with the Code in a number of inspection reports and Mental Health Act reviews. Whilst the provider's response had been slow, records of independent doctors' attendance for independent reviews were now maintained. Front line staff were also acting to ensure the Code of Practice was adhered to, for example, chasing up doctors to complete reviews of patients in seclusion.

The provider acknowledged the use of blanket, non-individualised restrictive practices and the rate of use of restrictive interventions was too high at St Andrew's Healthcare and disproportionate to the required need for use of these practices for safety and patient recovery. The reasons given for the high use included, culture, lack of clarity, lack of knowledge, inadequate environment and failure of multidisciplinary teams holding each other to account.

The provider had a reducing restrictive practice and violence plan, overseen by the restrictive practice monitoring group. The provider's plan (only seen as a presentation) set a target for reduction in restrictive practices and violent behaviour by one-third by 2020. The plan identified a need to provide further training to staff, including trauma informed training and injection site training. Plans also included experts by experience delivering training to staff. The provider also operated a trauma response service for staff, accessed via email. Following further requests for additional detail about the plan, the provider sent as part of their challenge to the draft report, a detailed document outlining how this work may be achieved in line with the national reducing restrictive practice strategy.

We reviewed data for incidents of patient restraint, seclusion and long-term segregation across all services between May and October 2019. Overall, incidents of

patient restraint were significantly increasing. In May 2019, 767 incidents were reported. In October 2019, this had risen to 1128. The highest number of incidents reported across this period were 216 in July 2019 on Meadow Ward adolescent service (17% of all restraints for that month). Increases in the use of restraint were also seen for Maple ward (adolescents), Bayley ward, Hazelwell ward, Spencer South ward, Springhill, Seacole ward and Stowe ward (all women's' wards).

The psychiatric intensive care units, Frinton and Bayley wards, reported the highest use of prone restraint and rapid tranquilisation (26% and 29% respectively).

The provider reported an average reduction in length of seclusion episodes. We reviewed data between August 2017 and August 2019 from the safety framework data management tool, which confirmed these reductions. However, there was little change in the number of episodes of both seclusion and long-term segregation. Therefore, there was a lack of evidence that the provider's restrictive intervention reduction plan had been successful in reducing incidents of restraint, seclusion or long-term segregation, but a decrease in length of seclusion episodes had been achieved.

Modern matrons reviewed daily reports of patients in seclusion to check the length and frequency of seclusion episodes. These were further reviewed with staff. All wards had their own restrictive practice log. Staff and patients log all restrictive practices and review these in meetings. Each ward and/or IPU had a restrictive practice reduction champion, that functioned as a change co-Ordinator.

The medical director was the assigned 'responsible person' under the Mental Health Units (Use of Force) Act 2018.

The provider was completing a thematic review across services, for example, their low secure units, to understand where and why there were differing levels of restriction placed on patients.

A review of the Mental Health Services Data Set (MHSDS) for the period January to December 2018 showed:

- For the rates of recorded assaults, adverse events and restrictive interventions, Northampton flagged as being in the highest fifth when ranked in relation to other independent health providers reporting these events for six of the seven indicators examined and in the second highest fifth for the seventh. However, Essex and Nottinghamshire have also flagged across a number of these indicators as well.
- All four sites flagged as 'much worse' for rates of recorded assaults by patient on patient, and Nottinghamshire was flagged as the worst location in the whole cohort of mental health independent health providers (that were supplying data to MHSDS). However, some of these results may reflect better recording than other independent health providers or may indicate higher rates

The provider produced an annual mortality report; however, this was undated and lacked detail. Detail contained in the mortality report did not match that in the quality accounts report. For example, the mortality report covered the period 1 January to 27 November 2018 and discussed 16 deaths, plus a further three which were unexpected and subject to serious incident investigation. The quality accounts covered the period April 2018 to March 2019 and recorded 15 patient deaths, two of which were unexpected and under investigation. We were unable to reconcile these figures.

The mortality report showed six cases of pneumonia. However, there was no evidence of trend analysis for these deaths. Learning from deaths concentrated on the process rather than the clinical practice or clinical learnings. The report showed two further reviews of deaths in November and December 2018 had not yet been completed. We were concerned any important lessons to be learned would be significantly delayed as it was not intended to publish these reviews until the January 2020 report. The report recommends refinement of governance structures to ensure learning occurs in concert with quality and compliance processes. No further detail on how this refinement should occur was provided in either report.

The provider launched a new integrated practice unit 'community partnerships' on 01 October 2019. Formerly known as the consultancy service, the IPU offered medico-legal services, outpatients' clinics, criminal justice and a service for veterans, on behalf of NHS England.

**Research**

The provider was actively involved in research. The provider had an allocated research budget and a focus on research projects that were practical and meaningful to

care, and services provided. Examples of recent areas of study included the virtual reality in dementia project; where patients living with dementia, took part in a study, using a virtual reality headset to 'visit' one of five virtual environments. Findings concluded that the use of virtual reality technology could vastly improve the quality of life for people with dementia by helping to recall past memories, reduce aggression and improve interactions with caregivers. The provider was also participating in the National Institute for Health Research (NIHR) funded study on clozapine in borderline personality disorder and research projects into sleep and exercise in secure mental health.

**Accreditation**

Independent providers can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The provider's women's secure services were accredited by the quality network for forensic mental health services (QNFMHS). The psychiatric intensive care units were members of the national association of psychiatric intensive care units (NAPICU) and the adolescent service mental health wards were members of the quality network for inpatient CAMHS (QNIC).

**Processes for managing risks, issues and performance**

The provider was developing systems and process to monitor risks, issues and performance. However, these were still developing, and improvements were required.

The provider was not always aware of risks within services. Qualitative analysis suggested that data gathered by the provider that would allow them to identify and record risks may be of poor quality. Mental Health Act reviewers' reports and provider action statements indicated that patient records, seclusion records and medication records were judged to be improperly completed. A related risk is of the service not being aware of key risks and therefore unable to take appropriate action.

Qualitative analysis highlighted that similar safety incidents had recurred multiple times across services, this may suggest that any systems in place to learn from such incidents were either not fully embedded or not effective in mitigating risks. Provider action statement data highlighted that safety risks related to ward environments, including ligature points, were identified during Mental Health Act visits.

The provider had a newly developed strategic assurance framework (SAF) and corporate risk register. However, it was difficult to see how risks were escalated from ward to board through this process. Staff told us the process was still developing.

The provider used the strategic assurance framework to monitor risks against the strategy. However, this document was still developing, and gaps were identified. The document covered the provider's six focus areas and detailed the objectives, controls, responsible managers and lines of assurance. Executive leads had been assigned to each of the six focus areas, with members of the charity executive committee assigned to oversee specific objectives, and members of senior functional management assigned as objective owners.

The strategic assurance framework was reviewed monthly by the charity executive committee, during its strategy meeting. However, the document was last reviewed by the board in May 2019 and despite being updated in July 2019, contained gaps. For example, all overall board assurance levels were recorded as 'to be determined' and one goal, around 'further specialist services, utilising technology and innovation, are developed, that will enhance existing offers' did not contain a description of assurances. Whilst there was a clear desire to implement and use this tool to gain assurances against strategic risks, this was still in its early stages.

The provider monitored risk via a number of risk registers. Staff reviewed risk registers during meetings. We reviewed a risk register from an integrated practice unit, a support function (pharmacy) and the corporate (material) risk register. All risk registers used a standard format, including identified risks, actions, risk owners and target completion dates. The provider included risk mitigation within all registers. We noted that 'failure to comply with existing or changing regulatory requirements' was recorded on the material risk register, with action to continue to embed the new governance model as an action. A completion date of

# Are services well-led?

29 November 2019 was recorded. There were escalation paths, however operational leads were not always clear who would escalate the risks and what criteria would be used.

The provider had developed an innovative safety framework, a data management tool which produced live data from the electronic incident reporting system. The framework had been available since May 2019, and allowed front line staff, managers and senior leaders to view live data for a few incidents, for example seclusions, long term segregation, staffing, complaints, medication errors and restraints. Staff reviewed data broken down by individual patient, wards, IPUs or service overall. Managers reviewed trends over time to establish where 'hotspots' were occurring to complete investigations or take other necessary action. The tool alerted staff to anomalies in the data by a series of coloured dots, set to alert where data exceeded set parameters. The provider had worked with NHSI to set the current parameters, but these could be amended over time as required. Senior managers told us this tool gave them the information they needed to review practice and make improvements in a way not possible previously. The provider informed us that outside agencies had taken a keen interest in this tool and the charity was willing to share this technology outside of its services.

The provider was producing a new integrated performance report to allow a variety of information to be visible in one area, for example, agency use, staffing and incidents of violence. This will allow all the information to be brought together so staff can start to overlay performance from different areas. This report was in final stages of development.

We reviewed incidents (per 1000 occupied bed days) at unit level for a six-month period to October 2019. Trends over this period showed an increase in incidents of self-harm, restraints and prone restraints, safeguarding, and violence. Gaps in staffing were reducing. Other areas showing as static included rapid tranquilisation, long term segregation complaints, falls, pressure ulcers, serious incidents, seclusions, enhanced support, infection prevention and control and medication errors. As the framework was early in its development and use, it was not yet possible to determine what positive impact on patient outcomes had been achieved.

The provider reported high numbers of injuries to staff following assaults by patients. Recent inspections had found the provider had support in place via trauma counselling and occupational health. The provider had recently launched a 'zero tolerance' campaign.

All NHS providers are required to provide information security and protection assurances to the NHS on an annual basis. The provider had met its mandatory requirement for the year, with a reducing number of incidents reported. Two incidents were reported to the Information Commissioner's Office during the year, but no action was required.

The provider had an incident command manual to support the management team in organising and delivering a proactive response to significant disruptive events, which have or may have the potential to cause major disruption to patient care, and to the services and functions that support the delivery of patient care. All potential significant events were included. A pandemic preparedness plan was also available.

**Engagement with the people who use services, the public, staff and external partners to support high-quality sustainable care**

The provider had recently formed better working relationships with external stakeholders to begin the process of including others in a way that contributed to delivering high quality sustainable care.

The provider had begun looking outside of St Andrew's Healthcare services to improve practice and develop services. The provider had established links with two NHS mental health trusts to review their quality improvement programmes, with the intention of taking learning, and have sought support from another NHS organisation to undertake a review of their adolescent services to promote improvement in that service.

Staff were also sent externally to other organisations to view practice. However, we were advised this had taken place for a few years and therefore we questioned its success; given recent inspection findings.

Stakeholders, including commissioners were positive about their experiences of services. Overall, stakeholders reported good relationships with the provider and were mostly satisfied with outcomes for their patients.

# Are services well-led?

Healthwatch provided information relating to two complaints; both of which were known to CQC. The provider was working with Northamptonshire carers organisations and clinical commissioning groups.

The provider participated in the 'Reach out Partnership', a partnership between the three providers of secure inpatient care in the West Midlands: who worked collaboratively across the partnership, streamlining processes and care pathways and focusing on care in the community, Reach Out has reduced the number of patients in hospital by 32 (5.8%) and significantly reduced the proportion of out-of-area placements from 33% to 26% (48 fewer patients).

**Engagement with people who use services**

The provider had a patient involvement strategy 2016-2021, overseen by the patient involvement team. This included five patient involvement standards. The strategy identified that updates on progress against the strategy would be published on its website each quarter and updates on progress of the implementation of the strategy will be provided to the board of directors and the court of governors at regular intervals. We were unable to locate updates on the website, or discussion within board papers we reviewed.

We reviewed the patient engagement assurance report to court of governors 31 April – 31 July 2019 and saw the carers strategy monitoring group had met on two occasions during this period. Plans were identified for the appointment of two carer governors and six patients were involved in developing the least restrictive practice training module for staff. A patient-led focus group was held to review and develop the draft patient charter.

Results from the patient survey were included in the report which showed a significant improvement in the response rate on previous years, having increased to 66%. The top issues identified were receipt of written information, leave and/or activities cancelled due to staff shortages. Forty two percent of patients who made a complaint felt that it was addressed.

We reviewed the board meeting minutes for March, May and July 2019. The board dedicated time and effort to engagement matters. Attendees of the March 2019 meeting discussed focus groups exploring the organisation's values and strategy that had taken place with patients, carers and staff. Board meetings discussed specific cases and complaints and a member of the patient involvement team was in attendance of the July 2019 meeting.

The March 2019 minutes also referred to the creation of two 'staff constituency governors', however the detail of the role was not explicitly detailed in the three board meeting minutes we reviewed.

The provider subsequently advised they had appointed two carer governors and two staff governors to the court of governors, to bring the role more in line with that recognised within NHS foundation trusts.

In each of the three meetings, time was dedicated to patient voices including compliments and complaints. In July 2019, a patient acting as the chair of Birmingham, Essex, Nottinghamshire, Northampton sites (BENNs) committee attended the board. She gave an update on her work placement within the patient engagement team, indicating efforts to improve patient engagement with the charity. She also shared her blog in the meeting which she had started on the St Andrew's Healthcare website to break the stigma of mental health and show what it was like to live in a hospital.

The provider involved patients with staff appointment at all levels including chair, chief executive and board appointments. Patients attended and opened induction programmes. All training, courses and programmes were co-produced within the recovery and everyday skills academy (REDS).

The provider had innovative and successful arrangements to support carers and families. We were particularly impressed with the carers centre, opened just over a year ago. The centre was open seven days a week, provided a homely environment, support and information for visitors and signposted carers to local services. Carers spoke highly of this facility and those working within it.

The provider operated a Workbridge programme at the Northampton and Birmingham sites. The service supported patients with opportunities to learn new skills and access vocational activities. The employment support service supported patients to access paid and voluntary opportunities. Over the past year 60 patients had secured work placements in the local communities.

# Are services well-led?

The provider had a target of ten schools to be signed up for their quality mark and training packages by 2019. The quality mark is an award, assessed against a set of criteria, for schools who support students suffering with mental health issues. To date, 20 schools had signed up. A further target of 50 schools had been set by 2022.

The provider offered access to free family accommodation in local properties for visiting families. The provider also funded a set number of patient visits home by agreement.

**Engagement with staff**

The provider had an annual employee engagement survey 'your voice'. The 2018 survey identified an overall engagement score of 66%, up from 64% in 2017. It also showed that 60% of staff were proud of their workplace, 62% were optimistic about the future and 75% were willing to give extra effort. The top three issues identified were: leadership and leadership visibility, recognition and communication. The provider described a variety of interventions for improvement, but we did not see any clear action plans with proposed or completed dates.

The provider supported learning and development for staff, investing over £3.5 million in staff education each year with over a £1 million coming from education grants and by maximising the use of the Apprenticeship Levy funding. The provider reported 23,000 days of learning a year, six days of learning per staff member per year, and 108 apprentices. The provider achieved approved apprenticeship provider status and had developed and run range of management and leadership programmes.

The provider offered an educational programme known as 'Aspire'. This programme supported health care assistants to qualify as nurses. The annual report 2018/19 reported 90 staff at various stages of training, and 25 staff qualifying during the year. The provider provides 25 bursaries each year.

The provider held awards for staff. Every month, staff from across all services nominated one another for displaying the provider's value behaviours in their day-to-day work. The provider reported increases in staff nominations, year on year from 2015. In 2015/16 there were 406 nominations, 1,080 in 2019/19 and 1141 for 2019/20 to date. Each quarter, integrated practice units (IPU) and enabling functions nominated the best monthly winner per value for their area (28 in total). Four winners were selected for recognition at an annual awards dinner along with awards for: Making a Difference, Team of the Year, Inspirational Individual, Volunteer of the Year and the CEO Award.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>• The provider's governance systems were not yet integrated. There was minimal evidence of scrutiny or challenge, to either corporate or clinical governance, being delivered by the non-executive directors at governance committees.<br><br>• The provider had not completed actions required from previous inspections in a timely manner.<br><br>• The provider had not ensured learning from breaches and concerns from MHA reviews were shared across services to prevent recurrence.<br><br>• The provider had not ensured staff were appropriately supported to raise concerns in accordance with the Protected Disclosures Act 2014 and that policies and procedures were adhered to.<br><br>This was a breach of Regulation 17 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Assessment or medical treatment for persons detained under the Mental Health Act 1983<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>• The provider had a reducing restrictive practice plan in place. However, there was no clear strategy for this. Incidents of restraint were increasing significantly.<br><br>This was a breach of Regulation 12 |