Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS PART 1

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📅 26 July 2023

🕐 10:00 GMT+1 Europe/London

📍 Microsoft Teams

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AGENDA

REFERENCES Only PDFs are attached

Agenda Part 1 26.07.2023.pdf

	Meeting of the Board of Directors held in Public Wednesday 26 July 2023 at 10:00			

Vision: To be the leading health and wellbeing service in the provision of mental health and community care

PART ONE: MEETING TO BE HELD IN PUBLIC VIA MICROSOFT TEAMS

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION Moving Away from Care Program Approach (CPA) Mark Travella, Associate Director			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 31 May 2023	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Discussion
7.2	Committee Chairs Report	Chairs	Attached	Discussion
7.3	Board Safety Oversight Group Assurance Report	SS	Attached	Discussion
7.4	CQC Compliance Update	DG	Attached	Discussion
7.5	Summary of the Rapid Review into Data on Mental Health Inpatient Settings – Final Report and Recommendations	NL	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework 2022/23	DG	To follow	Approval
8.2	Emergency Preparedness and Resilience Annual Report	NL	Attached	Discussion
8.3	Infection Control Annual Report	NH	Attached	Noting
8.4	Learning From Deaths – Mortality Review Q4	NH	Attached	Noting

	Board of Directors 26 July 2023	

8.5	Mental Health Act Annual Report	NH	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
9.1	Ligature Risk Management Annual Report	AG	Attached	Information
10	**STRATEGIC INITIATIVES**			
10.1	Transformation Team Annual Report	ZT	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
11.1	Safe Working of Junior Doctors Report	MK	Attached	Noting
11.2	A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report	MK	Attached	Approval
12	**OTHER**			
12.1	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
12.2	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
12.3	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** Wednesday 27 September 2023 (TBC)			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 29 November 2023			

Professor Sheila Salmon
Chair

APOLOGIES FOR ABSENCE

⬤ Standing item　　　👤 SS　　　🕐 2 minutes

Manny Lewis

DECLARATIONS OF INTEREST

● Standing item   👤 SS   🕐 2 minutes

PRESENTATION - MOVING AWAY FROM CARE PROGRAM APPROACH (CPA)

● Other   👤 Mark Travella   🕐 15 minutes

MINUTES OF THE PREVIOUS MEETING HELD ON: 31 MAY 2023

⬤ Decision Item　　　👤 SS　　　🕐 5 minutes

REFERENCES

📄 Board Minutes 31 May 2023 (Final Draft).pdf

Minutes of the Board of Directors Meeting held in Public **Held on Wednesday 31 May 2023** **Held at Anglia Ruskin University**

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Nigel Leonard (NL)	Executive Director of Major Projects and Programmes
Natalie Hammond (NH)	Executive Nurse
Zephan Trent (ZT)	Executive Director of Digital, Strategy and Transformation
Trevor Smith (TS)	Executive Director of Finance and Resources
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Janet Wood (JW)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Stephen Heppell (SH)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Clare Sumner	Trust Secretary Coordinator
Dr Gbola Otun	Deputy Medical Director (For Milind Karale)
Alesia Waterman	Director of HR – Medical (For Sean Leahy)
Ian Carr	Director of Specialist Services (For Alex Green)
John Jones	Lead Governor
Stuart Scrivener	Governor
Pippa Ecclestone	Governor
Dr Mary Edmonds	Deputy Dean for Practice Learning and Simulation, ARU

SS welcomed Board members, Governors, members of the public and staff joining this in public Board meeting

The meeting commenced at 10:02

047/23	**APOLOGIES FOR ABSENCE**

Apologies were received from Sean Leahy, Dr Milind Karale, Mateen Jiwani and Alex Green.

048/23	**DECLARATIONS OF INTEREST**

There were no Declarations of Interest.

049/23	**PRESENTATION – THE SELF HARM REDUCTION PILOT**

Diana Luckie, Head Occupational Therapist (Adult Inpatient Services) advised that the Self-Harm Reduction Pilot had been taking place across the Trust over the past two years. In 2021 NHSE invested funding in STP, ICS and CCGs to establish or develop local suicide prevention plans to reduce the number of deaths by suicide in the UK by 10% by 2020/21.

EPUT was approached by MSE CCG to submit a self-harm reduction proposal. The pilot was developed over three locations, which at the time had the highest incidents of self-harm – Willow

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Date: ………………………………

In the Chair

Ward, Galleywood Ward and Christopher Unit. A proposal was put forward looking at staffing, training and resources to help reduce self-harm.

Staffing: It was identified that all round activity was needed on wards. It is often difficult to provide all round activity due to other interventions required by occupational therapists but by bringing in activity co-ordinators, routines and activities were created for patients. The pilot proposed two band 3 activity coordinators per ward including evenings and weekends.

Training: Psychology staff also attended DBT training and were then able to cascade this training to all ward staff, focussing on trauma informed skills and working with people with personality disorders and those who self-harm. Occupational Therapy staff were to also undertake training in sensory modulation and interventions, which is a practical technique that helps patients identify their own sensory needs.

Resources: Sensory modulation space and resources to be made available or the wards.

The proposal was submitted in 2021 and all requests were agreed.

The overall aim for pilot is to:
- Increase recreational activities to provide daily structure for inpatient service users
- Offer opportunities for physical and emotional expression.
- Diminish SIs relating to boredom including self-harm
- Reduce risk of suicide
- Free up clinical staff to increase therapeutic offer for all inpatients
- Enhance staff skills to support working with patients with self-harming behaviours.
- Support patients to better manage their self-harming behaviours

Progress so far:
- Sensory modulation training complete for all occupational therapists and occupational therapy assistants. Resources have been purchased and staff are putting training into practice. Sensory rooms are available on some wards across the Trust
- Discussions taking place with Mark Palmer to support trauma and self-injury (TASI) training with sensory techniques
- Psychology staff completed dialectical behaviour therapy (DBT) training and provided in house training for staff
- Activity coordinators recruited, and now extended to include all adult inpatient units across the Trust
- Time to care recommendations have included activity coordinators in staffing structures.
- Planned training for Activity Coordinators includes trauma informed care, managing group dynamics, sensory techniques (for those wards with no sensory room there is mobile sensory equipment to bring to the ward), introducing physical activity, relaxation and mindfulness.

Service user feedback has been sought including a smart survey carried out on Gallewood and Willow in November 2022.
- 100% respondents reported they attended activities on wards
- 40% attended more than once a day and 26.7% attended at least once a day
- 62.5% found activities to be very helpful for their mental health
- 68.8% felt there were enough activities on the weekend. The Trust are looking to increase this via the Time to Care programme.
- 85% reported have attended a sensory based session
- 93% found helpful or very helpful
- 31.3% currently self-harm or have previously, of those, 80% found activities on the ward helpful or very helpful in reducing urges to self-harm.

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In the Chair

Feedback feels conclusive that the increase in activity has had a significant impact on patient's experience of the ward.

RH queried whether there was any quantitative data to demonstrate the impact beyond qualitative information gathered. It is recognised there are many recommendations going into Time to Care and significant investment so it would be useful to have understanding of quantitative data also. RH also noted that it is widely acknowledged that there are recruitment challenges within the NHS and whether DL had any thoughts on this. DL advised that there had been a high number of applications, but the difficulty was getting right person in the role. The posts had now been filled but all had been on fixed term contracts during the original pilot. These original pilot activity coordinator roles are now permanent but activity coordinators for other wards are fixed term. Secondment opportunities are being explored. The Activity Coordinator role is an attractive role and should they be permanent DL did not foresee any issues that may affect recruitment. SS added that the Time to Care programme as well as apprenticeships would also offer route for progression, which also made roles more attractive.

LL queried how when a patient transitions, how we manage the transition to retain independence. DL responded that the change in approach has allowed OTs to adapt support provided. An AHP review has also been undertaken and are keen to start incorporating transitional work. It is recognised that there is a lot of support when on the ward that ceases when a patient leaves. The team have already begun to explore working closer with community team OTs regarding transitional support. There is a pilot in Colchester, Rochford and Basildon for secondment opportunities for OTs to look at what that transitional support looks like, making links with community services and other services available, as well as linking with other organisations to enable closer working. There is a key role for OTs to find out what support is available beyond the ward environment and signpost and introduce patients to those services so that when they are discharged support is available.

LL suggested that there may be an opportunity to consider patients taking on the role providing evening and weekend cover as part of their transition process / volunteering arrangements to expand the service in a creative way. DL agreed that peer support workers could be considered as a possibility.

ML referred to a recent visit to Hennage ward where had had found the ward manger's feedback around the role of the activity coordinator to be very positive and that they make such a huge difference. During the visit ML had witnessed a session where the coordinator was actively engaging with patients and agreed that this was an essential role therapeutically for our patients and supported the suggestion of volunteer positions as part of the transition process. ML also queried whether there were any opportunities to link with charitable organisations to support as there may be real opportunities to expand this to support our patients. DL agreed advising that activity coordinators were also looking at bringing people and support into wards, e.g. support dogs etc. and were actively looking at voluntary services to help support.

GB advised that as a consultant on Christopher unit he had seen a reduction in aggressive incidents, and agreed that there would be a missed opportunity to not include quantitative data although acknowledged that there are other elements that also impact occurrence of incidents. DL agreed stating that the difficulty is in how to evidence quantitative data. ZT offered the support of the IT team.

EL commented that social interactions play such an important role in recovery and are proven to have effect, suggesting that it may also be beneficial to track whether there was any impact on length of stay. EL queried whether DL and team felt an integral part of multi-disciplinary team; DL responded that all OTs attended MDT meetings and are part of treatment planning. OTs bring a

different perspective to MDT and different skills, and combined with other members of the MDT all bring something to the table.

SS agreed that there was a real richness from different professional perspectives coming together and thanked DL for sharing with board.

050/23	MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 29 March 2023 were agreed as an accurate reflection of discussions held subject to the following amendment:

P8 – Peer Support Pilot is ongoing rather than in past tense.

051/23	ACTION LOG AND MATTERS ARISING

The action log was reviewed and noted actions closed.

The Board discussed and approved the Action Log.

052/23	CHAIRS REPORT

SS presented the report and formally welcomed EL as NED. SS advised that sadly Jill Ainscough had stepped down from the NED role for personal reasons, which had enabled EL to step up earlier than anticipated.

Executive Chief Nurse Prof Natalie Hammond will be leaving EPUT at the end of July. On behalf of the Board, SS extended congratulations to NH on her new role in HWE ICB as Executive Chief Nurse. SS thanked NH for her significant contribution, vision and leadership during her tenure with EPUT and formally NEP.

NEDs were able to attend a HWE ICB event last week, with NH in attendance in her designate role. This was a prestigious event with Rt Hon Patricia Hewitt sharing outcomes of the Hewitt Review and a keynote speaker from EPUT on virtual wards.

NH was pleased to note celebrations that had taken place across EPUT as part of International Nurses Day, noting further cause for celebrations with a significant number of international nurses welcomed into EPUT. NH was pleased that feedback shows the passion and pride international nurses have brought. NH noted the Board of Director's appreciation and celebration of all nurses across the Trust.

The Board received and noted the Chair's Report.

053/23	CEO REPORT

The CEO report was taken in combination with Quality and Performance Scorecard.

PS highlighted the following:
- PS echoed SS's comments that NH is great loss to the organisation, however acknowledged the achievement of NH as a MH nurse of such standing going into a system leadership role and the value of NH's experience to this role. PS looked forward to continuing the improvement journey.

Signed: ……………………………………….   Date: ………………………………

In the Chair   Page 4 of 18

- Feedback coming in from MHED shows the number of patients leaving with a care plan is up to 90% - this was a positive outcome for patients to be able to work with professionals to put together a structured care plan.
- Crisis response continues to expand with a joint response car with the ambulance sector receiving good feedback. Enhancing the quality improvement approach will allow the Trust to build in measures of success to monitor impact and this is something to consider when building in to initiatives.
- Addressing IT and infrastructure issues around EPR, ZT had played a valuable role in raising the profile and working with MSE to get national attention and funding, a visit of the national director and positive feedback. PS thanked ZT for working to raise the profile and receiving positive feedback from the national team.
- Executive Directors visited Brockfield House recently and were pleased to see the impact of international nurses on our wards. There was learning from the process but nurses that are here are committed and passionate.

Referring to the Independent Inquiry and supportive visits to services by NL and team, EL queried whether examples of questions staff members have raised have helped to see the inquiry from a front line perspective. NL confirmed that visits had been made to inpatient sites; this had been prompted by discussion at ET following feedback from staff. Generally staff are concerned what the inquiry will mean for them; many questions were from staff that had answered the call to give evidence and were seeking assurance when they may be likely to hear from the Inquiry Team and what the process would be. The site visits had provided the opportunity to talk through levels of support available to front line staff and speak to staff directly. Good response had been seen and visits to inpatient areas will continue as well as picking up with community teams.

EL referred to the recent Dispatches documentary that focussed on Autistic patients in other NHS Services and queried whether there were any issues or learning for EPUT to pick up. NH responded that information has now been received around the new consultant role for autism and the role that will have. EPUT will have a senior psychiatrist taking up this role and there will potentially be great interest externally as this is the only role of its type across the region. This provides an opportunity to enable and educate and the role will be drawn out with the national team as well. Dr Zaman has also altered the suicide prevention strategy so we are clearly engaging with those on that pathway.

NL picked up on the information within the report around the Dispatches relating to two EPUT inpatient wards stating that the response made within the report is comprehensive in terms of the action plan. NL continued that the presentation on the self-harm reduction pilot further demonstrates the positive impact on wards and the trust overall.

ML noted the positive impact seen as internationally recruited nurses have gone into wards, during service visits this had also been reinforced strongly by ward managers and colleagues. ML noted that one issue monitor is that the majority were RGN and not MH qualified. Some feedback received is that while the staffing complement had gone up, support RGNs require in the mental health setting is significant, and they are unable to medicate or care independently. There is still a challenge around how each ward works practically and how to ensure RGN qualified nurses are converted to RMN. It is important to support managers and staff with coaching and development. Another key element is how to retain staff.

In response to EL's comment around autism, PS stated that it was positive to have the consultant position commencing but what was also important, was to work with families and voluntary groups. Autism is a condition that goes beyond EPUT and MH boundaries and as such, we need to work with Local Authorities and Social Care, working closely with partners, service users, and families to build and strengthen networks. There is more to do but EPUT are on the right track with the specialist consultant role.

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Performance – PS
The Trust continue to work hard on a number of areas including IAPT waiting time, Lighthouse Centre and Out of Area Placements (OOAP). There is currently an intensive piece ongoing around OOAP and making sure inpatient capacity is right. There is dedicated support to inpatient flow and PS was pleased to see a reduction in OOAP made over the past months. PS commented that we need to try to secure this important issue over the summer and make sure it is sustainable over winter.

Psychology services has seen a reduction in waiting times, with PS pleased to have recruitment plans in place which should get to a more sustainable space.

As previously referenced the international recruitment programme is beginning to have a positive impact but the Trust had also seen domestic recruitment begin to improve, as well as ongoing support with student placements and recruitment.

Finance – TS
TS advised that the final accounts for the 2022/23 financial year remain subject to audit. External auditors have been with us on site for the first time since the Covid pandemic. The finance team are currently preparing for closure of the Month 2 position. It is acknowledged that this will be challenging year to continue to deliver to plans on the revenue position, however there is also opportunity. Capital is increasing and a plan for £20m in investments and an increase in investments since the last financial year are underway.

NH advised that the planned joint Safety Conference with ARU continues to be planned and advertised. At the last Board meeting, NH had outlined the achievements of year 2 of the safety strategy and now the focus moves to year 3 priorities. The conference held in partnership with ARU on 15 June looks to be an exciting and informative event with speakers from the national patient safety team, Civil Aviation Authority, EPUT staff and Oxehealth. NH encouraged as many colleagues as possible to attend the safety conference.

PS stated that what had been heard through the report was challenges faced and the work the Trust are doing to continue to progress performance and safety; there is a significant amount of good work taking place across the Trust and we are beginning to see improvements as a result. All of this is underpinned by sound management of resources and use of resources in creative ways to achieve different outcomes.

SS was pleased to see the impact of international recruitment and also the improvement in domestic recruitment. SS also noted that the Trust also have apprenticeship provision as a main provider of apprenticeships in the locality. This will help with recruitment around psychologist apprenticeships and other pathways.

The Board received and noted the CEO's Report.

054/23	QUALITY AND PERFORMANCE SCORECARD

Discussed as above.

The Board of Directors received and noted the report.

055/23	COMMITTEE CHAIR'S REPORT

Signed: ……………………………………… Date: ………………………………

SS noted that this report summarised assurance reports from the Board of Directors standing sub-committees, which were crucial for governance and for the Board to be able to discharge responsibility appropriately.

Audit Committee – JW
- Thanks to TS and DG and teams for submitting the draft annual reports, this would hopefully be concluded by end of June.
- The Internal audit had now been finalised on operational performance.
- Work had been commissioned to look at accountability framework arrangements and substantial assurance of design. Two recommendations had been received one medium and one low, both had now been accepted and implemented across the organisation.

Finance & Performance Committee – LL
- The F&P Committed had received a number of significant business cases for approval, EPMA, EPR, conclusion of data strategy and Time to Care. All are significant transformation programmes for EPUT. F&P will keep an eye on this work as the organisation works on implementation of these programmes and investment managed through F&P
- A new electronic dashboard had been launched for F&P, LL was pleased to see this first step that has within it the promise to allow much fuller discussions.

People Equality and Culture Committee – ML
- Real innovation is coming through in terms of data on workforce and what that means for developing our teams and diversity.
- There is a very positive ambition around recruitment targets and a strong pipeline of domestic nurses.
- Overall this continues to be good meeting.

Quality Committee – RH
- Complaints new process has been in place from January and there is already emerging evidence of this having a positive impact.
- Patient experience, there has been a significant increase in the number of lived experience ambassadors across the Trust and we are beginning to see influencing of coproduction.

The Board of Directors:
1. **Received and noted the contents of the report and the assurance provided.**

056/23	BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

SS continued to chair this group on an interim basis which was moving forward efficiently and effectively. SS was grateful to executive directors for their strong support of oversight which keeps things moving in the safety space and maintains positive traction.

EL was pleased to note that within the report confirmation that the Lakes Garden refurbishment was underway, and commended the staff for additional efforts to ensure patients get fresh air and time out during these works.

The Board of Directors:
1. **Received and noted the contents of the report.**

057/23	STAFF SURVEY AND BANK ONLY SURVEY 2022

Signed: ……………………………………   Date: ………………………………

AW advised that the national survey had seen an increase in the response rate, and in addition EPUT had also carried out a bank only staff survey. The response rate is lower than the national rate, however is higher than the average bank return.

Responses from the bank worker only survey indicates that staff are responding to say that they felt safe and healthy and less likely to feel burnt out at the end of a shift. Results from this year will be drawn on to focus on key areas for engagement, with an action plan developed into four priority areas around raising concerns, creating an inclusive environment, staff wellbeing and engagement.

Focus groups are also taking place including bank staff as well as substantive staff, following which an action plan will be built around feedback from staff and what they would like to see.

NH stated that often it is spoken about how our staff and colleagues need to feel supported and wrapped around the organisation and it is inherent on us to make people want to work for EPUT. NH was curious what can be done together to make a change and encourage bank staff to take up substantive positions. AW confirmed that as a key action and the team were working with temporary staff around how to engage. Information has been taken from the free text element of the staff survey and discussed at focus groups. There is also a key campaign to encourage bank to substantive positions and to understand if bank staff did not want to do so, why not and what we could do to encourage uptake.

ZT thanked AW for the helpful report which gave huge insight into how staff experience working in EPUT. ZT was encouraged to see some notable improvements year on year around WRES, although acknowledged BAME colleagues continue to report experiencing more bullying and harassment than white colleagues, this is an area making improvement but there was still some way to go. WDES show some areas of improvement, although again outcomes for staff with disability compared to those without long-term condition or illness still see some marked differences. ZT would be interested to hear more about focus in responding to that feedback and acknowledged the time and effort the director of EDI had put into improving these metrics.

LL reflected that organisations where results of the staff survey are high are likely to be an outstanding organisation. LL suggested that the Trust could reach out to outstanding organisations to understand what makes an outstanding organisation outstanding. The Trust needs to be more outward looking to see what it can learn and incorporate.

EL noted that out of 27 actions, the employee experience team were identified as the owner of an action, and queried whether there was sufficient resource in the team. AW responded that the employee and engagement team are the leads and were working closely with operational teams as well. The key focus for actions include a key focus around partnership and as such, an MDT approach is being taken being represented and supported properly to carry forward actions.

SS commented that this was an important temperature gauge; the Trust is on a journey and it is important to keep momentum up and close off those loops as we move forward with equal focus on not only recruiting new staff but retaining existing staff.

PS stated that the Trust were building good relationships as part of our collaborative work, this includes outstanding trusts and so there may be a good opportunity to make connections and learn from each other. NH added that having seen some comparison around results and how other trusts fare, EPUT were second in the ranking when compared to acute organisations. NH agreed this is where system partnership should come in with cross fertilisation and learning from neighbours. .

ACTION:
1. **To consider process for linking with and learning from outstanding organisations.**

Signed: ………………………………………….   Date: ………………………………

In the Chair   Page 8 of 18

SS commend the work ongoing and ambitions moving forward. IC agreed stating that work had commenced through HR business partners and the leadership team examining what the report is telling us and particular areas of focus across care units.

The Board of Directors:
1. **Received and noted the contents of the report.**

058/23	SAFE WORKING OF JUNIOR DOCTORS ANNUAL REPORT

GB presented the report stating that Junior Doctors were essential for the organisation and were involved in the development of urgent care. There are many initiatives in place across the Trust to support this cohort of staff including safe working and interventions. There has been an increased number of junior doctors in the organisation and an increase in the number of applications over the past few years. Similar to issues around nursing, recruitment team are looking to encourage foundation trainees.

In terms of junior doctor industrial action, meetings took place with HR to ensure patient activity was not adversely affected. An MDT approach was taken to ensure patients remained safe during this action and it is hoped for a resolution to avoid any future strike action. Contingency planning is however taking place in the event of future strikes.

SS expressed thanks to consultants and colleagues for providing cover to ensure medical care continued during the recent strike action.

The Board of Directors:
1. **Received and noted the content of the report.**

059/23	CQC COMPLIANCE UPDATE

DG presented the report which gave feedback from Willow and Galleywood inspections that took place in October 2022. The final report was published in April. It was reassuring that the final report listed the majority of items were all known within the warning notice which the Trust had taken immediate steps to address. There were minor differences between the warning notice and final report, in particular the removal of all blanket restrictions, this now states that restrictions will be removed where safe to do so and is in recognition some restrictions are in place on the back of environmental issues. The second is around Oxehealth and it is now stated the Trust must make people aware of how this system is used within our services. There is a pause between publication of the report and the report from November inspections to complete reflection around what can be done to keep sustainable over time. The Trust are working with KPMG to put in metrics to feed to the Quality Committee and Executive Team to check and balance that so we don't lose sight of these important issues.

There are some areas of positive practice and good work taking place which are also highlighted in the report.

The report contained an update on all actions and progress to date. Areas that are behind timescale are in relation to recruitment but have made significant inroads and are starting to make some traction.

NH commented that the volume of everything to get right at any given point is significant for our workforce. As we look at practice, NH wanted to recognise the work that had gone in to clinical records, and the kindness displayed by our staff. The safety element never stops and since the CQC

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visit the Trust have been in constant motion, but must continue to keep going back to check where we were good, has this been maintained.

SS agree is important to note the good and be encouraged by that on this continuous journey of quality improvement.

The Board of Directors:
1. **Received and noted the content of the report.**

060/23	BOARD ASSURANCE FRAMEWORK 2022/23

Following the report on year two of the safety first safety always safety strategy, NH as SRO had completed a review and proposed a reduction in SR1 in recognition of work done.

There were no new risks and no closed risks to note.

SR3 is a complex risk around system processes and infrastructure, a view had been taken split into two discrete and distinct risks. SR3 with a focus on finance and SR9 will focus on digital.

Internal audit of risk management arrangements took place and it is positive to note movement up the maturity scale. The plan is now to accelerate and achieve full maturity across the organisation.

Susan Barry Risk Manager has been in the organisation for many years and will retire at the end of July; on behalf of the Board DG expressed thanks for her contribution to the BAF process and shared well wishes for the future.

RH stated that it was good to see risk score reduced. RH sought an update regarding the corporate risk around loggists that was due to be discussed at the Executive Team in April. DG advised that the issue was around training being provided at a regional level and was waiting for courses to be put online. There is currently a pool of loggists however this was around building a resilient bank of loggists.

With regards to the reduction in score around safety, ML stated that realistically safety is our biggest risk and did not understand how that does not translate across to our risk assessment. NH agreed this was difficult to balance, but needed to acknowledge the impact some of the efforts of safety strategy and outcome measures that had been seen to suggest that we are becoming a safer organisation and continuous review will need to take place. Actual outcomes are significant enough for us as a board to say what is impacting in the safety agenda is allowing us to have more control and mitigation. ML stated that there was a perception point here also, and requested the Executive Team to consider further, and challenge this review. JW agreed that this was a point well made and was something to reflect on in Quality and BSOG. The Trust's biggest risk was safety and so there needs to be full confidence and possibly build something in to internal audit to build into our confidence. DG commented that although reduced, this continues to be a significant risk; the Trust is seeing less high-level harm than historically but acknowledge and recognise this is a significant risk with lots to do.

SS noted that this was a very structured piece and clear arguments expressed and requested the Executive Team and DG to keep on track as we move on.

The Board of Directors:
1. **Received and noted the contents of the report.**

061/23	END OF YEAR GOVERNANCE REVIEWS

Signed: ………………………………………… Date: ………………………………

On an annual basis as a foundation trust, EPUT are required to make self-certification against its foundation trust licence. Each have been through relevant forums for review and discussion prior to submission to the Board.

General Condition 6 – G6 within FT licence. Twenty-eight individual statements to be compliant with – EPUT reporting compliance with all.

Continuity for services 7 COS 7 – statement to confirm that within next 12 months the Trust will have resources available to sustain services going forward.

FT 4 – compliance with code of governance. There are a small number of items highlighted as yellow but overall are still compliant. Items highlighted noted effectiveness reviews for committees are in progress but not competed.

Certificate around provision of governor training and have provided sufficient training to allow them to discharge their duties as governors.

The Board of Directors:
1. **Noted the findings of the internal review of the Trust's compliance with the Code as a pre-requisite assurance to the Board of Directors in the preparation of the Trust's Annual Report 2022/23; and confirmed acceptance of assurance given as evidence that the Trust complies with the provisions of the Code.**
2. **Approved the detailed review of Trust compliance against the Provider Licence for the preparation of relevant submissions within the annual report.**

062/23	COMPLAINTS AND COMPLIMENTS ANNUAL REPORT 2022/23

ZT presented the annual report for approval. During 2022/23 631 complaints were received which was a 2% increase on the previous year (acknowledging that there are some changes around how complaints were reported). 2195 compliments were received in the same period which was an increase of 13%. 1337 inquiries were received by PALS, which was a 15% increase. This requires a significant amount of activity to support people to navigate EPUT, NHS and social care services.

Set out clearly within the report is that the Trust had made some fundamental changes in how complaints were handled with effect from January 2023. This was following a comprehensive review of existing processes and took principles of coproduction including the view of people who had made complaints to the Trust, which had led directly to the changes made. ZT also advised that in the spirit of demonstrating the importance of coproduction, the proposal for change was made jointly by a service user and the head of the complaints team.

A key change is the move to a model of complaints liaison to have better and more focussed relationships with complainants, and treat all complaints as complaints rather than trying to categorise them, with a focus on how to get to the most appropriate outcome resolution.

Principles of change include wanting to ensure the approach was fair and accountable, that we communicate and respond in a timely manager, have a just and learning culture and staff feel supported when responding to complaints.

Following the review of the complaints process, the ability to respond and resolve complaints had improved with a 35% reduction in time to resolve a complaint since January this year. This indicates a positive outcome and significant change.

JW noted that within the report information is given around NED quality reviews of complaints – JW was delighted at the new process and system, JW was working with MJ and SH to design a feedback loop based on a five point assessment. This was coming together and seeing improved timelines of response.

SS was encouraged, acknowledging the process required revision and regeneration and to do so consistently with the coproduction piece is having a real impact which is important to track through. LL reflected that last year when discussing the annual complaints report, the Board noted a developing backlog with the potential to look at differentiating those that can achieve local resolution and was encouraged to see increasing local approach to speedy resolution often diffusing before reaching formal complaint stage, LL was encouraged to see improved outcomes for our patients.

IC welcomed the new approach which had released leadership time and a joint working approach with earlier engagement and speedier resolution is really welcomed. PS added that there is real strength in engaging families and patients to see change. As a Trust we have now set the bar for that across a range of services. ZT agreed that it is now about embedding and seeing results. Having adopted a new process there is encouraging early data but it is hoped to develop sustained and high quality improvement as well as open our doors to encourage feedback through other resources such as I Want Great Care and continue to offer and expand our services around PALS.

ML stated that what has been seen is real cultural change, with empathy in letters significantly improved.

The Board of Directors thanked the team for a comprehensive report and for the ongoing work to continually improve experience of patients / families that have had cause for complaint.

The Board of Directors received and noted the contents of the report.

063/23	PATIENT EXPERIENCE ANNUAL REPORT 2023/24

ZT presented the comprehensive report for noting. The report was framed with reference to 2021/23 public involvement strategy, which set out ambitions for EPUT, the report sets out a significant area of improvement.

P7 in particular demonstrated real change and a success measure of increased involvement – compared to September 2021 and April 23 the Trust had:
- Gone from having 5 involvement activities to 46.
- An increase from 130 volunteers to 270.
- Average time to resolve complaints being 34 working days has reduced to 22 working days.
- The number of people with lived and living experience becoming lived ambassador from 10 to 131. This number is growing with ambitions to grow further.
- Gone from 300 hours of involvement to over 700. This is a quantifiable increase in how we have been involving people with lived experience in how we do business at EPUT.
- ZT used this public space welcome others who want to come forward as a lived experience ambassador to help improve services at EPUT.
- The report acknowledged that there have been challenges and sets out recommendations for the future, including a point around growing the lived experience team but also moving to a position where there is more involvement of lived experience on all major programmes of change in the organisation as well as recruitment, particularly senior roles in the organisation.

RH had been fascinated to watch this area develop from the first steps regarding the recompense scheme for lived experience ambassadors and was pleased to see the Trust investing in these sorts

of programmes and showing the benefits that can be achieved from targeted investment. A dramatic difference since the implementation of complaints liaison was also evident.

PS agreed that this had been built over a period of time with infrastructure to support. It is important that this is underpinning of everything we want to do with our decision making. It is difficult to shift culture and this is recognised in the challenges highlighted, something for us to take back is what do we need to do to change some of the cultures that would allow patient experience and lived experienced ambassadors to feel more welcome to make an impact. PS commended the team for the massive achievement and great platform for celebrating and including service users and their families in decision making.

LL agreed that the lived experience ambassadors were making good progress, and there is work to do on embedding that philosophy and culture. With regards to the challenge about engaging wider public and members and governors, what can we do as an organisation to help governors engage the wider public? SS agreed stating that public Governor and patient safety partner Mark Dale had flagged the importance that coproduction continues from a learning perspective. ZT stated that the Executive Team had really put this at the heart of the strategic plan with a focus on people who use our services and their families and how we involve them more. There are lots of opportunities and good work taking place. Lived experience ambassadors have joined the transformation steering group and there are peer support workers in MHED so the Trust is really growing opportunities and will take time to keep embedding this culture. There is a real opportunity for clinical leaders on the front line to engage and encourage current service users to continue to come forward to be involved as lived experience ambassadors.

GB advised that during a recent investigation he had met with a complainant who had shared lots of good suggestions regarding how to improve quality of care, agreeing that it is important to listen to patients and their families and encouraged staff to pick up on that.

SS thanked ZT for his executive leadership and thanked the team and all lived experience ambassadors and all that had been involved in this important agenda.

The Board of Directors:
1. **Received and noted the contents of the report.**

064/23	OPERATIONAL PLAN 2023/24

TS presented the plan which had been approved by the Board of Directors in the private session held in March. This plan is overseen by F&P and is clinically and operationally led whilst corporately supported and enabled. TS was pleased to say the Trust were now in a position to release in the public domain.

ZT added that the approach to developing this plan was to be corporately enabled but clinically and operationally led. Care units took ownership from the start and have been pivotal in shaping and agreeing the plan. ZT repeated that observation has been led from the front line in terms of the commitments set out in the paper.

The Board of Directors:
1. **Received the report.**
2. **Noted the Operational Plan as approved in March 2023 private Board and updated by delegated authority on 2nd May 2023.**

065/23	DUTY OF CANDOUR ANNUAL REVIEW

NH presented the report advising that Duty of Candour is serious obligation the Trust must conduct. This report provided the Board with assurance that the Trust has complied with legal requirements. Alongside the ability and willingness to give an apology is the supporting elements around DOC. A key role is the family liaison officer (FLO), there are currently 173 trained FLO and this is a mark of willingness of our clinicians who want to engage with this agenda. During the reporting period there were 53 occasions and were fully compliant within the time frame. Last year there were 75 occasions; this is almost a third less of a requirement to undertake.

The Board of Directors:
1. **Received and noted the contents of the report.**

066/23	TRUST CONSTITUION

DG advised that the Trust Constitution was reviewed annually, with many changes eternally needed to reflect from the wider NHS i.e. changes in Health and Care Act, changes in ICB / ICS and from April this year the new code of governance for Foundation Trusts and NHS Trusts. External legal review had taken place and changes made in line with that. The Constitution has also been submitted through various forums including COG for approval.

The Board of Directors:
1. **Noted the review process.**
2. **Approved the amended Constitution following consultation and agreement with the Council of Governors.**

067/23	NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.

068/23	REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

JW reflected on discussion held around the MH ED and comparison of 10% of patients attending an acute setting and 90% attending MHED leaving with care plan, stating that this was really tackling inequalities.

There is challenge regarding building on improvements and closing the gap for protected characteristics and this coming through PECC disc,

The discussions around lived experience and how this is at the heart of what we do and transformation also demonstrated the Trust's commitment to equality and ensuring the patient voice is heard.

069/23	CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that all Board members had remained present during the meeting and heard all discussions.

070/23	ANY OTHER BUSINESS

There was no other business.

Signed: ………………………………………… Date: ………………………………

In the Chair

Page 14 of 18

071/23 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 26 July 2023.

072/23 QUESTION THE DIRECTORS SESSION

Questions from Governors submitted to the Trust Secretary prior to the Board meeting and also submitted during the meeting are detailed in Appendix 1.

Thanks to members of ARU and Student Nurses for attendance, thanks to Dean and Deputy Dean but also wider staff group and look forward with excitement to the safety conference.

The meeting closed at 12:50.

Signed: ………………………………………. Date: ………………………………

In the Chair

Appendix 1: Governors / Public / Members Query Tracker (Item 072/23)

Governor / Member / Public	Query	Response provided by the Trust
Stuart Scrivener	**Chief executive report 1.3.** I welcome the CQC's focus on improvements. Excellent news that all 56 actions are on track. Are the NEDs actively looking at the 2 remaining outliers, whiteboard and regularity of staff on the ward? Will the CQC take a negative view of us missing these 2 outliers?	The plan for whiteboards to put in place had now been superseded by electronic interactive whiteboards, with the ability to push out corporate messages. Regularity of temporary staff on rotas has improved significantly on Willow and Galleywood Wards, work continues with HR and workforce development about how to build that into our workforce statistics for accountability framework to keep an eye on that but ultimately will be picked up through Time To Care.
Stuart Scrivener	**Quality and performance. Section 2. (Inpatient capacity at PICU)** What actions are the NEDs taking to address 2.9.2a It worries me to read that we are consistently failing to reach target	LL responded that the Finance & Performance Committee has been scrutinising key metrics like inpatient capacity, average length of stay, out of area placements, agency staffing, and other such metrics that are important indicators of the performance of our services. We concluded that it would be unwise to focus on the metrics individually and rather, we should consider their inter-dependencies and create a whole system view. Drawing upon that wider perspective has helped us as a group to contribute to, and where appropriate, provide robust challenge to, strategic investment cases such as the international nurse recruitment programme, Time to Care, data strategy and integrated performance reporting, and the Electronic Patient Record programme. There is still much to do but we are seeing some early signs of success when taking the whole system view. For instance, we have abandoned the target of zero Out of Area Placements because it was not helpful in taking the right decisions for patients. Instead, we are focusing on procuring appropriate out-of-area capacity at the best possible value so that our services are right sized for the demand we see. In the longer run, we are looking for investment opportunities in more digital services to increase capacity and flexibility.

Signed: …………………………………………   Date: ………………………………

Stuart Scrivener	**Quality and performance. 4.5 (page 22 of pdf)** Are there any actions that the NEDs have considered to address the increase to 2077 bed days? It is so tough for families to be separated like this.	PS responded that there had been significant improvement in OOAP and want to ensure people get care as close to home as possible. Actions taken are having impact and should continue to come down. LL stated this had been a topic of challenging conversation at F&P, in LL's personal view if someone needs our care we can't turn them away and if there is no capacity in our ward we have to place the patient in an appropriate place, having a target for zero OOAP in LL's view was meaningless because there are not the levers to achieve that target immediately. The Trust are doing the right things with TTC especially, to ensure therapeutic intervention and facilitate appropriate discharge into community services. This takes time to play out but there is a feeling of confidence we are doing the right thing. There is a whole flow model and reduction in LOS as part of this. NH is on top of this agenda and is a very strong quality and safety piece with a view to ensure right patient in the right place for the right length of time. There is an ambition to get occupancy to 85%, which is considered a safe space and allows flex. The Trust are working with the national team, this is a big agenda that we should see some successes going forward.
Stuart Scrivener	**Quality and performance. 5.7 (page 12 of pdf)** Just a comment - Great that agency staff reduced to 9.4%. It is scary that we are needing this many agency though.	Comment only.
John Jones	P71 efficiencies of £2.9m is this a realistic figure?	TS advised this is a stretch figure. Lot of discussion had taken place at F&P and ET. National expectation is all organisations to find savings of c£2.5m, there are opportunities for us but the biggest challenge will be on recurrent savings. There is a full programme of efficiencies identified by Q1 and will look to deliver them with any shortfall of recurrence to be made up.
	P81 phrase student supernumerary status to be reemphasised	NH commented that this was around recognising that student positions is supernumerary, i.e. not to be included within the numbers of clinicians to deliver care. The student role is to observe but not be relied upon for direct care.
	Strategic risks – SR2 and SR4 re people and demand, score of 20 for last 18 months or more, doesn't give confidence that score is right or actions taken to address what the issue may be.	PS advised that the strategy is 3-5 year programme so would not expect lots of movement. Of the two, there is a huge amount of activity taking place and trying to change the workforce market. Work had to put in to build international recruitment and work on build relationship with student cohorts, anticipate to see impact over time and anticipate recalibrate people score within next 12 months.

Signed: ………………………………………

Date: ………………………………

In the Chair

Cathy	As member of public, asking for statement about MET police comment that from September police are not attending public mental health events, how will this effect EPUT.	NH advised that this was MET police specific as far as communication shows. EPUT are aware that our police colleagues are looking at how this will land in London and the health conversations happening at the moment are similar to statements made many years ago that did not go in to full action. We do know that he police still have legal duties for care and control under a MHA requirement so cannot complete that statement as stated. Underlying is that we might see further innovation and father support. We know that police resources and capacity is stretched and care and treatment if not handed over quickly into MH services is a pull on their resources, so is a challenge for us to look at how handover and transition is taking place. In Health Based Places Of Safety, this is working well. Acute A&E is where there are challenges. It is about getting innovation and transformation happening and that will be the drive. Within the local area there are also some things we have been involved in i.e. MH practitioner in ambulance which helps partnership working, also street triage programme.

Signed: …………………………………………… Date: ………………………………

ACTION LOG AND MATTERS ARISING

⬤ Decision Item　　　👤 SS　　　🕐 2 minutes

REFERENCES

Only PDFs are attached

📕 Board Part 1 Action Log 26.07.2023.pdf

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting 31 May 2023

Lead	Initials	Lead	Initials	Lead	Initials
Marcus Riddell	MR				

Requires immediate attention /overdue for action	🟥
Action in progress within agreed timescale	🟧
Action Completed	🟩
Future Actions/ Not due	⬜

Minutes Red	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
057/23 May 2023	Referring to the Staff Survey -to consider process for linking with and learning from outstanding organisations.	MR	Sept -23		Open	

CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

⬤ Discussion Item   👤 SS   🕐 10 minutes

REFERENCES   Only PDFs are attached

📄 Chair Board Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023
Report Title:	**Chair's Report (Including Governance Update)**	
Executive/ Non-Executive Lead:	Professor Sheila Salmon, Chair	
Report Author(s):	Angela Laverick, PA to Chair, Chief Executive and NEDs	
Report discussed previously at:	N/A	

Level of Assurance:	Level 1	✓	Level 2		Level 3	

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report			
This report provides a summary of key headlines and information for sharing with the Board and stakeholders and an update on governance developments within the Trust.	**Approval**		
	Discussion	✓	
	Information	✓	

Recommendations/Action Required

The Board of Directors is asked to:
1   Note the contents of the report

Summary of Key Issues

The report attached provides information in respect of:
- Changes to the Board of Directors
- CQC Report
- Pioneering Developments
- Quality and Excellent Awards
- Welcome to New Principal Freedom to Speak Up Guardian
- Medical Recruitment Fair
- Celebrations for NHS 75th Birthday

- Junior Doctors Industrial Action
- Southend Pride Festival
- Service Visits

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications:	Capital £		
	Revenue £		
	Non Recurrent £		
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	~~YES~~/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			
CAMHS	Children and Adolescent Mental Health Services	NED	Non-Executive Director
CQC	Care Quality Commission	EMHII	Essex Mental Health Independent Inquiry

Supporting Reports/ Appendices /or further reading
Main report

Lead
Professor Sheila Salmon   **Chair**

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0	PURPOSE OF REPORT

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust.

2.0	CHAIR'S REPORT

2.1 Changes to the Executive Team / Board of Directors

As colleagues will be aware Natalie Hammond, Executive Nurse leaves EPUT at the end of July to take up the role of Chief Nurse at Hertfordshire and West Essex ICB. Sean Leahy, Executive Director of People and Culture has also left EPUT to take up an exciting opportunity. An executive recruitment search is underway and I am pleased to confirm that Frances Bolger is taking up the role of Interim Executive Nurse and Ruth Jackson (Executive People Officer at Mid an South Essex ICB) is giving strategic leadership to the People and Culture Directorate at EPUT whilst the recruitment process happens. On behalf of the Board I would like to extend our best wishes to both Natalie and Sean and wish them well with their future endeavours. We extend a warm welcome to Frances and Ruth.

As advised previously, Elena Lokteva has now transitioned into the role of Non-Executive Director and has taken up the role of Audit Committee Chair. I welcome Elena to this role, to which she brings a wealth of experience, and I would like to extend sincere heartfelt thanks to Janet Wood for her outstanding service in that role since the inception of EPUT.

2.2 Pioneering developments

We must keep firmly in our view, the ground-breaking developments that are being driven forward to systematically improve and in some instances revolutionise the care that we provide. I want to draw attention to the pioneering work of the Mental Health ED that opened at Basildon in March 2023. Evidence is already showing significant improvements to the service user experience with indicative positive outcomes. Supporting data will be published in due course and I am delighted that this initiative has been nominated for **four** national awards. This exemplar development is founded on service user involvement in the design and delivery and we express our sincerest thanks to those participating in both the design and delivery of this impactful joint venture.

I want to emphasise further, the central theme of service user, carer and family involvement across an increasing range of our services, this being a pivotal component of our corporate strategy 23-28. Some examples are; the involvement group is integral to our Time To Care initiative, lived experience leads are now identified for a developing number of governing committees, Patient Safety Partners (PSPs) are in place and the Peer Support Worker (PSW) pilot is in train at the Linden Centre, subject to systematic evaluation, before progressing to wider roll out across services. All together, we have over 100 lived experience ambassadors working in a wide variety of roles across the Trust and with our ICS's also, with further growth projected.

2.3 Quality and Excellence Awards

I was delighted to present awards at the in person event held on 5th July. Because of the Covid pandemic, this is the first time that we have been able to host a largescale in person event since 2020. Paul Scott and I were delighted to be joined by members of the Board of Directors, Governors and other leaders from across our services and systems. The recognition and celebration of so many excellent actions and quality initiatives that make a major positive impact on the quality of care that the people that we care for receive. In total there were 19 award categories with nearly 300 nominations received. We were grateful to our judging panels and for the external sponsorship that enabled the event to take place. I extend heartfelt thanks and congratulations to everyone involved.

2.4   Welcome our New Principal Freedom to Speak Up Guardian
I am delighted that Bernie Rochford MBE has joined EPUT as the new Principal Freedom to Speak Up Guardian. Bernie brings a wealth of experience and knowledge with her surrounding F2SU at the Mersey Care NHS Foundation Trust and she was duly recognised in the Queen's Birthday Honours list in 2021. We extend a warm welcome to Bernie and express our thanks to Elliot Judge who has acted as the Trust's Interim Principal to Speak Up Guardian for the past 12 months.

2.5   Medical Recruitment Fair
EPUT recently hosted a medical recruitment fair at Broomfield Hospital giving medics and medical students across the country the opportunity to find out more about careers at EPUT. This was the second event of its kind held by EPUT and gave the opportunity to attend both in person and virtually online.

2.6   Celebrations for the NHS 75th Birthday
The 5th July marked 75 years since the formation of the NHS with celebrations taking place across the Trust to mark this significant milestone. Operational Service Manager for Older People's Community Mental Health, Dementia and Frailty in mid and South East Essex also joined other NHS staff and their Royal Highnesses the Duke and Duchess of Edinburgh for a special service at Westminster Abbey.

2.7   Junior Doctors Industrial Action
You may be aware of further potential industrial action by junior doctors, the Trust respects junior doctors' right to take action and provides assurance the contingency plans are in place to ensure we maintain urgent care and preserve patient safety throughout strike days.

2.8   Southend Pride Festival
EPUT once again hosted a stall at the Southend Pride Festival on Saturday 15 July. Colleagues from our LGBTQ+ Staff Equality Network hosted the stall where visitors could find out more about the Trust, career opportunities and support that the Trust offers to LGBTQ+ colleagues.

2.9   Service Visits
The NEDs and I are pleased to be able to continue our schedule of visits to services across the Trust. Since the last Board meeting numerous visits have taken place to Rochford inpatient wards, Finance Team, Virtual Hospital, Basildon MHUCD, Colchester Community Specialist Team, Crystal Centre (Ruby and Topaz wards), Children's Asthma Clinic and North Essex Dementia Service. The value of these visits cannot be underestimated and provide a real insight into challenges faced by our staff at the coal face, but also are an opportunity for the Board members to see first-hand the excellent care provided by our dedicated staff.

3.0   LEGAL AND POLICY UPDATE

The Government's 2023 Mandate to NHS England
Please see the link below for a copy of a report published on 15 June 2023 that addresses a 3 year delivery plan to improve patient safety and quality of mental health care.
For Information: Link

NHS Plan To Improve Workforce Experience
Please see the link below for a copy of a report published on 8 June 2023 advising that the NHS should draw up talent management plans to reduce staff turnover, increase recruitment and improve diversity in leadership positions, as part of the NHS's first equality improvement plan aimed to boost patient experience and support staff.
For Information: Link

CQC New Public Engagement Strategy
Please see the link below for a copy of a report published on 21 June 2023.

The new strategy supports the CQC organisational strategy published in 2021 and sets out how the CQC will listen, inform and involve people and work in partnership with the organisations that represent people.
For Information: Link

Interim Service Specification For Specialist Gender Incongruence Services For Children And Young People
Please see the first link below for a copy of the report published on 9 June 2023 that sets out how care will be provided to children and young people, and their families, who express gender incongruence and who are likely to benefit from clinical support. The second link is a copy of the consultation report. The third link is a copy of the public consultation analysis and summary on the interim service and the fourth link is a copy of the equality and health inequalities impact assessment.
For Information: Link; Link; Link; Link

Rapid Review Into Data On Mental Health Inpatient Settings: Final Report And Recommendations
Please see the link below for a copy of the report published on 28 June 2023. The purpose of the review was to consider the way that data and evidence relating to mental health inpatient settings and pathways was collected, processed and used to identify risks early, and mitigate them to protect to the safety of patients.
For Information: Link

Annual Assessment Of Integrated Care Boards 2022-23: Supporting guidance
Please see the link below for a copy of the annual assessment published on 26 June 2023 that details the areas that the annual assessment will cover, as well as information on timing and process.
For Information: Link

What The NHS Long Term Workforce Plan Means For You
Please see the first link below for a copy of a report published on 30 June 2023 that outlines that they aim to double the number of medical school training places, almost double the number of adult nurse training places and aims to retain staff.
The second link is a copy of the Spring Budget, the third link is a correction slip to the Spring budget and the fourth link is a copy of distributional analysis to accompany Spring Budget.
For Information: Link; Link; Link; Link

5.0	RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by
Angela Laverick, PA to Chair, Chief Executive and NEDs
On behalf of
Professor Sheila Salmon, Chair

CHIEF EXECUTIVE OFFICER (CEO) REPORT

● Discussion Item   👤 PS   🕐 20 minutes

REFERENCES Only PDFs are attached

📄 CEO Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	**Chief Executive Officer Report**
Executive/ Non-Executive Lead:	Paul Scott, Chief Executive Officer
Report Author(s):	Paul Scott, Chief Executive Officer
Report discussed previously at:	N/A

Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report

Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes/~~ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes/~~ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report

This report provides a summary of key activities and information to be shared with the Board.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:
1. Note the contents of the report

Summary of Key Issues

The report attached provides information on behalf of the CEO and Executive Team in respect of performance, strategic developments and operational initiatives.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:		
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives		
Data quality issues		
Involvement of Service Users/Healthwatch		
Communication and consultation with stakeholders required		
Service impact/health improvement gains		
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**		
Governance implications		
Impact on patient safety/quality		
Impact on equality and diversity		
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading

Lead
Paul Scott **Chief Executive Officer**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Statutory Inquiry Update

On 28 June 2023, the Secretary of State for Health and Social Care announced that the Essex Mental Health Independent Inquiry would be granted statutory status, under the Inquiries Act 2005. We are awaiting further information around the terms of reference, implications for the Trust and next steps.

This announcement and the uncertainty around next steps will of course cause concern. However, as a Trust our position remains the same, in that we are committed to supporting the Inquiry and ensuring families, carers and service users receive the answers they rightly deserve. We will continue to engage with openness, honesty and transparency, and work with the Inquiry to encourage staff, service users and families to come forward. Patient safety remains our absolute priority, and we welcome this inquiry as an opportunity to learn lessons to ensure the best and safest care possible for our patients.

It is important to recognise the compassionate care we see every day across EPUT and the huge achievements and transformation that has and continues to take place. Everything we have achieved so far gives us solid foundations to continue building on giving our patients the very best care.

1.2 CQC Update

The CQC published its report earlier this month following our well-led inspection back in January. As expected, the report contains areas for improvement and the CQC rated the overall Trust as requires improvement. Although this is disappointing, it is important we do not lose sight of the positives in the report and the significant progress we have made in the six months since the inspection.

For context, 30 core domains were inspected by the CQC – 53% of those saw no change to their rating, 7% saw an improved rating and only three core services saw a decrease in overall rating. Some of the issues identified by the CQC include storage of medicine, monitoring of fridge temperatures, being up to date with mandatory training, colleagues remaining alert during observations and staffing levels.

Much of the change that has taken place in recent months goes a long way to address the issues raised by the CQC. Patients say they feel safe, valued and respected and their loved ones describe the care they witness as compassionate. The rating for our substance misuse services has improved to good, the CQC recognised the action we are taking to develop a learning culture, new reporting, and support systems in place for colleagues who experience racial abuse and the vital role we played to ensure everyone can access COVID-19 vaccinations.

We are taking great strides on our journey of improvement and our work with patients, service users and their families to transform the care we provide is resulting in positive change on a wide scale. We will keep you updated on the actions we are taking and the progress we continue to make.

1.3 Quality and Excellence Awards

On Wednesday 5 July, the Trust held its annual Quality and Excellence Awards at Three Rivers Golf and Country Club in Cold Norton. Fittingly taking place on the NHS' 75th birthday, the evening was a celebration of all that the NHS and the Trust stands for, showcasing inspirational stories and examples of outstanding compassionate care, innovation and commitment to public service. We received nearly 300 nominations this year, all of whom deserve recognition for their amazing achievements, and the judges had a difficult job choosing the shortlist for the 19 categories. I would like to extend my congratulations to everyone who was a winner, highly commended, or shortlisted. I could not be more proud of what our staff do every day to care for people and transform lives and I look forward to seeing what we will achieve over the coming months and years ahead.

1.4 RISE Graduation

This month we held our second RISE graduation event. The scheme, developed for colleagues from black, asian and minority ethnic backgrounds and designed to help nurture rising stars working in any role within EPUT, sees participants attend a number of sessions across multiple topics including change management, effective leadership and cultural and emotional intelligence. The successful event celebrated the 47 colleagues, who graduated from the programme. I would like to congratulate all graduates for their exciting achievements, and I look forward to seeing their careers progress further throughout the organisation.

1.5 National Award Nominations

Our new Mental Health Urgent Care Department, which opened in March this year, has been shortlisted for four national awards. The first of its kind in Essex, providing urgent mental health support for anyone over 18 in mid and south Essex. The department is open 24 hours a day, seven days a week, and has been shortlisted in three categories of The Nursing Times Awards for Critical and Emergency Care Nursing, HRH the Prince of Wales Award for Integrated Approaches to Care, and Nursing in Mental Health. It is also a finalist in the Royal College of Nursing Awards for the Mental Health Nursing category. Since the department opened, we have seen a reduction in the number of people in mental health crisis being admitted to emergency departments at Basildon, Southend and Broomfield hospitals. The winners for both awards will be announced later this year, and I wish the Team all the best and would like to congratulate all on the huge achievement.

1.6 EPUT International Recruitment programme receives national award for high-quality pastoral support

I am delighted to share that this month; EPUT's International Recruitment (IR) programme received an NHS Pastoral Care Quality Award. This award recognises that the support we offer colleagues who joined the Trust through our IR programme meets best practice standards.

All members of our IR programme team, supported by our nursing managers and directors, have worked tirelessly to ensure our international colleagues receive enhanced support as they join our Trust and start their NHS career. Over the last 18 months, they have personally welcomed more than 220 nurses, allied health professionals (AHPs), and helped them start their lives in the UK. Within the wider programme team, the dedicated IR pastoral care team have played an integral role in championing international colleagues' wellbeing.

A recent survey of international colleagues showed 99% felt safe and welcomed upon their arrival to the UK, and 94% said their experience of pastoral care met their expectations.

This award is an incredible achievement, recognising the tremendous effort we have made to best support our internationally educated colleagues, and would like to congratulate the Team on their achievement.

2.	PERFORMANCE AND OPERATIONAL ISSUES

2.1. Operations

Following roll out of the interactive performance dashboards in May, these are being utilised by staff and leadership teams and are informing our Trust Committees, turning attention to an enhanced level of detail and predictive analysis. Staff now have the ability to monitor their performance in real time and utilise this in decision making for improvement.

Our Therapy for You (IAPT) services continue to have great success following the introduction of Limbic Access, which since going live in December 2022 has enabled over 4,000 additional referrals into the service. In addition, patients are now able to choose and book their own appointments, which has resulted in a 15% improvement in attendance rates.

Whilst the Lighthouse Children's Centre contract has provided some challenges since its transfer from MSEFT, I can report that EPUT has maintained excellent communication avenues with NHS England and regional partners throughout recent months. Most recently, EPUT met with these partners and as a collective agreed the referral to treatment definitions, providing a uniform approach to this monitoring. I can confirm there are currently no patients waiting over 78 weeks, and none are currently expected to wait over this at the end of July.

Within Psychological services, monthly risk calls to patients who are waiting have been successfully rolled out ahead of the previously scheduled commencement date of September 2023. Services are scheduling around 120 review calls per month. Wait times continue to be managed and reductions in the number waiting for various therapy interventions are continuing to reduce.

The number of patients placed in an out of area bed has reduced significantly following additional process implemented to improve Flow and Capacity, which have Executive oversight. In June there were 10 patients placed in an out of area bed, significantly reduced from a monthly peak of 44 in November 2022 that witnessed 44 placements.

There are no contract performance notices issued to the Trust, and no new contracts identified with inadequate performance.

2.2. People and Culture

Staffing levels - We are continuing to exceed fill rate targets although acuity and staffing challenges persist, leading to continued high use of back and agency staff. We are working to reduce bank and agency costs, focusing on increasing managerial oversight, improved roster management, updated booking processes and enhanced agency management.

Our vacancy rate has returned to 12%. The increase since the start of the financial year has been driven by establishment increases in community settings funded by the Mental Health Investment Standard. We recruited a net 30 nurses in June, and remain confident in our workforce plan. The six care units continue to develop their own workforce improvement plans with QI initiatives linked to specific issues in their settings.

This year we established an appraisal window to give staff clarity about when objective setting and appraisals should take place. Owing to operational pressures, staff have

fed back that a larger window or return to an irregular appraisal pattern might be preferable. We will consider next steps after we have received data for July.

Industrial Action - Notification of strike action was received for 13-18 July 2023 (Junior Doctors) and 20-21 July 2023 (Consultants). The British Medical Association (BMA) announced that consultant doctors would be taking strike action for 48 hours from 7am on Thursday, 20 July to 7am on Saturday, 22 July. During the two days of action, the BMA has advised that consultants will provide Christmas Day cover, meaning they will continue to provide an emergency care level of service.

The Trust respects the right of consultants to take action and contingency plans were put in place to ensure we maintain urgent care and preserve patient safety throughout the strike days. Our contingency plans were put in place with Deputy Medical Directors and socialised with our JLNC, standing up our Silver and Gold Command structures, and providing our self-assessment on preparedness via the integrated care boards. Some patient appointments were cancelled and all impacted patients notified if their appointment required rescheduling.

The BMA have a mandate for strike action with Consultants until 26 December 2023. They are also currently balloting with Junior Doctors for further mandate for strike action that, if achieved, will last until February 2024.

We recognise that recovery after each event is becoming more difficult, and would like to thank all involved for what they are doing over this protracted period of industrial action.

There are no other Trade Unions with a mandate for industrial action at EPUT.

2.3. Medical

Stephen Metcalfe MP opened the Mental Health Urgent Care Department on the 14 July. The event was well attended by various stakeholders.

Dr Gladvine Mundempilly has been appointed as the new Chief Clinical Information Officer for the Trust. Dr Milind Karale will transfer responsibilities to Dr Mundempilly from the 1 August.

EPUT organised a Medical Recruitment Fair on 7 July at the Crystal Centre in Chelmsford. The fair was well attended by more than 30 doctors and EPUT was able to offer a number of positions.

2.4. Finance

Revenue results at M3 are a Year to Date deficit of £2.8m, £1.4m behind plan. Key overspends are associated with demand and capacity, acuity and associated observations and staffing requirements and non-pay pressures. The Trust continues to forecast a breakeven position with a continued focus on value for money, delivery of efficiency programmes and the development and realisation of opportunities across EPUT and with System partners. Payments relating to the pay settlements for 2022/23 and 2023/34 were processed for our staff in June. The Trust's capital and cash positions are on plan.

The Trust has signed off its 2022/23 Accounts and Annual Report after receiving a clean external Audit Opinion on the financial statements and our associated value for money with no concerns raised over our use of resources. The quality of the Accounts and the associated working papers was commended. The Accounts and Report have now been submitted to Parliament ahead of summer recess

QUALITY & PERFORMANCE SCORECARD?

● Discussion Item   👤 PS   🕐 5 minutes

REFERENCES

<div align="right">Only PDFs are attached</div>

📕 Quality & Performance Scorecard 26.07.2023.pdf

NHS
Essex Partnership University
NHS Foundation Trust

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	Quality and Performance Scorecards
Executive/Non-Executive Lead:	Paul Scott Chief Executive Officer
Report Author(s):	Janette Leonard Director of ITT
Report discussed previously at:	Finance and Performance Committee Quality Committee
Level of Assurance:	Level 1		Level 2	✓	Level 3	

Risk Assessment of Report		
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators.	
State which of the following Strategic risk(s) this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.	

Purpose of the Report		
This report provides the Board of Directors • The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance "inadequate indicators". • The scorecards are provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board. The content has been considered by those committees and it is not the intention that further in depth scrutiny is required at the Board meeting.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the reports. 2. Request further information and / or action by Standing Committees of the Board as necessary.

1

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 3 (June 2023). The Finance & Performance Committee (as a standing committee of the Board of Directors) have reviewed performance for June 2023).

Six inadequate indicators (variance against target/ambition) have been identified at the end of June 2023 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- Inpatient MH Capacity Adult & PICU
- IAPT Access Numbers
- Out of Area Placements
- Psychology
- Lighthouse Children's Centre
- Temporary Staffing

There are two inadequate indicators which are Oversight Framework indicators for June 2023.

- Out of Area Placements
- Temporary Staffing

There is one inadequate indicator in the EPUT Safer Staffing Dashboard for June 2023.

- No. wards with more than 10 days of unfilled shifts

There are no CQC actions past timescale for the 8 must do and 2 should do actions issued following the Adult Acute Services & PICU CQC inspection.

The Well Led CQC inspection report was published in July 2023; an action plan is being developed as a result.

Within the Finance scorecard there are no items RAG rated inadequate for June 2023.

Where performance is under target, action is being taken and is being overseen and monitored by standing committees of the Board of Directors.

Relationship to Trust Strategic Objectives

SO1: We will deliver safe, high quality integrated care services	✔
SO2: We will enable each other to be the best that we can	✔
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered

1: We care	✔
2: We learn	✔
3: We empower	✔

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✔
Data quality issues	✔
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✔
Financial implications: Capital £ Revenue £ Non Recurrent £	
Governance implications	✔
Impact on patient safety/quality	✔
Impact on equality and diversity	✔
Equality Impact Assessment (EIA) Completed YES/NO If YES, EIA Score	

2

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Paul Scott
Chief Executive Officer

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
June 2023

Are we Safe? | Are we Effective? | Are we Caring? | Are we Responsive? | Are we Well Led?
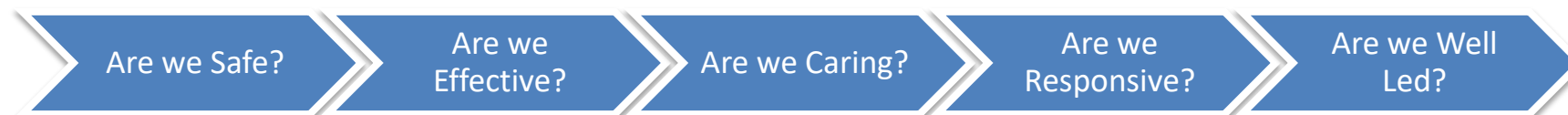
Report Guide

Use of Hyperlinks

Hyperlinks have been added to this report to enable electronic navigation. Hyperlinks are highlighted with an underscore (usually blue or purple colour text), when a hyperlink is clicked on, the report moves to the detailed section. The back button can also be used to return to the previous place in the document.
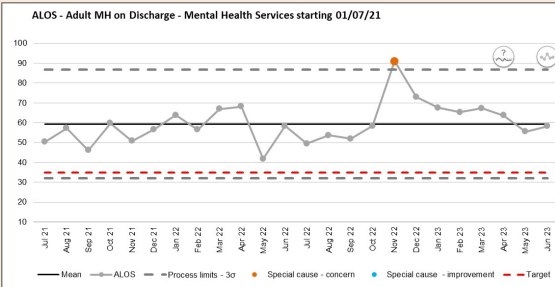
How is data presented?
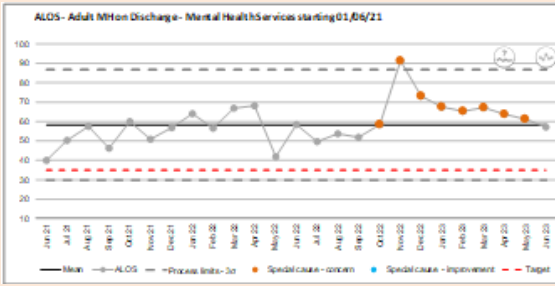
Data is presented in a range of different charts and graphs which can tell you a lot about how our Trust is performing over time. The main chart used for data analysis is a Statistical Process Chart (SPC) which helps to identify trends in performance a highlight areas for potential improvement. Each chart uses symbols to highlight findings and following analysis of each indicator an assurance RAG (Red, Amber, Green) rating is applied, please see key below:
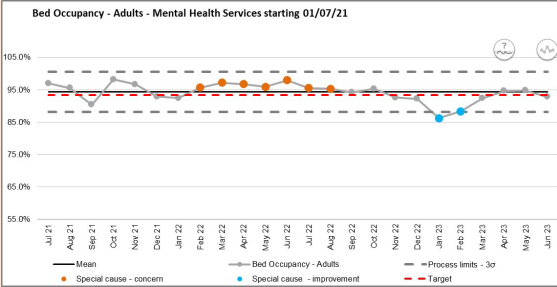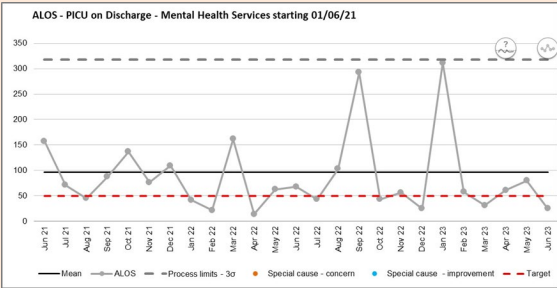
Statistical Process Control (Trend Identification)					
Variation				**Assurance**	
Common Cause – no significant change	Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values	Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting and passing and falling short of the target	Variation indicators consistently (P)assing the target	Variation Indicates consistently (F)alling short of the target
Assurance (How are we doing?)					
Meeting Target EPUT is achieving the standard set and performing above target/benchmark	Requiring Improvement EPUT is performing under target in current month/ Emerging Trend	Inadequate EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL	Variance Trust local indicators which are at variance as a whole or have single areas at variance / at variance against national position	For Note These indicate data not currently available, a new indicator or no target/benchmark is set	Indicators at variance with National or Commissioner targets. These have been highlighted to Finance & Performance Committee.

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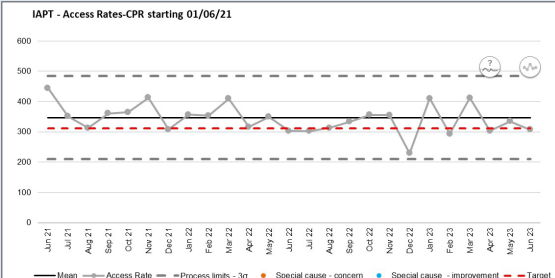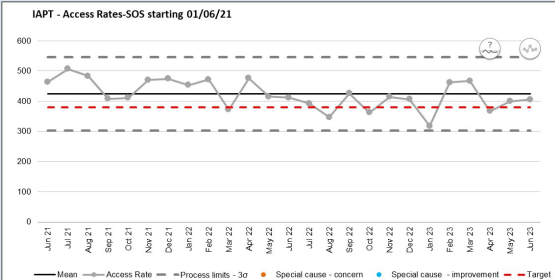
SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators **June Inadequate Performance** - Inpatient MH Capacity Adult & PICU - IAPT Access Numbers - Out of Area Placements - Psychology - Lighthouse Children's Centre - Temporary Staffing	**Summary of Oversight Framework Indicators** **June Inadequate Performance** - Out of Area Placements - Temporary Staffing (Agency)	**Summary of Safer Staffing Indicators** **June Inadequate Performance** One inadequate item identified within the Safer Staffing section for: - No. wards with more than 10 days of unfilled shifts This data is collected from SafeCare.

Summary of CQC Indicators On 3 April 2023, the Trust received the CQC report for our Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units, the CQC have rerated this service as inadequate and issued 8 Must do and 2 Should do actions. An action plan has been created, which captures CQC feedback within the report. Overall progress continues to be made. On 12 July 2023, the Trust received the CQC EPUT Well Led inspection report, following the inspections in January 2023. Action plans are being developed following this.	**Finance Summary** **June Inadequate Performance** There are no Finance Indicators noted as inadequate.

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SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Effective Indicators

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
2.9 Inpatient Capacity Adult & PICU MH 🔴	Inadequate Adult average length of stay has increased in June, and remains outside the National Benchmark of <35. This is due to 102 discharges, 24 of whom were long stays (60+ days). Adult average length of stay including the Assessment Units has reduced in June and remains outside the National Benchmark of <35. This is due to 162 discharges, 27 of whom were long stays (60+ days). Adult Occupancy has decreased slightly in June, and is now within the target of <93.4% at 92.8%. PICU ALoS has reduced in June and is within benchmark of <50 days, there were eight discharges, one of whom were long stays (60+ days). Please note that bed occupancy figures do not account for closed beds due to covid or other reasons.						
Committee: Quality Indicator: Local Data Quality RAG: TBC	2.9.2a Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	57.2 days	🔴	Below Target = Good ALOS - Adult MH on Discharge - Mental Health Services starting 01/07/21	🔴	102 discharges, 24 of whom were long stays (60+ days).	TBC
	2.9.2b Adult Mental Health including Assessment Unit ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	41.0 days	🔴	Below Target = Good ALOS - Adult MH on Discharge - Mental Health Services starting 01/06/21	N/A	This is due to 162 discharges, 27 of whom were long stays (60+ days).	

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Effective Indicators

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
	2.9.4 % Adult Mental Health Bed Occupancy below national benchmark **Target: 93.4%** (Adult Acute Benchmark 2020 93.4%)	92.8%	🟢	Below Target = Good 	🔴	Adult Occupancy has decreased slightly in June, and is now within the target of <93.4%.	N/A
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: <50** (PICU 2020 Benchmark 50)	25.1 days	🟢	Below Target = Good 	🟢	PICU ALoS has reduced in June and is within benchmark of <50 days, there were eight discharges, one of whom were long stays (60+ days)	

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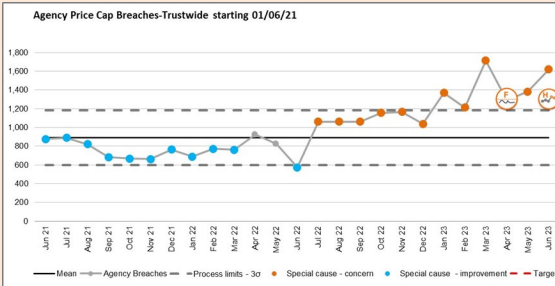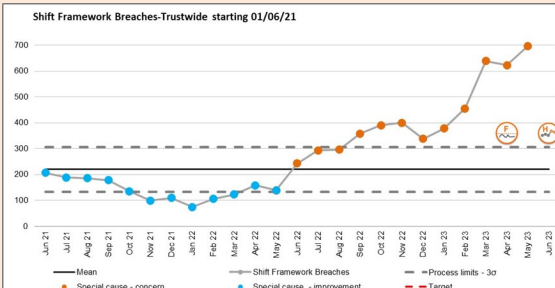
Effective Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat**	**Narrative**	**Recovery**
		Perf	**RAG**		**RAG**		**Date**
2.16 NHS Talking Therapies (IAPT) ⬤ (red circle)	**Inadequate**						
	A large scale improvement drive is underway across EPUT's NHS Talking Therapies Services with an avenue of focus dedicated to improving the number of patients entering treatment. Across the service there has been increased communication with patients whilst they await their first appointment, deep dives are taking place in to DNA and Cancelled appointments, and an ongoing study to evaluate and compare attendance rates for those received via the contact centre and those via Limbic Access is underway.						
Committee: FPC Indicator: National Data Quality RAG: **Green**	2.16.1 IAPT Access Rate CPR CCG **Target – 311**	307	⬤ (red)	Above Target = Good IAPT - Access Rates-CPR starting 01/06/21	⬤ (red)		
	2.16.2 IAPT Access Rate SOS **Target – 380**	405	⬤ (green)	Above Target = Good IAPT - Access Rates-SOS starting 01/06/21	⬤ (red)		

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Effective Indicators

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	**RAG**				
	2.16.3 IAPT Access Rate NEE **Target – 844**	646	🔴	Above Target = Good	🔴		

Responsive Indicators

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	**RAG**				
4.5 Out of Area Placements 🔴 Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	**Requires Improvement** There were ten new clients placed OOA (eight Adult & two PICU) in June. Following the repatriation of 18 (17 Adult & one PICU), there were 33 remaining (27 Adult & six PICU) OOA at the end of the month. There were 1,240 OBD's in June (excluding Danbury & Cygnet).						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2023**	1,240 Days	🔴	Below Target = Good	🔴	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester.	

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Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M3**
4.10 Psychology 🔴 Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Risk calls to patients waiting have now been stood up to once a month, this is earlier that the previously scheduled commencement date of September 2023. Services are scheduling around 120 review calls per month and robustly reviewing our protocol to improve it during initial meeting. The number of people waiting for PAP or assessment in the South East has reduced. The number of people waiting for an intervention after assessment has increased, largely due to a push on completing assessments. A new STEPPS programme has begun, reducing the numbers waiting for this 20 week intervention. In turn they have reduced capacity to pick up new therapy cases. Within South West wait times have reduced significantly since May 2022. The average wait time for individual therapy across SWE has reduced from 62 to 32 weeks in the past year. The wait times for people waiting for group interventions (PAP/DBT skills and STEPPS) fluctuates depending on when the next group is due to be facilitated, however, there is still a significant reduction. New modules of DBT and a new STEPPS group began in June 2023. In Basildon and Brentwood, there has been a significant reduction for the EMDR wait list. This is in part due to a number of clinicians trained in EMDR having increased. Schema therapy wait list remains the highest wait time. Two clinicians are currently being trained in schema therapy with one more clinician due to start schema therapy training later this year. There has been a significant reduction in individual therapy and a reduction in the schema therapy wait lists. In Thurrock, assessment wait times have reduced due to employing a locum psychologist. Therapy wait times have slightly increased. Three qualified psychologist posts are recruited (all due to start September 2023), and are interviewing for one trainee CAP post in July 2023. This will help to reduce the wait lists. Waiting times, referrals, and staffing performance is monitored regularly through the Psychology Accountability Frameworks meetings.

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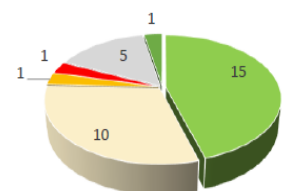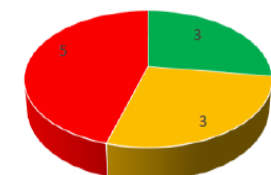
Responsive Indicators		
RAG	**Ambition / Indicator**	**Position M3**
4.11 Lighthouse Children's Centre 🔴 Committee: FPC Indicator: National	4.11 Clients waiting on a Lighthouse Centre waiting list	At a meeting on 10th July with NHSE and regional partners, the activities that stop an RTT clock were agreed. This enables an RTT clock to be stopped before diagnosis, at a point of delivering advice / support which helps manage the condition. This is expected to have a significant impact on the ability to improve reported wait times. As at 10th July there were 2 patients reported to NHSE as waiting over 78 weeks. Both of these have since been identified as no longer waiting, one has already been diagnosed and the other had received an assessment appointment with a consultant on the 4th June which would stop the clock in line with this week's agreement. There are currently none expected to be reported beyond 78 weeks at the end of July.
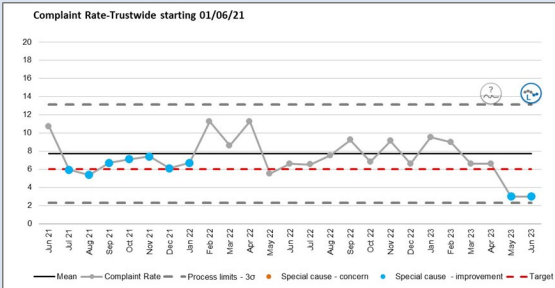
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Well Led Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.7 Temporary Staffing (Agency) 🔴 Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: Green	**Inadequate** There were 1,620 agency cap breaches and 750 shift framework breaches in June. In addition to the above, there were 610 breaches of both framework and price cap. All non-medical agency cap and shift framework breaches have Service Director approval. All medical breaches have been signed off by the Chief Medical Officer and the Chief Executive Officer.						
	5.7.1 Agency Cap Breaches Shift Price Cap **Target = 0**	1,620	🔴	Below Target = Good Agency Price Cap Breaches-Trustwide starting 01/06/21	N/A	781 of these breaches were pertaining to the Medical & Dental and 780 Nursing Registered staffing groups.	
	5.7.2 Shift Frame-work **Target = 0**	750	🔴	Below Target = Good Shift Framework Breaches-Trustwide starting 01/06/21	N/A		

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Well Led Indicators							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	7.8%	🔴	Temporary Staff - Trustwide starting 01/06/21	N/A	Medical and Inpatient & Urgent Care are consistently the care units with the highest proportion of agency staff.	

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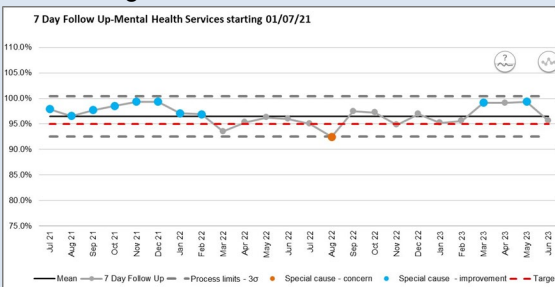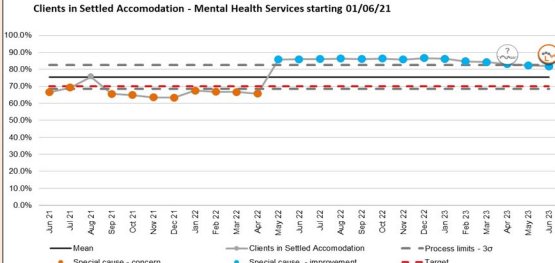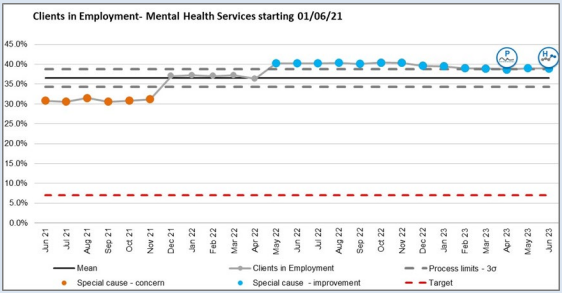
Quality of Care and Outcomes

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
5.1.1 CQC Rating 🟢 Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good	🟢	The Trust is fully registered with the CQC. A restriction has been imposed onto the registration for the Adult Acute service.			
	No significant lapses in Compliance Progress against action plans		🟢	On 3 April 2023, the Trust received the CQC report for our Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units, the CQC have rerated this service as inadequate and issued 8 Must do and 2 Should do actions. An action plan has been created, which captures CQC feedback within the report. Overall progress continues to be made, the table below shows the progress made as of June 2023. On 12 July 2023, the Trust received the CQC EPUT Well Led inspection report, following the inspections in January 2023. Action plans are being developed following this.			

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Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
4.1.1 Complaint Rate 🟡 Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	3.0	🟡	Below Target = Good Complaint Rate-Trustwide starting 01/06/21	🟡	In June, the complaint rate remained consistent with May.	N/A
5.6 Staff FFT 🟢 Committee: FPC Data Quality RAG: **Green**	National Quarterly Pulse Survey Results			The most recent report outlines results and insights from the survey period of Q1 which includes all permanent staff and bank workers. The Q1 survey window was open between 01.04.23 – 30.04.23. Q1 Engagement Results There has been a 44% decrease in response rates vs. Q4. A total of 244 less responses were received (315) vs. Q4 (559). Most significant falls as a proportion of historic response rates are in South East Essex Community and Mental Health Operations. Overall Highlights EPUT results are a mixed picture, with 5 questions seeing an improvement from Q4 2022/23, 3 questions with a deterioration in scores and 1 score which remained the same. In Q1, the percentage of staff who scored favourably (strongly agree/agree) increased in all nine NQPS Questions vs Q2. Progress this Quarter - The Staff Survey Focus Groups and Staff Survey Action Plan have been held and finalised, from which improvements across the Trust will be implemented. This involved close support from the Communications Team and various stakeholders who presented at these sessions. - We have secured the People Pulse system via NHS England, meaning future NQPS windows will enable stronger analysis of survey data, leading to greater insights for our organisation.			
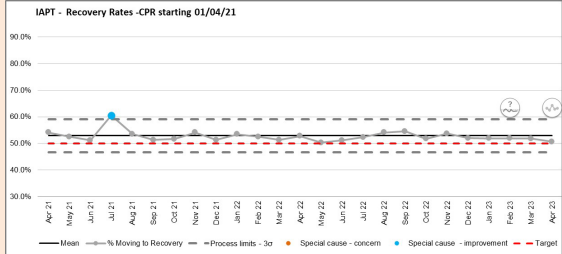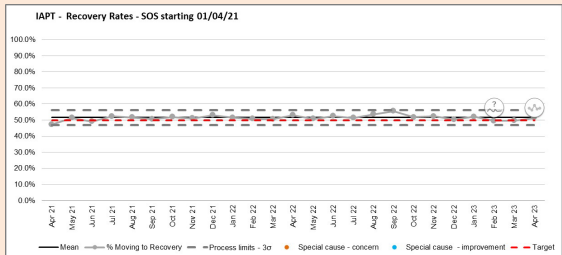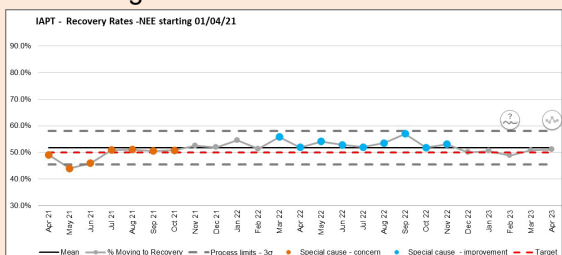
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Quality of Care and Outcomes

RAG	Ambition / Indicator	Position M3		Trend	Nat	Narrative	Recovery Date
		Perf	RAG		RAG		
		- We have listened to positive feedback from staff who requested more mindfulness sessions. This is kindly supported by the facilitator to be supported for a month-long trial of 2 sessions per week (up from 1).					
1.1 Never Event 🟢 Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2021/22 Outturn 0**	0	🟢	Year to Date 0	🟢		N/A
1.6 Safety Alerts 🟢 Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2020/21 Outturn 0**	0	🟢	There have been no CAS safety alerts incomplete by deadline.	🟢		N/A
3.1 MH Patient Survey 🟢 Committee: Quality Indicator: Oversight Framework	Positive Results from CQC MH Patient Survey	During the 2022 survey 1,250 EPUT clients were invited to take part, and 238 responded. This is a response rate of 20%, in line with the 21% response rate for all Trusts. EPUT achieved "about the same" for 21 questions in the 2022 survey when compared with other Trusts. Two questions scored "somewhat worse than expected". Seven scored "worse than expected"; these pertained to Support & Wellbeing.					

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Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
Data Quality RAG: **Green**							
3.3 Patient FFT ● Committee: Quality Data Quality RAG: **Green**	3.3.1 Patient FFT MH response in line with benchmark Target = 88% (Adult Acute 2020 Benchmark 88%)	98.3%	●		●	In June, 98.3% of MH respondents submitted a score of Good or Very Good. This equates to 57 out of a total of 58 responses.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%	91.6%	●		●	In June, 91.6% of CHS respondents submitted a score of Good or Very Good. This equates to 413 out of a total of 451 responses.	
2.8.1 Mental Health Discharge Follow up ● Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95% Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	95.6%	●	Above Target = Good	●	Whilst dropping in June, EPUT does remain above target for patients followed up within 7 days. Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. It should be noted there is a financial penalty that will be issued by Commissioners	
2.4 MH Patients in Settled Accommodation ●	We will support patients to live in settled accommodation **Target 70% (locally set)**	81.8%	●		●	Above Target = Good	N/A

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Quality of Care and Outcomes

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**							
2.5 MH Patients in Employment ⬤ Committee: Quality Indicator: OF Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	38.9%	⬤	Above Target = Good	⬤		N/A
1.8 Incident Rates ⬤ Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** Benchmark	52.3	⬤	Above Target = Good	⬤	In June Incident Rates improved and remain positively above benchmark.	
1.15 Admissions to Adult Facilities of under 16's ⬤	0 admissions to adult facilities of patients under 16	0	⬤	Zero patients under the age of 16 were admitted to an Adult ward in June 2023	N/A		N/A
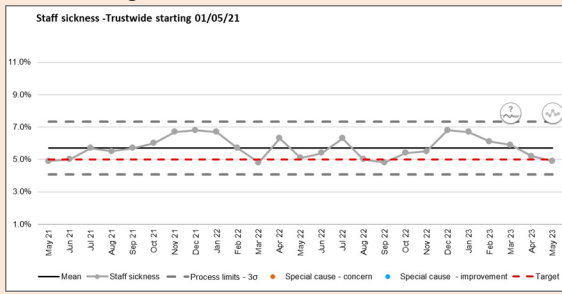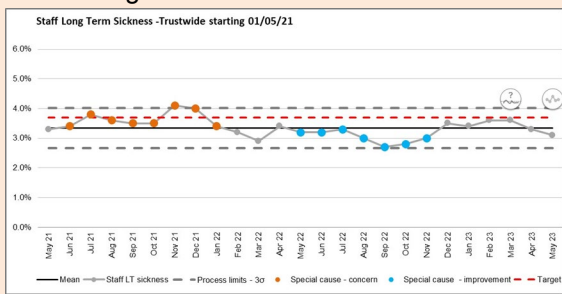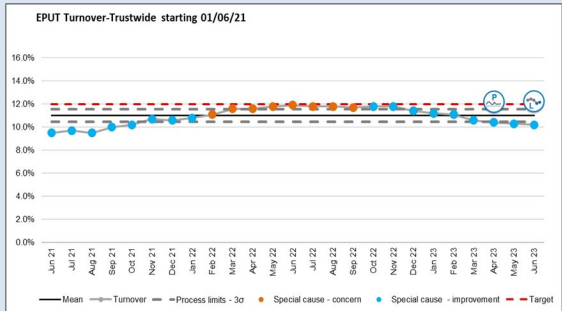
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Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**							
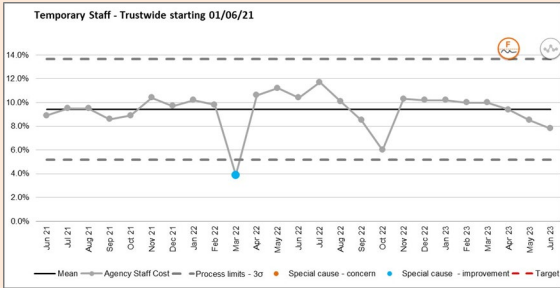
Operational Metrics							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.6 First Episode Psychosis 🟢 Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	82.4%	🟢	Above Target = Good	🟢	June performance represents 14 / 17 patients. There were 3 / 18 breaches in June, 1 / 6 West Essex, 1 / 4 Basildon & Brentwood, and 1 / 1 Castlepoint & Rochford.	N/A
2.2.1 Data Quality Maturity Index 🟢 Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	95.8%	🟢	Above Target = Good	🟢	Latest published figures are for January 2023. A Data Quality Improvement Plan for Mental Health has been produced to identify the areas of the MHSDS that we can improve upon.	

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Operational Metrics

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
2.16.4/5/6 IAPT Recovery Rates ● Committee: FPC Indicator: National Data Quality RAG: **Green**	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	50.6%	●	Above Target = Good 	●		
	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	51.4%	●	Above Target = Good 	●		
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51%	●	Above Target = Good 	●		
2.16.7/8 IAPT Waiting Times ●	2.16.7 % Waiting Time to Begin Treatment – 6 weeks CPR & SOS **Target 75%**	99.7%	●	Above Target = Good	●		

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Operational Metrics							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: FPC Data Quality RAG: **Green**				Waiting Times (seen within 6 weeks) - IAPT (CPR and SOS) starting 01/04/21			
	2.16.8 % Waiting Time to Begin Treatment – 6 weeks NEE **Target 75%**	98.3%	🟢	Above Target = Good Waiting Times (seen within 6 weeks) - IAPT (NEE) starting 01/04/21	🟢		
2.16.9/10 IAPT Waiting Times 🟢 Committee: FPC Data Quality RAG: **Green**	2.16.9 % Waiting Time to Begin Treatment – 18 weeks CPR & SOS **Target 95%**	100%	🟢	Above Target = Good	🟢		
	2.16.10 % Waiting Time to Begin Treatment – 18 weeks NEE **Target 95%**	100%	🟢	Above Target = Good	🟢		

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Operational Metrics							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**		**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**			**RAG**		
4.5 Out of Area Placements 🔴	There were ten new clients placed OOA (eight Adult & two PICU) in June. Following the repatriation of 18 (17 Adult & one PICU), there were 33 remaining (27 Adult & six PICU) OOA at the end of the month. There were 1,240 OBD's in June (excluding Danbury & Cygnet).							
Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by end of March 2024**	1,240 Days	🔴	Below Target = Good		🔴	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward & Cygnet Colchester	

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Workforce and Leadership

RAG	Ambition / Indicator	Position M3		Trend	Nat RAG	Narrative	Recovery Date
		Perf	RAG				
5.3.1 Staff Sickness 🟢 Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	4.9%	🟢	Below Target = Good Staff sickness -Trustwide starting 01/05/21	🔴	The sickness figures are reported in arrears to allow for all entries on Health Roster. The latest local data is for May 2023. The latest National data for sickness absence covers February 2023: The overall sickness absence rate for England was 5.0%. This is lower than January 2023 (5.3%) and is lower than February 2022 (5.6%). EPUT reported lower than the England average for this period at 4.9%. Anxiety/stress/depression/other psychiatric illnesses was the most reported reason for sickness.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	3.1%	🟢	Below Target = Good Staff Long Term Sickness -Trustwide starting 01/05/21	N/A		
5.2.2 Turnover 🟢 Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC Target <12%**	10.2%	🟢	Below Target = Good EPUT Turnover-Trustwide starting 01/06/21	🟢	SPC analysis shows performance consistently passes target. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
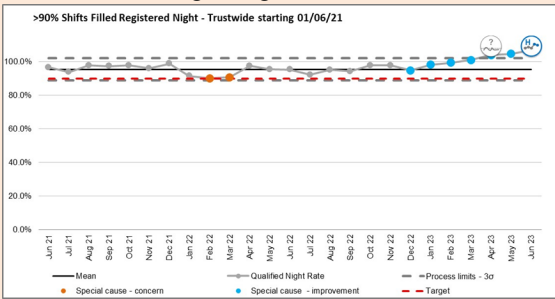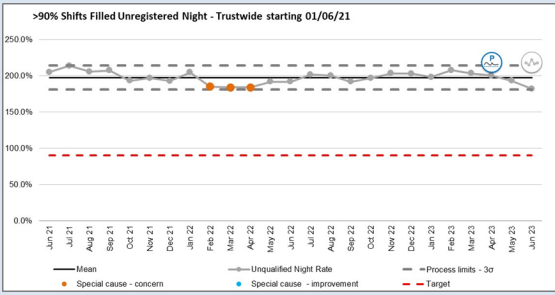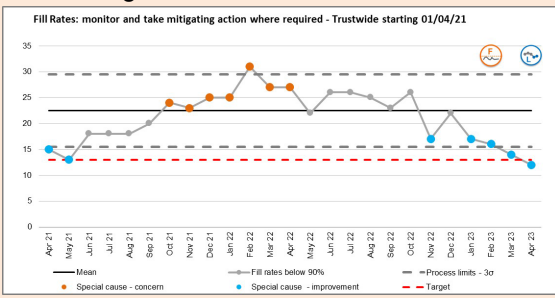
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Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat**	**Narrative**	**Recovery Date**
		Perf	**RAG**		**RAG**		
5.7.3 Temporary Staffing (Agency) ● Committee: FPC Indicator: Oversight Framework Indicator Data Quality RAG: **Green**	Medical and Inpatient & Urgent Care are consistently the care units with the highest proportion of agency staff.						
	5.7.3 Proportion of temporary Staff (Provider Return) No Oversight Framework Target	7.8%	●		N/A		
5.5 Staff Survey ● Committee: FPC	5.5 Outcome of CQC NHS staff survey			Since release of the results from the staff survey, the Engagement Team and wider organisation have been working hard to increase the sense of progress, engagement and that staff voices are heard and acted on. Since the release of the Staff Survey results we have had one National Quarterly Pulse Survey (NQPS Q1 – April 23/24). This NQPS Data showed a mix of both improved and worsening responses, but a marked decline in response rate as was the case for the Staff Survey. The current NQPS Window (Q2 – July 23/24) is now open. Actions Taken • Following results being communicated across the organisation, Focus Groups were held with staff, informing the subsequent Staff Survey Action Plan which was signed off at Board. This plan is ongoing and work is being progressed against four key priority areas:			

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Workforce and Leadership						
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Indicator: Oversight Framework Data Quality RAG: **Green**				• Priority 1:Raising Concerns, Quality and Improvement • Priority 2: Creating an Inclusive Work Environment • Priority 3:Staff Wellbeing • Priority 4:Engagement in Work, Recognition and Development • Highlights since the last update include an increased focus on supporting Staff Wellbeing, with Trust-wide promotions for National Walking Month, National Bike Week and Stress Awareness Month. These have landed well with staff and we have seen increased engagement from the workforce in these events. Work will continue to support all engagement themes (involvement, motivation and advocacy). • There has been a strengthening of messaging regarding progress being made following staff feedback. Actions taken include the repeat of the 'You Asked, We Delivered' communications campaign, and a move to a new NQPS Provider (People Pulse), which offers better information and data insights • Supporting a sense of inclusion and recognition, Staff Engagement and the Communications Team worked together to organise a Trust-Wide bottom-up recognition scheme, with over 5000 Thank You Cards being sent across sites for staff to use to recognise a colleague. This initiative coincided with EPUT celebrations and communications for the NHS 75th Birthday. • The Engagement Champions Network Terms of Reference has been revised, so that the network has a wider reach and be more impactful on the experience of staff. This was developed alongside feedback from Engagement Champions and other stakeholders not part of the network. • A special event 'The Grill' was held in May, where Executive Team Members were asked questions based on anonymised free-text comments from the Staff Survey, aligning to each of the 7 People Promises. This session landed well and aimed to reinforce that comments from staff are listened to and acted upon. • Trust Events relating to Safety and Inclusion are being supported by a Staff Engagement Presence, including the Safety Conference in June (Anglia Ruskin University, Chelmsford) and the upcoming RISE Graduation Ceremony (Weds 12th July) • Funding has been secured for Wellbeing Roadshows, which are being organised for later in 2023 and 2024. These will focus on supporting and encouraging staff to look after both their physical and mental wellbeing needs.			

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SECTION 5 - SAFER STAFFING SUMMARY

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards. Safe staffing performance continues to be monitored by the Quality SMT and Quality Committee.						
Day Qualified Staff 🟢	We will achieve >90% of expected day time shifts filled.	108.4%	🟢	Trend below target	🔴	The following wards were below target in June: Older: Beech(Rochford) Specialist: Rainbow, Lagoon, Robin Pinto Nursing Home: Rawreth Court	N/A
Day Un-Qualified Staff 🟢	We will achieve >90% of expected day time shifts filled.	139.2%	🟢	Trend above target = good	🟢	The following wards were below target in June: Adult: Finchingfield, Galleywood CHS: Cumberlege Specialist: Rainbow	N/A

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Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff ⬤	We will achieve >90% of expected night time shifts filled	106.9%	⬤	**Trend above target = good**	⬤	The following wards were below target in June: Adult: Ardleigh CHS: Cumberlege Nursing Home: Rawreth Court Specialist: Rainbow, Lagoon, Robin Pinto Older: Beech	N/A
Night Un-Qualified Staff ⬤	We will achieve >90% of expected night time shifts filled	182.0%	⬤	**Trend above target = good**	⬤	The following wards were below target in June: CHS: Cumberledge, Beech Specialist: Rainbow	N/A
Fill Rate ⬤	We will monitor fill rates and take mitigating action where required	13	⬤	**Below Target = Good**	N/A	The following wards had fill rates of <90% in June: Adult: Ardleigh, Finchingfield, Galleywood Nursing Homes: Rawreth Specialist: Edward House, Aurora, Lagoon, Robin Pinto, Rainbow CHS: Cumberledge, Poplar, Beech Older: Beech	N/A

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Safer Staffing							
RAG	**Ambition / Indicator**	**Position M3**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Shifts Unfilled 🔴	We will monitor fill rates and take mitigating action where required	5	🔴	Below Target = Good	N/A	The following 5 wards had more than 10 days without shifts filled in June: Adult: Willow, Topaz Adult Assessment: MHAU Basildon PICU: Hadleigh Unit Nursing Home: Rawreth	N/A

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FILL RATES

	Day Rates		Night Rates		Day Rates		Night Rates		Day Rates		Night Rates	
	Apr-23				May-23				Jun-23			
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
MH ADULT ACUTE												
ARDLEIGH WARD	57.6%	121.4%	75.8%	107.2%	80.6%	134.2%	82.0%	128.5%	82.2%	127.9%	79.7%	106.1%
CEDAR	142.6%	227.7%	131.6%	245.5%	150.0%	208.4%	145.3%	236.9%	144.8%	217.8%	142.3%	249.6%
WILLOW	129.9%	279.3%	120.6%	292.8%	118.6%	266.5%	114.8%	270.2%	124.5%	259.4%	122.7%	287.4%
CHELMER WARD	98.2%	399.3%	96.9%	686.7%	135.0%	383.3%	105.9%	701.7%	138.8%	369.9%	127.2%	672.8%
FINCHINGFIELD WARD	48.6%	75.6%	200.6%	203.0%	39.6%	76.2%	200.6%	191.4%	50.7%	66.9%	196.6%	191.7%
GALLEYWOOD WARD	93.7%	84.2%	110.0%	126.1%	97.7%	85.5%	100.1%	140.2%	95.8%	291.2%	107.0%	499.1%
GOSFIELD WARD	113.4%	216.2%	117.6%	419.6%	100.1%	280.9%	114.8%	459.7%	150.9%	252.1%	128.3%	326.7%
KELVEDON	159.5%	238.0%	126.7%	282.2%	163.4%	248.5%	124.2%	303.9%	138.4%	226.4%	128.3%	380.0%
STORT WARD	115.6%	206.5%	102.9%	319.8%	140.0%	199.0%	107.6%	322.6%	120.0%	391.2%	103.8%	557.7%
TOPAZ WARD	164.5%	184.1%	100.1%	595.0%	145.9%	166.8%	115.0%	531.8%	157.0%	116.8%	105.1%	360.8%
CHERRYDOWN	149.0%	394.8%	101.7%	523.3%	124.8%	372.3%	102.3%	518.9%	120.0%	391.2%	103.8%	557.7%
MH ASSESSMENT UNIT												
BASILDON MHAU	138.4%	323.6%	97.5%	373.3%	135.5%	346.0%	107.3%	385.5%	118.1%	299.4%	105.2%	358.9%
PETER BRUFF UNIT	87.4%	182.6%	130.8%	178.0%	92.4%	178.8%	124.6%	177.0%	101.1%	149.9%	117.2%	165.4%
MH OLDER ADULT												
BEECH (ROCHFORD)	105.1%	180.7%	84.9%	385.7%	109.0%	139.1%	73.8%	293.6%	127.1%	163.5%	79.6%	352.1%
GLOUCESTER	110.0%	188.5%	112.2%	318.5%	96.8%	165.6%	111.4%	230.6%	101.7%	134.8%	116.7%	150.4%
HENNEAGE WARD	127.0%	267.4%	102.2%	486.1%	148.3%	273.9%	107.6%	480.1%	119.8%	234.2%	126.7%	357.5%
KITWOOD WARD	115.7%	183.3%	153.0%	152.3%	147.9%	195.5%	145.7%	185.5%	163.1%	168.3%	148.0%	198.7%
MEADOWVIEW	108.8%	159.0%	109.3%	196.1%	95.2%	81.5%	108.1%	96.1%	94.2%	97.7%	115.0%	120.5%
RODING WARD	108.0%	164.3%	140.0%	158.1%	108.2%	179.2%	151.6%	159.7%	129.5%	148.1%	156.7%	150.0%
RUBY WARD	119.4%	490.2%	193.4%	490.9%	110.5%	514.9%	200.0%	448.4%	117.8%	415.1%	200.0%	431.2%
TOWER	113.3%	191.1%	93.5%	193.6%	145.4%	167.6%	93.9%	189.2%	130.2%	161.0%	97.1%	157.5%
MH ADULT PICU												
CHRISTOPHER UNIT	183.9%	129.1%	101.7%	197.7%	166.6%	121.1%	100.0%	184.7%	168.1%	148.8%	100.3%	215.9%
HADLEIGH PICU	115.1%	316.5%	111.4%	561.3%	107.0%	249.5%	110.3%	442.3%	102.4%	119.5%	115.5%	256.0%
MH ADULT REHAB												
IPSWICH ROAD	108.6%	100.6%	122.9%	200.0%	124.8%	103.9%	113.5%	151.2%	120.8%	98.9%	120.9%	100.0%
CAMHS SERVICES												
LARKWOOD	115.8%	141.4%	106.8%	122.8%	114.6%	182.2%	114.7%	178.2%	101.4%	159.0%	105.8%	147.0%
LONGVIEW	93.8%	234.7%	99.0%	313.3%	114.2%	246.7%	98.9%	343.2%	97.9%	163.1%	93.5%	226.7%
POPLAR	103.0%	125.2%	95.1%	227.2%	121.9%	161.5%	99.0%	312.9%	123.7%	159.9%	100.1%	287.3%

| | Day Rates | | Night Rates | | Day Rates | | Night Rates | | Day Rates | | Night Rates | |
| | Apr-23 | | | | May-23 | | | | Jun-23 | | | |
	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED	REGISTERED	UNREGISTERED
TARGET >90%												
SPECIALIST SERVICES												
EDWARD HOUSE	95.1%	143.3%	116.6%	112.5%	98.8%	126.7%	114.9%	101.9%	102.0%	117.7%	121.8%	79.8%
ALPINE	94.4%	114.6%	91.7%	107.8%	95.1%	99.0%	95.9%	95.6%	99.1%	101.8%	92.0%	102.4%
AURORA	100.7%	91.2%	100.2%	110.1%	103.4%	100.2%	101.7%	90.3%	114.3%	106.6%	114.7%	76.9%
CAUSEWAY	123.9%	117.1%	88.5%	107.8%	108.5%	120.5%	87.5%	111.3%	108.5%	121.6%	98.9%	98.3%
DUNE	102.3%	120.4%	110.3%	112.6%	112.3%	124.0%	109.2%	109.3%	107.5%	117.7%	99.9%	98.3%
FOREST	143.4%	136.0%	95.0%	100.0%	102.0%	136.3%	95.1%	103.2%	136.8%	132.1%	96.6%	99.6%
FUJI	100.2%	182.7%	93.5%	153.6%	100.0%	179.7%	95.5%	155.2%	98.7%	221.9%	99.7%	192.4%
LAGOON	103.0%	101.5%	95.7%	102.1%	100.1%	111.6%	91.0%	115.9%	97.5%	153.5%	86.5%	176.3%
ROBIN PINTO UNIT	115.3%	158.6%	106.7%	292.1%	117.9%	119.5%	97.2%	225.1%	128.2%	129.4%	88.1%	292.9%
WOODLEA CLINIC	136.0%	172.8%	218.5%	100.0%	151.3%	158.2%	213.3%	98.4%	103.8%	119.8%	196.4%	116.1%
RAINBOW UNIT	93.8%	53.6%	50.0%	66.6%	90.7%	57.8%	50.0%	75.3%	93.7%	63.4%	50.1%	81.0%
LEARNING DISABILITY SERVICES												
HEATH CLOSE	98.3%	110.2%	95.1%	106.7%	90.3%	114.1%	82.3%	131.4%	92.3%	117.2%	97.2%	113.3%
NURSING HOMES												
CLIFTON LODGE	162.1%	146.6%	87.9%	278.9%	157.7%	132.3%	93.5%	259.1%	144.8%	106.0%	102.0%	231.3%
RAWRETH	121.6%	131.2%	63.8%	107.5%	107.0%	125.2%	77.4%	104.0%	139.0%	110.2%	83.3%	99.3%
COMMUNITY HEALTH SERVICES												
CUMBERLEGE ICC	84.9%	56.6%	66.7%	79.2%	112.0%	123.0%	98.7%	122.7%	68.0%	56.8%	66.6%	79.9%
AVOCET	121.0%	126.4%	101.8%	154.6%	81.4%	97.4%	100.0%	89.7%	100.7%	115.7%	98.5%	130.6%
BEECH WARD	80.0%	96.8%	98.6%	86.7%	83.1%	57.7%	66.3%	80.0%	85.3%	94.8%	100.0%	91.4%
PLANE	100.4%	115.3%	100.4%	102.2%	100.6%	111.2%	100.0%	100.9%	107.6%	107.3%	100.0%	102.1%
POPLAR UNIT	96.4%	80.7%	100.0%	122.1%	104.4%	81.0%	100.0%	124.7%	111.5%	87.4%	101.7%	130.3%

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SECTION 5 – CQC

Click here to return to summary page
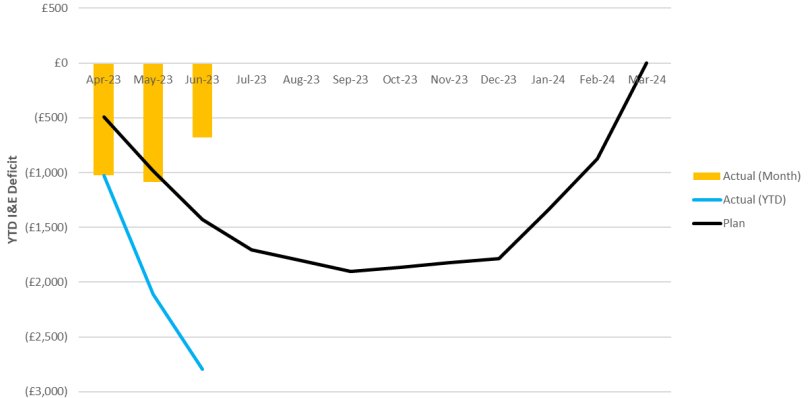
On 3 April 2023, the Trust received the CQC report for our Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units, the CQC have rerated this service as inadequate and issued 8 Must do and 2 Should do actions. An action plan has been created, which captures CQC feedback within the report. Overall progress continues to be made, the table below shows the progress made as of June 2023.

Adult Acute and PICU (April 23) Action Progress

Legend: Complete, On track, Slippage, Risk, Under development, Complete with evidence

Action Assurance

Legend: Green, Amber, Red

On 12 July 2023, the Trust received the CQC EPUT Well Led inspection report, following the inspections in January 2023. Action plans are being developed following this.

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SECTION 6 - Finance

[Click here to return to summary page](#)

RAG	Ambition / Indicator	Position	Trend
Income and Expenditure	Income and Expenditure	The 23/24 approved revenue budget is to deliver a break-even plan. The plan requires an efficiency target of £22.9m to be met. M3 results are a deficit of £2.8m, £1.4m adverse variance to plan. The adverse variance includes pay overspends in Inpatient areas associated with acuity, observations and capacity. Shortfalls on efficiency plan are being offset by vacancies across the Trust. The Trust continues to forecast a breakeven outturn position.	2023/24 Operating I&E Performance against Plan
Efficiency Programmes	Efficiency programme	In order to deliver the 23/24 financial plan, the Trust has to deliver £22.9m of efficiencies equivalent to 4.4% of operating spend. The M3 position is a delivery of £3.8m against the plan of £4.8m, £1m behind plan. Additional work has identified opportunities with EPUT and joint opportunities with System partners.	(see table below)

	Efficiencies £000	YTD Plan £000	YTD Delivery £000	YTD Variance £000
	£000s	£000s	£000s	£000s
Identified	19,044	3,803	3,752	51
Unidentified	3,848	962	0	962
Total	**22,892**	**4,765**	**3,752**	**1,013**

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RAG	Ambition / Indicator	Position	Trend
Temporary Staffing	Temporary Staffing Costs	Total temporary staffing spend in the month was £6.7m; bank spend £4.2m and agency spend £2.4m. For 23/24, the increased deployment of International Recruitment nurses and increased financial controls will support the reduction in temporary staffing costs.	
Maximising Capital Resources	Maximising Capital Resources	The Trust has incurred capital expenditure of £0.9m at M3, slightly ahead of plan by £0.1m. The total planned capital of £20.4m for the year excludes the £1.4m of discretionary capital with release of these funds to be agreed via the System Investment Group.	(see table below)

2023/24 Pay Cost Analysis

Legend: Agency (red), Bank (green), Substantive (blue), 23/24 Plan Total Pay (solid line), 22/23 Total Pay Comparator (dashed line)

Capital

	Annual Plan £000	YTD Original Plan		
		Plan £000	Actual £000	Variance £000
C'fwd Schemes	2,914	439	609	(170)
ICT	2,263	93	70	23
Medical / Other Equipment	100	25	0	25
Safety & Ligature	500	0	0	0
Health & Safety	500	0	0	0
Backlog Maintenance	500	50	0	50
EPMA	587	18	10	8
Strategic	4,149	158	156	2
Charge against Allocation*	**11,513**	**783**	**845**	**(62)**
EPR	6,000	0	0	0
MH UEC (SNEE)	169	0	0	0
Leases	2,625	0	0	0
PFI Residual Interest	117	30	30	0
CDEL	**20,424**	**813**	**875**	**(62)**
Variance (%)				-8%

* Excludes discretionary capex of £1,387k held for system

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RAG	Ambition / Indicator	Position	Trend
Cash Balance	Positive Cash Balance	The cash balance as at end of M3 is £68.3m, ahead of plan by £0.8m.	

END

COMMITTEE CHAIRS REPORT

● Discussion Item   👤 Chairs   🕐 10 minutes

REFERENCES   Only PDFs are attached

📄 Committee Chair's Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	**Committee Chair's Report**
Executive/ Non-Executive Lead:	Chairs of Board of Director Standing Committees
Report Author(s):	Chairs of Board of Director Standing Committees
Report discussed previously at:	N/A

Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
	SR7 Capital	✓
	SR8 Use of Resources	✓
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report provides a summary of key assurance and issues identified by the Board of Director Standing Committees.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to:

1   Note the report and assurance provided
2   Provide feedback for any identified issues for escalation

Summary of Key Issues

The Board of Directors regularly delegates authority to the Standing Committees in line with Trust Governance documents (SoRD, SFI's etc.). Standing Committees are expected to provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve identified issues.

Each Board meeting, Chairs of Standing Committees will provide details of meetings held and:

- Any key assurance to be provided to the Board
- Any issues identified for noting where the Standing Committee is taking action (Alerts)
- Any issues / hotspots for escalation to the Board for further action (Escalation)

- Any issues previously identified which have now been resolved, including the identification of lessons learnt.

The attached report provides updates in relation to the following Standing Committees:
- Audit Committee (Elena Lokteva)
- Finance & Performance Committee (Loy Lobo)
- People, Equality & Culture Committee (Manny Lewis)
- Quality Committee (Rufus Helm)

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	~~YES~~/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Committee Chair's Report

Lead
Janet Wood, Chair of Audit Committee
Loy Lobo, Chair of Finance & Performance Committee
Manny Lewis, Chair of People, Equality & Culture Committee
Dr. Rufus Helm, Chair of Quality Committee

Committee Chairs Report

July 2023

CONTENTS

1. INTRODUCTION

Purpose of the report

The Board of Directors regularly delegates authority to standing committees of the Board in line with the Trust's governance arrangements (SoRD, SFI's, etc.)

Standing committees provide regular reports to the Board of Directors, providing assurance on the key items discussed and any progress made to resolve any identified issues.

For each Board meeting, the Chairs of standing committees will provide details of meetings held and report:

- **Assurances** - Any key assurances to be provided to the Board

- **Alerts** - Any issues / hotspots for escalation to the Board

- **Action** - Any issues identified for noting where the standing committee is requesting or taking action

- **Information** – Any issues previously identified which have now been resolved, including the identification of lessons learned

2. QUALITY COMMITTEE

Chair of the Committee:
Dr Rufus Helm (Non-Executive Director)

Assurance

Committee meeting held:
8 June 2023
13 July 2023

Quality Performance Report (June) - The Committee received, discussed and noted the Quality Performance Report:

- 17 Indicators are within target
- 10 areas require improvement
- 3 areas of continuing inadequate performance discussed:
- ➤ Cardio metabolic performance improvement through use of EPR and SystmOne
- ➤ Patient Harm target improvement through improved use of local performance management information at Care Unit level
- ➤ Capacity performance line of enquiry focused on the development of the personality disorder pathway, which is not yet in place, an update was requested in 3 months

CQC Exception Report (June) – The Committee received, discussed and approved the CQC Assurance Report :

- CQC Inspection Report for Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units, an action plan has been created to capture improvements identified which was submitted in line with the agreed timescales
- CQC 'draft' Core Service Inspection Report, which included 6 core services inspected in November 2022 and the Well Led inspection in January 2023, is currently undergoing factual accuracy checking before submission on 08/06/23
- A project is underway with KPMG to strengthen Trust processes following receipt of CQC reports/feedback, and to strengthen action ownership, development and implementation
- There has been 1 CQC MHA inspection undertaken during this reporting period and the outcome report is awaited at the time of writing this report.

Clinical Audit Annual Report (June) - The Committee received, discussed and approved the Clinical Audit Annual Report. The report provided details of the Trust's governance and support for clinic audit, progress with delivery of the annual priority audit programme that includes participation in national audits and implementation of action plans developed, and the development of the 2023/24 annual priority audit programme. The Committee recommended greater involvement of students in the audit process.

Sub-Committee Combined Assurance Report (July) – The Committee received and discussed the Combined Assurance Report, requesting action and updates on progress where required. The Committee noted no new significant risks were identified, however as previously reported, attendance at sub-committee meetings continues to be an issue, in particular for the MHA and Safeguarding Sub Committee. Capacity for staff to attend training is a risk for the Physical Health Sub-Committee. Training attendance is also identified as a risk area within the Restrictive Practice Group. The Clinical Governance Group identified a risk with 21007 POMH-UK Prescribing high dose and combined antipsychotics, this risk is related to availability of an appropriate clinical lead. The Sexual Safety Group reports good progress with the near completion of a new OLM based training module, an online resource for sexual safety best practice and a new flow chart for reporting incidents. The Committee requested greater clarity on assurances within Sub-Committee reports.

Mental Health Act Annual Report (July) - The Committee received, discussed and approved the Learning Disability Improvement Standards Report. The Committee noted the success of the Oliver McGowan training, with 1,000 staff having completed the training and a further 816 enrolled on the course. The Committee noted that as improving care for people living a learning disability or autism is of national importance the Committee requested the continuation of 6 monthly reports on progress.

2. QUALITY COMMITTEE (cont.)

Chair of the Committee:
Dr Rufus Helm (Non-Executive Director)

Committee meeting held:
8 June 2023
13 July 2023

Assurance

CQC Report (July) - The Committee received, discussed and approved the CQC Assurance Report. The Trust has received the CQC draft Comprehensive Inspection report including the EPUT Well Led inspection report. The Trust is now awaiting the final version of the report to be published by the CQC.

Learning from Deaths Quarterly Overview of Learning and Data 2022/23 (July) – The committee received, noted and approved the Learning from Deaths Quarterly Overview. This is an extensive report that identifies themes of learning and Trust actions in learning from deaths. There is on-going work on data quality and the use of existing systems to ensure all relevant data is captured. The Committee acknowledged the sensitivities associated with reporting deaths without full context. Work is also on-going following the recent Norfolk and Suffolk report to ensure there is absolute clarity on what services are included when recording and reviewing deaths.

Ligature Risk Management Annual Report (July) - The Committee received and noted the content of the Ligature Management Annual Report. While the Committee acknowledged that there is no room for complacency the report identifies substantial assurance with the Trust processes and procedures. Compliance with ligature risk reduction training has recovered well post pandemic, reaching 88%. There continues to be a year on year reduction in incidents. The report was well received by the committee, noting that ligature risk management is a continuously changing area of harm reduction, requiring constant vigilance and reappraisal of training and potential environmental hazards.

Infection Prevention and Control Board Assurance Framework (July) – The Committee received and noted the new revised IPC BAF. The Committee acknowledged the framework is clearer in identifying potential gaps in assurance and the mitigations in place to resolve risks. The revised framework will assist the Committee in assessing confidence in IPC assurance in the future.

Infection **Prevention** and Control Annual Report (July) - The Committee received and noted the Infection Prevention and Control Annual Report. The report is detailed and comprehensive, clearly demonstrating the diligent work of the Infection Prevention and Control Team through the challenging times of the pandemic and then onto the recovery period, ensuring that the Trust complies with all regulations pertaining to the maintenance of a safe environment for patients, visitors and staff. The Team continues to lead in staff vaccination campaigns, environmental audits, providing expert advice and training. The Committee thanked the Team for their hard work and celebrated their success in achieving a quality award.

2. QUALITY COMMITTEE (cont.)

Chair of the Committee:
Dr Rufus Helm (Non-Executive Director)

Alert

None to note.

Action

Quality Account 2022/23 (June) - The Committee received, discussed and approved the Final Draft Quality Account 2022/23 to the Board of Directors.

Information

System Learning and PSIRF Implementation Update(June) – The Committee received, discussed and noted the presentation and the PSIRF Implementation update
- The presentation was an in depth appraisal of progress to date including examples of how incidents and near misses are used to inform and improve patient safety and experience
- The presentation was well received by members of the Committee, emphasising how the PSIRF framework supports the Trust culture of learning
- The Committee noted that the PSIRF investigative approach identifies issues that would not have been readily apparent using previous patient safety methodologies
- The presentation was recommended for wider broadcast across the Trust including to the Board, both for information and assurance regarding the robust approach the organisation takes in learning from incidents and embedding changes in practice

Information cont.

Update on progress made against the LD improvement standards - The Committee received, discussed and approved the Learning Disability Improvement Standards Report. The Committee noted the success of the Oliver McGowan training, with 1,000 staff having completed the training and a further 816 enrolled on the course. The Committee noted that as improving care for people living a learning disability or autism is of national importance the Committee requested the continuation of 6 monthly reports on progress

Patient Story (July) - The Committee received an eloquent presentation from a service user on their experience of using EPUT services. The presentation offered a rich insight into the personal experience of entering and then leaving services, the use of terminology such as discharge and what this means to individuals. The story offered insight into using IAPT services and the Committee recommended that this story should be shared with colleagues at the ICB. It is noteworthy that the service user has become an EPUT lived experience ambassador, now part of several different work streams. The Committee requested that the service user should be personally thanked for the valuable feedback provided through participation in the patient story initiative.

3. AUDIT COMMITTEE

Chair of the Committee:
Elena Lokteva (Non-Executive Director)

Committee meeting held:
13 July 2023

Assurance

Final Auditor's Annual Report 31 March 2023– Noted that the Auditors Results Report circulated to the Committee as part of the final accounts process, has been updated to reference the move to statutory inquiry status and the change to the losses and special payments note in respect of vouchers issued.

Waivers of Standing Orders - During the period from the 1 April 2023 to 30 June 2023, competitive quotations were waived on 17 occasions totalling £846,195. There is a decrease compared to the same period last year where 28 competitive quotations were waived totalling £1,019,280.

Annual Review of Waivers - The total value of waivers was £4.2m lower in 2022/23 (£5.5m) than 2021/22 (£9.7m) although the volume of waivers was higher (127 compared with 92). The units with the highest level of waivers were Digital with 23 waivers, totalling £1,462,978.34, and Estates & Facilities with 37 waivers for £1,426,550.82.

Information

Cyber Security & Information Governance Assurance Report – The Committee received a comprehensive update on cyber security and information governance.

Losses and Special Payments - As at the end of Month 2, the Trust is reporting losses and special payments of £1,068.

Finance Policies and Procedures - The following procedures were approved:
- Fraud and Bribery Policy (CP11)
- Financial Redress (FP13)

Alert

None to note.

Action

None to note.

4. PEOPLE EQUALITY AND CULTURE COMMITTEE (cont.)

Chair of the Committee:
Manny Lewis (Non-Executive Director)

Committee meeting held:
22 June 2023

Assurance

Staff Survey and Quarterly Pulse Survey - Lorraine Hammond presented summary of the results for the National Quarterly Pulse Survey which provides additional and more frequent opportunity to hear from staff. Five of the nine NQPS questions saw improvements in staff responding favourably (strongly agree / agree), one remained in line with Q4 2022/23 survey, and 3 saw a deterioration in score. Highlights included a marked improvement in 'I am able to make improvements happen in may area of work', with a 7.08% improvement, and 75% of staff agreeing or strongly agreeing with the statement. The related question 'there are frequent opportunities for me to show initiative in my role' also saw improvement. These indicate positive steps being made in line with our Trust value 'We Empower'.

Deteriorations in scores relate to care, treatment and time working. Notably, 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' saw a 2.16% worsening score, whilst also being our lowest ranking NQPS question with only 54% of staff agreeing / strongly agreeing.

The Staff Survey Focus Groups and Staff Survey Action Plan have been held and finalised, from which improvements across the Trust will be implemented.
We have secured the People Pulse system via NHS England, meaning future NQPS windows will enable stronger analysis of survey data, leading to greater insights for the Trust.
Refreshing the Engagement Champions terms of reference to encourage an increased membership, reach and active participation.

Introduction of Trust-wide recognition scheme, with Thank You cards and the continuation of a focus on wellbeing and the You Asked, We Delivered Campaign.

Freedom to Speak Up - Elliot Judge (Interim F2SU Guardian) attended and presented the annual report, providing case numbers for 2022/23, being a total of 232 people speaking up with concerns ranging over patient safety, worker safety, bullying and harassment and inappropriate behaviour. Assessment by the guardian was that 17 people speaking up had suffered detriment.

In relation to the NHS Staff Survey speaking up and being confident that concerns would be addressed – EPUT remains below the national average. Key actions:

- Appointment of a permanent F2SU Guardian, noting that Bernadette Rochford will be joining the Trust in July 2023
- National Guardian Office videos being added to the training tracker for all staff
- A collaborative model to support students speaking up has been put in place

The Board is asked to acknowledge the work of Elliot Judge in his tenure as interim F2SU Guardian.

Industrial Action - The Committee received an update on the business continuity plans in place to manage the impact of any industrial action involving the Trust, noting that the Junior Doctor action was managed very well. The Board is asked to acknowledge the work of HR team for their thoughtfully planning and management of the action. This showed that the Trust had good plans also in place for any future action.

Board Assurance Framework Risks - The Committee reviewed the BAF risks aligned, noting assurance received in the course of the meeting in relation to Time to Care, management discipline and the EDI agenda.

4. PEOPLE EQUALITY AND CULTURE COMMITTEE (cont.)

Chair of the Committee:
Manny Lewis (Non-Executive Director)

Information

Time to Care - The Committee received the update (noting the in-depth discussion held at the F&P Committee), noted the progress and that this will be presented to Board.

IA Thematic Review Equality Diversity and Inclusion Framework - The Committee received an overview of a thematic review carried out by IA across the NHS sector of their business, with some case study examples to illustrate the report. The key themes of the report were shared and noted that this remains a significant area of development through the EDI framework and ensuring embedded in all transformation and work flows throughout the Trust.

Health and Wellbeing Update – Lorraine Hammond provided an update on services available to staff, including information on feedback from staff using the services. Milestones and achievements in the six month period included:
- A number of awareness events e.g. stress awareness month (March 2023). These events were a mixture of activities with attendance and feedback being positive
- Initiatives designed to support staff e.g. Sleep School, promotion of Shiny Mind App, and increase in frequency of Mindfulness sessions.
- Achievement of Disability Confident Employer Accreditation, meaning we are recognised as an employer who is thinking differently and taking action
- Continuation of the Here for You staff support service (regional funding to the end of 2023/24)
- Act for You resilience training enabling people to develop greater psychological flexibility and ability to manage stress and distress in both their working and personal lives

Committee meeting held:
22 June 2023

Action

None to note.

Alert

None to note.

5. FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee:
Loy Lobo (Non-Executive Director)

Committee meeting held:
20 June 2023; and 20 July 2023

Assurance

Quality & Performance Reporting including Accountability Framework – Q1 2023/23 –
The Quality & Performance report for this committee was transitioned to Power BI in June 2023. Following two months of usage the committee shared their good feedback on the report and the news its KPIs will soon show relationships to transformation programmes.

The Executive Director of Operations provided a summary of escalated performance, covering ligature rates, violence & aggression incidents, psychological services wait times, out of area placements, and the Lighthouse children's centre.

The Trust's lead for the Accountability Frameworks attended the meeting to present progress through quarter 1. This highlighted key risks discussed, bringing forward what worked well, the reduction in red risks, and the improving domain ratings across care units. In addition, committee members were pleased to hear other Trusts are showing interest in how we have embedded this new function; in July the Chief Operating Officer from Birmingham and Solihull joined to observe an accountability framework meeting.

Finance M3 - Year to date there is a deficit of £2.8m, £1.4m adverse to plan. Key variances include continued overspends on Inpatients due to staffing costs with high levels of acuity and observations together with demand and capacity with out of area placements. Local capital spent is £0.8m, which is £0.1m adverse to plan.

Information

Estates and Facilities - The Senior Director of Estates & Facilities attended to present their Target Operating Model which is designed to improve the services provided by the Estates & Facilities Team. This sets out the work to be completed in key areas for the fiscal year 2023/24. Members were informed a quarterly update report will be submitted to Board. The committee shared support for the model and the department's approach to a bespoke Estates & Facilities system.

Brockfield - There has been significant further engagement and progress on the content of works and associated Standstill Deed, although further work is required to reach conclusion and execution. The committee was informed the Trust has protected its rights, and applied contract penalties. The improvement works have commenced and the content of the programme of works and timescales are reported through to the Executive Safety Oversight Group and into the Board Safety Oversight Group via the Accountability meetings with the Care Unit.

EPR Update - Regional and National reviews have taken place for the OBC. During July, two items will be sought for approval from EPUT Board; EPR Programme Governance, and Procurement & Contracting authority. Committee members shared their support for the progress being made and the comprehensive updates provided. The final business case is anticipated for the December 2023 Board

Time to Care - Members asked for further assurance to the oversight and governance of the Time to Care project. In July this action was closed with the submission of the projects governance structure.

5. FINANCE & PERFORMANCE COMMITTEE (cont.)

Chair of the Committee:
Loy Lobo (Non-Executive Director)

Committee meeting held:
20 June 2023; and 20 July 2023

Alert

MSE ICB 2023/3 Plan Close Down Letter, M2 System Review KLOE Response, Efficiency Update - The scale of risk inherent within organisational plans and outside of those plans has emerged at a greater rate and scale than the National team had anticipated. The scale of risk is noted particularly for acute colleagues. The sign-off of our Operating Plan includes financial conditions, enhanced and tighter controls, associated with the fact the system has a planned deficit at the start of the year. As a Trust we are taking action to put in place enhanced controls ourselves.

Efficiency schemes are progressing with the collation of ideas and actions from care units. This process is managed through the Transformation Steering Group. Committee members raised some concern for efficiency achievability, therefore an action was agreed for the enhanced reporting of probability, risk, and opportunities.

Action

The Estates Strategy - which is still undergoing some development, was presented to the meeting. The strategy will be addressed through key work streams, focussing primarily on the care units. It will be an iterative process throughout 2023, whereby updates and interim opportunities and issues are brought forward for decision. The Committee was informed of intentions to bring this forward at the Board Seminar in October 2023.

Out of Area Placement Contract - Committee members granted approval for the negotiation and agreement of a block contract for private beds, covering a period of 9 months with a 4 month review clause which will enable the Trust to reduce the number of block beds should we be in a position to do so. Assurance was provided that the continued use of these beds as appropriate Out of Area placements will improve the quality, safety and experience of our patients, and reduce financial risk. We have significant oversight of these beds using the "10 Steps" agreed by NHS England.

5. RECOMMENDATIONS / ACTION REQUIRED

The Board of Directors is asked to:

- Note the report and assurance provided

- Provide feedback for any identified issues for escalation

BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

● Discussion Item   👤 SS   🕐 3 minutes

REFERENCES   Only PDFs are attached

📕 BSOG Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	Board Safety Oversight Group Assurance Report
Executive/ Non-Executive Lead:	Professor Sheila Salmon, Chair
Report Author(s):	Alison Ives, Deputy Director of Transformation
Report discussed previously at:	Executive Safety Oversight Committee (ESOG) Board Safety Oversight Committee

Level of Assurance:	Level 1		Level 2	✓	Level 3	

Risk Assessment of Report

Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report

This report provides the Trust Board with an update on the progress of projects, programmes and activities linked to the safety priorities within the safety strategy. • Ligature Risk Reduction • EPUT Culture of Learning • Embedding Gold Standard SOPs • ePMA	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:
1. Note the contents of the report
2. Request any further information or action

Summary of Key Issues

The report provides an update on the progress of projects, programmes and activities linked to the safety priorities within the safety strategy:
• Ligature Risk Reduction
• EPUT Culture of Learning

- Embedding Gold Standard SOPs
- ePMA

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications:		**Capital £** **Revenue £** **Non Recurrent £**	
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
ESOG	Executive Safety Oversight Group	SOP	Standard Operating Procedure
BSOG	Board Safety Oversight Group		
LRRG	Ligature Risk Reduction Group		

Supporting Reports/ Appendices /or further reading
Board Safety Oversight Group Assurance Report

Lead
[signature]

Professor Sheila Salmon
Chair

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

BOARD SAFETY OVERSIGHT GROUP ASSURANCE REPORT

This report is provided as assurance to the Trust Board on the progress of projects, programmes and activities linked to the safety priorities within the Safety Strategy.

In this period the key areas of focus for the ESOG and BSOG remains with Ligature Risk Reduction, EPUT Culture of Learning and Embedding Gold Standard SOPs.

We also now spotlight report on the progress of Electronic Prescribing and Medicines Administration (ePMA) post Business Case approval at Trust Board.

Ligature Risk Reduction

The focus of the ligature risk reduction programme remains the environment of our in-patient estate, mobilisation of the ligature related training programme, and producing policies on a page relating to ligature risk reduction:

Environment
The planned programme of works for Brockfield House commenced in full mid-June and is making good progress. Once Aurora is complete the team will take any learning and feed it into the remaining programme in order to accelerate the work.

The door closer programme experienced initial delays due to challenges finding a closer which met the specification required. The team worked with various suppliers to find a suitable product which they then took to the Ligature Risk Reduction Group (LRRG) for approval. Following this, at the end of June 'Perko' door closers were ordered with delivery starting in mid-July.

The garden project at Ardleigh Ward commenced at the end of May and once finished the team will then transfer to Gosfield Ward at the beginning of July. It is anticipated both gardens will take approximately 5 to 6 weeks for completion.

A detailed list of the completed environmental works on our wards relating to ligature risk reduction, is included in Part 2 of this report.

Training
Following successful planning the ligature risk training pilot commenced delivery in June on Topaz Ward. This pilot will continue to take place for three months.

Policy
The Ligature Risk Assessment and Management 'Policy at a Glance' trial commenced on the CAMHS wards and following successful completion a facilitated feedback session took place. The team have now prepared recommendations following this and will present back to the Policy Oversight group.

EPUT Culture of Learning (ECOL)

Following contract agreement between EPUT and MASS Cohort PLC, development of the EPUT Safety Learning Management System (ESLMS) system began mid-June. This is planned to continue over the next 10 weeks in weeklong sprints.

Issues remain gaining access to some historical workforce data required for the development of the Safety Dashboard so a manual workaround is in place with a resolution plan being prepared.

Feedback was received on the lessons handbook and any required amendments have been actioned. This has now been submitted for approval by the Learning Oversight Sub-Committee at the end of July.

Embedding of Gold Standard Operating Procedures (SOPs

Work continues alongside Carradale futures to develop the 10 key SOPs, with a number of these now moving into approval stage.

The 10 key SOPs are:

- Local Induction
- Transfers
- Clinical Risk Assessment
- Admission
- Post Discharge Follow-up
- Record Keeping
- Disengagement
- Management of Deterioration
- Management of Falls
- RAG rating for Care Coordinators

A draft version of the Digital SOP product specification was presented to EPUTs Digital team, Carradale, the Project Lead and Transformation Exec. The first digitisation of the SOPs Board meeting took place in June with work now continuing on the product specification and app deployment onto EPUT's Power Platform.

Electronic Prescribing and Medicines Administration (ePMA)

Work has commenced on development of the detailed project plan to support implementation and configuration of the ePMA system. Following the go live of the upgraded pharmacy medication system the infrastructure set up will need additional configuration and in preparation for the full ePMA roll-out.

The project team have been finalising job descriptions for the ePMA Doctor and Nurse and once completed these will be submitted to the job matching panel ahead of advertising. As well as ongoing recruitment of the System Manager and digital integration roles.

The project team began mapping, documenting, validating and reviewing business case assumptions, project dependencies and the respective project timelines with project leads to identify any risks and develop mitigations.

Communication is underway with digital leads to also begin mapping their dependencies and identifying key stakeholders. Drafting of the specification for the business continuity solution is also underway and will be sent for approval and shared with proposed partner Digpacks.

Report prepared by

Alison Ives,
Deputy Director of Transformation

On behalf of
Professor Sheila Salmon
Chair

CQC COMPLIANCE UPDATE

● Discussion Item   👤 DG   🕐 10 minutes

REFERENCES

Only PDFs are attached

📄 CQC Compliance Update 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023
Report Title:	CQC Compliance Update	
Executive/Non-Executive Lead:	Denver Greenhalgh, Senior Director of Corporate Governance	
Report Author(s):	Nicola Jones, Director of Compliance and Risk	
Report discussed previously at:	Quality Committee	

Level of Assurance:	Level 1		Level 2		Level 3	✓

Risk Assessment of Report		
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report			
The purpose of this report is to provide an update on the key Care Quality Commission (CQC) registration requirements and related activities within the Trust.	**Approval**	✓	
	Discussion	✓	
	Information	✓	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report

2. Note that the improvement plan will be shared once fully developed

Summary of Key Issues

- EPUT is registered with the CQC.

- On 12 July 2023, the Trust received the final CQC Core Service and Well Led inspection report.

- The CQC rated the overall Trust as Requires Improvement

- The CQC have identified 45 Must do actions and 26 Should do actions. The Trust is undertaking analysis and development of actions to form an overarching improvement plan.

- Actions from the CQC Inspection Adult Acute and Psychiatric Intensive Care Units (PICU) April 2023 have continued to be progressed.

- Going forward there will be one overall EPUT CQC improvement plan superseding all the existing open action plans.

- There has been one enquiry raised by the CQC in this reporting period, which has been investigated and responded to.

- The CQC have undertaken one MHA inspections during the reporting period.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	

Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
CAMHS	Child and Adolescent Mental Health Service	EOT	Executive Operational Team
PICU	Psychiatric Intensive Care Unit	CCG	Clinical Commissioning Groups
MHA	Mental Health Act	PIR	Provider Information Return
COSHH	Control of Substances Hazardous to Health	CHS	Community Health Services
MHOST	Mental Health Optimal Staffing Tool		

Supporting Documents and/or Further Reading
Appendix A - CQC Report Published 12 July 2023

Lead
Denver Greenhalgh   **Senior Director of Corporate Governance**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC COMPLIANCE UPDATE

1. INTRODUCTION

The purpose of this report is to provide an update on the key Care Quality Commission (CQC) registration requirements and related activities within the Trust.

2. CQC REGISTRATION REQUIREMENTS

EPUT is fully registered with the CQC.

On 12 July 2023, the Trust received the CQC final report for the CQC Core Services and Well Led inspection.

The CQC have rated the Trust overall as Requires Improvement

Overall trust quality rating	Requires Improvement ●
Are services safe?	Requires Improvement ●
Are services effective?	Requires Improvement ●
Are services caring?	Good ●
Are services responsive?	Requires Improvement ●
Are services well-led?	Requires Improvement ●

3. CQC INSPECTIONS

3.1 CQC Action Plan Development

Over the last 9 months there have been a number of CQC inspections with a range of informal and formal feedback and inspection reports provided to the Trust including:

- Feedback received from the CQC following the October 2022 inspections at 2 adult acute wards with request for Immediate action (Section 29 warning notice – previously reported to the Board)

- Feedback received from the CQC following the November 2022 inspections at a range of trust services

- The Acute Wards for Adults and PICU Inspection report (published April 2023)

- CQC Comprehensive Inspection and the EPUT Well Led inspection report (published July 2023).

To ensure robust response to the CQC concerns a project has been undertaken to strengthen the Trust processes following the receipt of a CQC inspection report. The new process strengthens action ownership, utilises Systems Engineering Initiative for Patient Safety (SEIPs, or equivalent) to undertake

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analysis and use this to develop actions. The objective has been developing our processes in order to achieve long term sustained change and improvement for our staff, patients and families.

The graph below provides an overview of the changes made so far,

Greater focus on 'confirm and challenge' opportunities to push the robustness of proposed improvements ✓

A Standard Operating Process document containing all templates and processes for each step of the way ✓

Greater focus on long term sustainable changes ✓

Standard work to adhere to through TORs in order to set expectations and agree standard approaches for behaviours and reporting. Standard work is the foundation for improvement of processes ✓

All lines of responsibility clearly outlined through the documentation ✓

SEIPs used with the named leads to define and agree the actions to mitigate the CQC findings ✓

What has changed?

Behaviours with the addition of lessons learnt, celebrating successes and looking to provide psychological safety within the process ✓

Consolidated and simplified progress reporting so the teams can focus on what matters ✓

Automated informatics support to provide quantifiable changes to assurances

Daily huddles to drive pace, support and focus ✓

Responsibility of progress updates delegated to the action leads to drive pace, engagement and ownership ✓

As part of the project, work was undertaken to develop a robust central CQC action plan template which will bring together all CQC actions from the different inspections into one central framework.

3.2 Core Services Inspection & Well Led Inspection (published 12 July 2023)

On 12 July 2023, the Trust received the final version of the CQC report. ***The full report is included as Appendix A***

Overall EPUT provides 15 core services with 75 Core Domains (excluding our nursing homes). This inspection covered 30 (40%) of the core domains, and six services of which:

- 53% there was no change to domain rating

- 7% has an improved domain rating

- 40% moved down in domain rating (this is inclusive of the inadequate rating for our Acute wards for adults of working age and psychiatric intensive care service from the April 2023 report, previously reported to Board)

- Three services saw a deterioration of overall core service rating

  o Wards for people with a learning disability or autism

  o Acute wards for adults of working age and psychiatric intensive care service (note marked as remains the same in the CQC report but noted here in recognition of the outcome of the April 2023 report)

  o Community-based mental health services of adults of working age

- Two services remained static in overall core service rating
  - Wards for older people with mental health problems
  - Mental health crisis services and health-based places of safety

- One services saw an improvement in overall core service rating
  - Substance misuse service

The full matric of ratings for the services provided by EPUT is provided below (*extract from report published 12 July 2023*).

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022
Wards for people with a learning disability or autism	Requires Improvement ↓ Jul 2023	Requires Improvement ↓ Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement ↓ Jul 2023
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement →← Jul 2023	Inadequate ↓ Jul 2023	Inadequate →← Jul 2023
Wards for older people with mental health problems	Requires Improvement →← Jul 2023	Requires Improvement ↓ Jul 2023	Good →← Jul 2023	Good ↑ Jul 2023	Good →← Jul 2023	Requires Improvement →← Jul 2023
Forensic inpatient or secure wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Long stay or rehabilitation mental health wards for working age adults	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Community-based mental health services of adults of working age	Requires Improvement ↓ Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement ↓ Jul 2023	Requires Improvement ↓ Jul 2023
Mental health crisis services and health-based places of safety	Requires Improvement →← Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Good →← Jul 2023
Substance misuse services	Good ↑ Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Good →← Jul 2023	Requires Improvement →← Jul 2023	Good ↑ Jul 2023
Community mental health services for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for older people	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health services for children and young people	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health inpatient services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community end of life care	Good →← Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019	Outstanding ↑ Oct 2019	Good ↑ Oct 2019	Outstanding ↑↑ Oct 2019
Overall*	Good →← Oct 2019	Good →← Oct 2019	Outstanding ↑ Oct 2019	Good →← Oct 2019	Good →← Oct 2019	Good →← Oct 2019

Within the report the CQC list areas for improvement within two categories:

- 45 **Must Do** actions - necessary to comply with our legal obligations under registration

- 26 **Should Do** actions - to prevent failing to comply with legal requirements, or to improve services

We are currently reviewing all the areas noted by the CQC, utilising the new process, to set improvement actions which are preventative and sustainable. Our approach has categorised actions into 5 groups, to segregate those which build on any work already in place or indeed 'just do it' actions versus those which require analysis:

- Completed and no further action required

- 'just do it' quick remedial actions

- Need analysis to develop improvement action

- Already in existing plans but building on to address additional related concerns through SEIPS analysis

- Mitigated through transformation or ongoing QI work

We have planned the work flow to deliver the final action plan to comply with the required submission timeline with the CQC. On the page below is a thematic grouping of the identified areas for improvement:

Governance and Culture of Learning	Clinical Care	Environment and Equipment	Technology and Data	Staffing
• Ensuring breaches identified by CQC are addressed in a timely and effective way • Ensuring robust governance systems which enable identification of issued affecting quality of care • Embedding QI methodologies • Incident recording and reporting including Racial abuse • Ensuring audit processes are effective • Ensuring new vision and values are understood by staff	• Ensure robust observation and engagement processes including tackling sleeping on duty • Reduction of blanket restrictions • Ensure patients treated with dignity and respect with comprehensive care plans • Ensuring robust assessment and management of patient risks • Ensuring effective medicines management • Ensuring timely discharge planning from community MH services • Ensuring accurate record keeping • Monitoring of meaningful activities on wards	• Ensuring maintenance work is completed • Ensuring well maintained, clean and well-furnished including • nurse call alarms • Ensuring medical equipment is managed in line with policy	• Ensuring robust data quality and accuracy of data • Plan for implementation of a consistent patient record • Ensuring patients are aware of Oxevision and how this is used	• Ensuring sufficient numbers of regular staff and reduce vacancy rates • Ensuring sufficient numbers of qualified psychology staff • Ensuring all staff remain up to date with training, supervision and appraisal • Ensuring staff have access to specialist LD and autism training • Case load management

(See report for full details)

As with all reports, the CQC also identified a considerable amount of good practice. Examples are provided below:

Well Led

- Since our previous inspection in July and August 2019, changes had taken place to the board to increase accountability, strengthen clinical leadership and increase capacity.
- The trust leadership team had a comprehensive knowledge of current priorities and challenges.
- Leader's demonstrated commitment and drive to improving the care delivered in underperforming services.
- People appointed to positions of senior leadership had the appropriate skills, knowledge and experience to perform their roles.
- Clinical leadership had been strengthened.
- The patient experience team developed multiple ways for people to provide feedback on their experiences by working with local teams to understand what fitted their demographic.
- Since the launch of the strategy (Safety first Safety always) the trust have invested £20 million in their inpatient services addressing environments and safety
- In 2022 fixed ligature point incidents reduced by 32%.
- The trust participated in the early adoption of the patient safety incident response framework (PSIRF).
- The trust had played a significant role in the roll out of the COVID-19 vaccination programme.
- The new accountability framework provided the structures for team, care unit and senior governance meetings.
- The trust recognised the need to continually improve the culture of the organisation.

MH Inpatient and Crisis Services

- The ward staff participated in the provider's restrictive interventions reduction programme
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Some managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support
- They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.
- Managers made sure they had staff with the range of skills needed to provide high quality care
- Staff from different disciplines worked together as a team to benefit patients
- Staff supported patients to make decisions on their care for themselves.
- They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff informed and involved families and carers appropriately
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.
- Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes
- Staff treated patients with compassion and kindness.
- The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line.

Community MH Services

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose
- Managers, staff, and patients told us they had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Staff assessed the mental health needs of all patients. They worked with patients, families, and friends to develop individual care plans and updated them as needed.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- Staff treated patients with compassion and kindness
- Leaders we spoke with had the skills, knowledge, and experience to perform their roles. All leaders we spoke with said they felt supported to fulfil the role and responsibilities of their leadership role.

LD Inpatients and Substance Misuse

- The ward was safe, clean well-equipped, well-furnished, well-maintained and fit for purpose.
- Staff discussed and managed patient risks. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery.
- Staff understood how to protect people from abuse and the service worked well with other agencies to do so.
- They worked with people and with families and families and carers to develop individual care and support plans. Care plans reflected the assessed needs, were personalised and comprehensive.
- Staff supported people with their physical health and encouraged them to live healthier lives
- The ward team included or had access to the full range of specialist roles required to meet the needs of people on the ward.
- Staff supported people to make decisions on their care for themselves.
- Staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment or condition.

3.3 Willow Ward & Galleywood Ward October 2022 (published 3 April 2023)

As previously reported, the Trust received the CQC report for our Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units in April 2023. The report identified the ten areas for improvement; all of which have identified actions being taken forward to address the concern.

Delivery of the plan continues to be through the Inpatient Clinical Support Group and monitored through the Executive Operation Committee and oversight by the Quality Committee.

A summary of the action progress is included below:

Adult Acute and PICU (April 23) Action Progress

Pie chart legend values: 1, 0, 1, 4, 8, 20

Legend:
- Complete
- On track
- Slippage
- Risk
- Under development
- Complete with evidence
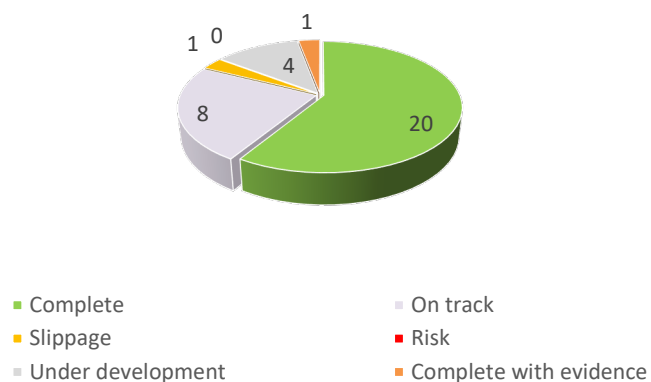
M1 Incident Reporting	Access to BWC footage roll out complete. CCTV cannot be taken forward at this time and a new group is being established to look at digital solution Service managers have utilised a range of methods to share information with staff reminding why it is important to review a patients risk assessment following an incident	On Track
M2 Observation and Engagement	Tackling Sleeping on Duty change in process: Action completed. Slippage on action around enhanced communication with further work to ensure communication reaches all staff alerting	Slippage
M3 Blanket Restrictions	Safeward training in place and continuing Trust-wide and a learning event took place on 23rd May 23 including blanket restrictions. Culture of Care Review tool now in use as part of DDQS role. Alongside this ward managers are using the Managers Assurance Tool.	On Track
M4 Sufficient Regular Staff	Time to care business case approved by TB in May 23 and now with partners for support	On Track
M5 Blind Spots	All actions complete. Complete, mirror was put up on Galleywood Ward (November 2022). Review of why there was a delay completed and identified human error.	Complete
M6 Oxevision	All actions complete. Tendable Matrons Assurance tool updated to include Oxevision questions to ensure ongoing testing and assurance.	Complete
M7 Ligature Cutters	Action was taken to address concern before final report was received	Complete
M8 Nurse Call Alarms	Current state review complete, 2 wards identified for alarms	On track
S1 Oxevision	All actions complete. Tendable Matrons Assurance tool updated to include Oxevision questions to ensure ongoing testing and assurance.	Complete
S2 Staff Morale	Follow up away days booked. New process of DDQS thank you letters being well received by staff. Ongoing visits by senior management, appreciated by staff	On track

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3.4 CQC Mental Health Act (MHA)

The CQC has undertaken 1 MHA inspection during May 2023, this was Rainbow Unit on 9 May 2023. The Provider Action statement is currently being processed.

Following each inspection a monitoring report is received by the ward with recommendations for improvement. All wards develop action plans to address these recommendations supported by the MHA Office.

3.5 CQC Enquiries

All CQC enquires received are reviewed in full and a formal response is returned following approval by the Chief Operating Officer / Executive Chief Nurse.

During April 2023, the CQC raised one enquiry in relation to Grangewaters, this was investigated by the Matron and Service Manage and a response has been provided to the CQC.

5	**Action required**

The Board of Directors is asked to:

1. Receive and note the content of the report

2. Note that the improvement plan will be shared once fully developed

Report prepared by
Nicola Jones,
Director of Compliance & Risk

On behalf of

Denver Greenhalgh,
Senior Director of Governance

Essex Partnership University NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement ●
Are services safe?	**Requires Improvement** ●
Are services effective?	**Requires Improvement** ●
Are services caring?	**Good** ●
Are services responsive?	**Requires Improvement** ●
Are services well-led?	**Requires Improvement** ●

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We inspected Essex Partnership University NHS Foundation Trust (EPUT) because we received information and had concerns about the safety and quality of services.

We carried out an unannounced comprehensive inspection of 6 core services:

- Wards for people with a learning disability or autism

- Acute wards for adults of working age and psychiatric intensive care units

- Mental health crisis services and health-based places of safety

- Wards for older people with mental health problems

- Substance misuse services

- Community-based mental health services for adults of working age

We also inspected the well-led key question for the trust overall.

We chose to inspect acute wards for adults of working age and psychiatric intensive care units to see how many improvements had been made following our inspection in October 2022 where we rated the safe domain as inadequate and issued a warning notice. We chose to inspect 3 core services based on their ratings at comprehensive inspections in 2018 and 2019 to see if the trust had made improvements to quality and safety. We chose 2 core services that were rated as good in 2018 to check if the trust had sustained the quality of care delivered.

The trust provides the following mental health services, which we did not inspect this time:

- Child and adolescent mental health wards

- Community mental health services for people with learning disabilities or autism

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- Community-based mental health services for older people

- Forensic / secure wards

- Long stay/rehabilitation mental health wards for working age adults

- The trust provides community health services, which we did not inspect this time:

- The trust delivers the following community health services:

- End of life care

- Children and young people's services

- Inpatient services

- Adult services

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We reduced the overall rating for caring from outstanding to good because this is a more accurate reflection of how the trust are currently performing overall. Our overall rating considered the current ratings of the 5 mental health core services and 4 community health core services we did not inspect at this time.

- The governance and safety culture of the trust did not always support the delivery of high quality, person centred care. Issues with timeliness in responding to lessons and inaccurate data impacted staff's ability to support people appropriately. Three core services had declined in their quality. Wards for people with a learning disability or autism and community based mental health services for adults of working age went from good to requires improvement and acute wards for adults of working age and psychiatric intensive care units went from requires improvement to inadequate. Two core services – wards for older people with mental health problems and mental health crisis services and health based places of safety had remained requires improvement overall. One of the 6 core services we inspected had improved from requires improvement to good overall: substance misuse services. The trust had plans or had recently launched new strategies to address key safety concerns for example around staffing vacancies and patient safety observation, but many were very new and not yet embedded.

- Across the 6 core services we rated 30 domains associated with the key questions. In 9 examples there was an overall reduction from good to requires improvement. In one example there was a reduction from requires improvement to inadequate. In 1 examples ratings remained the same. In 3 examples domains had improved from requires improvement to good and in 1 example the safe domain improved from inadequate to requires improvement.

- The most concerning ratings were for acute wards of adults of working age and psychiatric intensive care units. We rated safe and well led as inadequate, the other domains as requires improvement which means this service is still inadequate overall. The trust failed to ensure that all the concerns highlighted in the warning notice issued in October 2022 had been achieved consistently across all wards. For example, on some wards staff still applied blanket restrictions. Examples included searching all patients returning to wards and preventing patients from accessing fresh air freely.

- There remained ongoing challenges with staffing wards consistently and we identified problems with staff completing patient observations safely and in line with trust policies. The rating for safe had remained inadequate, the same rating applied during the inspection in October 2022. CQC recognised Trust wide plans to address issues such as staffing. However, several aspects of these plans were not fully implemented embedded to impact care on all the wards yet.

Our findings

- We also saw a reduction in the quality of care staff provided in wards for people with a learning disability or autism and community based mental health services for adults of working age. Both services overall ratings had reduced from good to requires improvement.

- Whilst there were still improvements required across a number of core services and leadership did not always support the delivery of improvement at pace, the trust recognised this and were in the early stages of implementing various programmes and processes which would drive the quality of care up. The leadership team had been increased to support executives in driving quality improvement. The CQC reflected the need to ensure pace and priority for this work and the trust agreed and committed to this.

Our inspection identified the following areas where further improvement was needed:

- The arrangements for governance, assurance and performance management did not operate effectively. The CQC recognised the timing of the inspection meant there were multiple examples of new strategies, systems, roles and approaches that were in the early stages of implementation. Examples included the trust safety strategy, the appointment of directors of quality and safety and the implementation of 'Time to Care' and safety dashboards. All of these required further embedding to directly impact the quality of care people received. The pace of change remained a concern along with ongoing and repeated breaches of regulation identified in services that had been highlighted to the trust during previous inspections dating back to 2019.

- The approach to service delivery and improvement was reactive and the trust were in the early stages of implementing more robust assurance arrangements to support a proactive response to improvement. There remained work to be done to ensure quality improvement initiatives were present in services and making an impact on the services people received.

- Staffing remained a challenge. Bank and agency use was higher than the trust targets. Managers described ways they attempted to book staff familiar with the wards and patients, but staff and patients told us unfamiliar staff were an issue, especially during evenings and weekends. Sickness was rated as 'amber' on the trust risk register at 6%. There were challenges in recruiting to roles, vacancy rates for qualified staff were 21%. We continued to find issues with how staff observed patients, with examples of staff sleeping and not interacting in a therapeutic way. However, it was recognised there were some early programmes of work which may have a positive impact in the future, such as the recruitment programme for internationally trained nurses.

- Data quality affected the trust's ability to monitor and mitigate against poor performance, risk and poor quality. Data provided about key elements of service performance from executive level did not match with information we found at ward level. An example that supports this can be found in the report for acute wards for adults of working age and psychiatric intensive care units relating to supervision and appraisal data. There was a lack of pace relating to over 10 items reflected on the board assurance framework. From October 2022 – January 2023 there were 7 strategic and 8 corporate risk items that had shown no movement is their score. We identified issues with quality audits not highlighting gaps in the quality of care being provided, an example of this related to governance systems providing false assurance to the board about the quality of patient observations being delivered on wards. There were issues with inpatient services having low bed occupancy despite community teams having increased caseloads and waiting lists. An example of this was seen in acute wards for adults of working age and psychiatric intensive care units and community home treatment teams, this had not been robustly addressed by the trust.

- The trust were due to launch their new data strategy following the inspection to build on their digital strategy. This would provide focus on how best to utilise data to provide robust intelligence and information to improve patient outcomes. Electronic systems and data quality required attention and pace. The trust have been using 7 different

Our findings

electronic patient record systems since the merger in 2017 and 6 years later are in a position of having funding approved to develop and implement a single system for the trust. In August 2019 we highlighted to the trust issues with training data, performance data and staff difficulties with multiple electronic recording systems. However, the health information exchange (HIE) remained in place to support record sharing between teams.

- Medicines optimisation and management across the trust required improvement. Pharmacy workforce challenges affected the quality and sustainability of medicines services. Pharmacy teams operated with a 45% vacancy rate overall. Organisational restructures and reporting lines meant Pharmacy teams felt removed from operational decision making. There were issues with medicines management on wards and the capacity of Pharmacy teams to audit and offer support was compromised by staffing challenges. The trust continued to advertise Pharmacy roles but had trouble in recruiting.

- Leaders did not always support staff effectively. Supervision and appraisal rates did not consistently achieve the trusts target meaning not all staff had regular access to this support. Meetings and opportunities to share learning did not take place consistently and regularly. This applied at all levels in the trust and minimised lessons and learning influencing strategy and practice. Feedback from staff about their engagement with the trust varied greatly, some staffing groups felt disconnected and that leaders did not listen to or recognise their concerns, whilst other groups were mainly positive. Forty two percent of the focus groups expressed some level of concern regarding their ability to express concerns and engagement with the organisation.

- Long standing complaints required attention to ensure complainants received responses in good time and knew what was happening with their case. One example showed a complaint being made in August 2021, not resolved and the most recent contact recorded as April 2022. Whilst recognising the very recent implementation of a new complaints process, we were not assured that there was enough focus on resolving long standing complaints.

Our inspection identified a number of areas where improvements had taken place:

- There was a full recognition by the trust of the need to continually improve the culture of the organisation. The freedom to speak up guardian, although in an interim post, had worked hard to increase their visibility and share the importance of speaking up. Many of the staff we met during the inspection talked about the improvements in the workforce culture, although there were still pockets of poor morale, mainly due to staffing challenges and some issues identified via an internal inquiry following a television broadcast. The trust board displayed positive role modelling behaviours which they demonstrated throughout the well led review. The trust made sure learning featured at different levels in the organisation from the executive level learning sub- committee group through to learning newsletters displayed on wards and in services. Executives made themselves available to staff via 'grills' where staff could directly challenge leaders about their concerns or any issues. The trust appointed 500 engagement champions who could access the CEO directly, however there remained challenges with capturing the voice of staff working on inpatient wards. The trust set expectations about staff behaviour and developed a behaviour framework to outline clear boundaries about unacceptable behaviour and consequences for those behaviours. This was initially driven by the need to support staff who experienced racial abuse (identified at the CQC inspection in November 2022) but was not limited to this issue.

- The trust was actively involved work across the systems relevant to Essex. Three members of the executive team served 3 integrated care boards (ICB's) relevant to the trust's portfolio. The trust was part of four integrated care systems and were involved in 6 place based alliances. The trust also engaged with 3 local authorities which served different areas to those associated with the ICB's. Trust leaders understood the need to design, plan and develop effective services to meet the needs of the local population. A priority for the board was to ensure that the trust faced outwards and developed a reputation of transparency and openness. The trust opened their committees to governors to increase challenge and accountability and support the work of the non-executive directors. Feedback from people was integral to planning and reviewing services. The patient experience team developed multiple ways for people to

Our findings

provide feedback on their experiences by working with local teams to understand what fitted their demographic. This included the use of text messages, quick response (QR) codes, paper ballot boxes and forms. The work on creating a variety of feedback methods contributed to an 800% increase in feedback from August 2022 – January 2023. Work was ongoing to ensure that patients and people who use service featured as a key stakeholder. The 'your voice' community provided challenge and feedback to the board and the trust launched 'I want great care' in January 2022. The patient experience annual review from November 2022 demonstrated positive results for involvement including 92% growth in the recruitment of volunteers (from 126 in 2021 to 243 in 2022) and a 720% growth in recruitment to the lived experience team (from 10 in 2021 to 82 in 2022).

- The trust participated in the early adoption of the patient safety incident response framework (PSIRF). This sets out the NHS's approach to developing and maintain effective systems and processes for responding to patient safety incidents. The purpose is to develop a culture of learning to improve patient safety. The patient safety team engaged regularly with the national team to support the re-design of materials to improve their quality. The trust made a commitment to PSIRF despite the fact it was promoted as a cost neutral programme but has needed investment. Responses to patient safety incidents demonstrated compassion and answered all questions and concerns put forward by families and carers.

- The trust was the lead provider for the COVID-19 vaccination programme and was integral to ensuring people of Essex had access to this. They set up multiple vaccination sites quickly, delivered 1.6 million vaccinations and worked with local systems and partners to offer vaccinations to hard to reach and marginalised groups. The trust used creative ways to increase vaccination uptake such as vaccination busses and home visits.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about each of the core services.

During the inspection visits, we:

- Visited 29 wards, 17 teams and 4 health based places of safety

- Spoke to 224 staff performing a wide range of roles

- Spoke to 104 patients and 17 relatives or carers

- Looked at 182 individual patient records

- Looked at over 116 medication records

- Attended 29 meetings including staff handovers, multidisciplinary meetings and patient community meetings. We observed 5 examples of patient care by sitting and watching from patient areas.

- Attended 4 home visits

- Held 12 focus groups with staff of all grades on a variety of topics

- Looked at records, policies and procedures involved in the day to day operation of the services.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Our findings

We spoke to 104 patients and 17 relatives and carers across the services we inspected. Patients and carers gave largely positive feedback about the way staff treated them and the support they offered. Patients and carers gave examples of staff treating them as individuals and involving them in their care.

On acute wards for adults of working age and psychiatric intensive care units, most patients told us staff working day shifts treated them with kindness and helped them to be independent. Patients liked the choice of food and the fact they could have snacks and drinks throughout the day. On wards for people with a learning disabilities and/or autism people told us staff treated them with kindness and that staff provided activities that they enjoyed such as cycling and colouring. Staff supported carers to attend the ward for visits and clinical meetings and involved them in planning the care and discharge of their loved one. On the wards for older people with mental health problems patients told us that staff listened and helped them to understand their care. Patients felt safe, valued and respected.

In the community-based mental health services for adults of working age, patients and carers praised the staff for making sure everyone was involved in care decisions and that staff looked at physical and social needs alongside their mental health. They felt the service responded to their needs quickly and involved other services which could help. Patients liked the frequency of their appointments and the fact that there was a team approach so they could be seen by others if their worker was on leave or absent and didn't have to repeat their care story. In the mental health crisis services and health-based places of safety, patients said staff treated them kindly and offered flexible appointments to meet their needs. Patients felt staff offered them opportunities to be involved in their care and did everything they could to provide care in the community and help people stay out of hospital. In substance misuse services, people felt staff had an excellent knowledge of substance misuse and this helped them feel supported. They described staff as being available when they needed them and making every effort to involve people in their care.

There were however some areas for improvement identified by people who used the services. On the acute wards for adults of working age and psychiatric intensive care units' patients and carers described issues with staff working nights. This included 5 patients describing staff falling asleep at night, 3 patients told us that staff talked in different languages during night shifts and were 'uncaring'. Four patients told us that staff observing them did not engage with them. One patient described issues with the food portions and 11 patients told us that the coffee was decaffeinated so staff could support them with good sleep hygiene. On wards for people with a learning disabilities and/or autism there had been an issue with a walk being cancelled due to staffing shortages and not all carers had a copy of their relative's care plan.

In the community-based mental health services for adults of working age, some people told us they would like more definite goals and to see the Doctor more often for reviews.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

Our findings

- The trust must ensure they have a robust process for implementing and monitoring improvement processes. Such as breaches identified in core service reports in a timely and effective way. (Regulation 17(1)).

- The trust must ensure that the governance systems are further embedded and reviewed to enable the identification of issues affecting the quality of care being delivered. (Regulation 17(1)).

- The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. (Regulation 17(1)).

- The trust must ensure they embed quality improvement methodologies across services to encourage ongoing improvements for people who use them. (Regulation 17(1)).

- The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (Regulation 17(1)).

Acute wards for adults of working age and psychiatric intensive care units.

- The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts 'policies and procedures for the recording and reporting of incidents. (Regulation 12 (1).

- The trust must ensure staff follow the provider's policy and procedures on the use of enhanced support when observing patients who have been assessed as being at higher risk harm to themselves or others and observe patients in a way that maintains the patients' safety. (Regulation 12(1)).

- The trust must ensure staff fully engage with patients when undertaking enhanced observations (Regulation 12(1)). The trust must ensure that staff do not fall asleep when undertaking patient observations. (Regulation 12 (2).

- The trust must take immediate steps to review and reduce all blanket restrictions on the wards, where it is safe to do so. (Regulation 12 (1).

- The trust must ensure there are sufficient numbers of regular staff working on the wards who are familiar with individual service user needs. (Regulation 12 (1).

- The trust must ensure that maintenance work is completed to address the inability of staff to observe patients from all areas (blind spots). (Regulation 12 (1).

- The trust must ensure patients understand the use of the contact-free patient monitoring and management system, including why it is used and how information will be stored and accessed. (Regulation 12 (1).

- The trust must ensure that all patients have access to nurse call alarms. (Regulation 12 (1).

- The trust must always treat all patients with dignity and respect. (Regulation 10. (1))

- The trust must support the autonomy of the patients in line with their needs and stated preferences. Patients admitted informally must be fully informed of their rights and able to leave the ward safely. (Regulation 10. (2) (b))

- The trust must ensure patients are always treated with respect and dignity whilst they receive care and treatment. Care plans must be fully complete, personalised, holistic, reviewed regularly and consider the full range of patient's needs. (Regulation 10. (1))

- The trust must review the current prohibited items lists as these varied from ward to ward. (Regulation 12 (1).

- The trust must ensure care and treatment is provided with the consent of the patient around the contact-free patient monitoring and management system. (Regulation 12 (2)).

- The trust must assess risks to the health and safety of patients receiving care and treatment, including patient's sexual safety; doing all that is reasonably practicable to mitigate such risks. (Regulation 12. (1) (2) (a) (b)).

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- The trust must ensure that any episode of abuse is reported, and appropriate actions taken, including incidents of racial abuse to staff; doing all that is reasonably practicable to mitigate such risks (Regulation 12. (1) (2) (a) (b))

- The trust must ensure staff used systems and processes to safely prescribe, administer, record and store medicines. The trust must ensure that staff regularly review the effects of medications on each patient's mental and physical health. (Regulation 12 (2))

- The trust must ensure all ward areas are clean, well maintained and well-furnished. This includes the seclusion room at Ardleigh ward. The trust must ensure that ward doors are robust. (Regulation 15. (1))

- The trust must ensure the premises are suitable for the purpose for which they are being used including patient search rooms for Willow, Cedar and Hadleigh wards. (Regulation 15. (1))

- The trust must ensure systems and processes established and operate effectively to ensure compliance with inspection requirements. Audit processes effective, pick up and effectively address gaps in care (Regulation 17 (1))

- The trust should ensure they have effective systems and process to identify, and where risk allows, mitigate and review restrictive practice. (Regulation 17 (1))

- The trust must ensure sufficient numbers of suitably qualified psychology staff deliver care at Willows and Cedar ward. (Regulation 18. (1))

- The trust must ensure that staff are made aware of the need for professional boundaries. (Regulation 18. (1))

- The trust must ensure staff receive regular mandatory training. This includes Fire compliance, prevention management of violence and aggression, Safeguarding adults and Children, Mental Capacity Act training (Regulation 18. (2))

- The trust must ensure staff receive regular supervision and appraisals. (Regulation 18. (2))

Mental Health crisis and health-based places of safety

- The trust must ensure that staff in the home treatment team east manage, store and monitor controlled drugs in line with trust policy. (Regulation 12 (2))

Community Mental Health services for Adults of Working Age

- The trust must ensure that they are compliant with all aspects of medicines management including. That there are no gaps in clinic room fridge and room temperature records. that there is always a robust system in place to ensure the security of all doctors FP10 prescription pads. That all out of date medicines are disposed of immediately. (Regulation 12(2)(g))

- The trust must ensure that all patients have fully completed discharge plans and that there are systems and processes in place to secure timely discharge for patients using the recovery and wellbeing part of the service as part of their recovery. (Regulation 17(2)(b))

- The trust must ensure that managers at Colchester EIP and Colchester wellbeing and recovery teams use effective systems for auditing patients' care records when they transfer between care co-ordinators. (Regulation 17(2)(b)).

- The trust must ensure that their electronic recording system/s can link up historical and current patient information. To ensure that staff can easily access all this information and ensure that no patient information is lost when transferring from one system to another. (Regulation 17(2)(f))

Wards for older people with mental health problems

Our findings

- The trust must ensure that emergency equipment is managed in line with trust policy (Regulation 12(2)(b)).

- The trust must ensure all Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information and recording is correct (Regulation 12(2)(b)).

- The trust must ensure staff on Henneage Ward maintain trust standards when observing and interacting with patients (Regulation 12(2)(b)).

- The trust must ensure that medicines are managed in line with trust policy, in particular medicines reconciliation and covert medicines administration (Regulation 12(2)(g)).

- The trust must continue its work to recruit psychologists as part of the multidisciplinary team. (Regulation 18(1)).

Wards for People with a learning disability and autistic people

- The service must ensure it has enough permanent regular nursing and support staff to keep patients safe (Regulation 18(1)).

- The service must ensure that blood glucose machines are fully calibrated (Regulation 12(2) (e)).

- The provider must ensure that all care and treatment records are complete and accessible (Regulation 17(2)(c)).

- The service must ensure that staff accurately record administration of medications, and that consent to treatment forms are easily accessible (Regulation 12(2) (g)).

- The service must ensure that staff record patient vital signs on the physical health observation charts, in line with trust policy. (Regulation 12(2)(a)).

- The service must ensure that staff have access to specialist learning disability and autism training. (Regulation 12(2) (c)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure they continue to work on the organisational culture, including addressing the recommendations made from the inquiry linked to recent television broadcasts.

Acute wards for adults of working age and psychiatric intensive care units.

- The trust should ensure the new vison and values are reviewed across wards to ensure staff understand their role and contribution to providing high quality care.

- The trust should ensure that staff are provided with clear guidance regarding how to hold patient forums.

Mental Health crisis and health-based places of safety

- The trust should ensure that the Home First West, Home First Mid, and Home First East teams are up to date with their mandatory training.

- The trust should ensure that teams do not have excessively high caseloads.

- The trust should ensure teams monitor physical health where necessary.

- The trust should ensure that care plans are personalised and individualised and demonstrate patient involvement.

Our findings

- The trust should ensure the Home First East team manage and store medication in line with the trust's medication management policy.

- The trust should ensure that vacancy rates are reduced so that teams are adequately staffed.

- The trust should ensure that the Home First West, Home First East and Crisis Resolution and Home Treatment west teams are up to date with staff supervision.

- The trust should ensure that doctors in the Home First Team East keep prescription pads stored securely.

- The trust should ensure the Home First East team complete audits to monitor the effectiveness of the service.

Community Mental Health services for Adults of Working Age

- The trust should ensure that all patient care plans are individualised and holistic.

- The trust should ensure that they address the waiting lists for psychological therapy.

Wards for older people with mental health problems

- The trust should ensure that work continues to recruit permanent staff to reduce vacancy levels.

- The trust should consider arrangements for formally monitoring meaningful activities for patients on each ward.

- The trust should ensure that staff on Tower ward meet its targets for compliance with mandatory training, in particular grab bag training.

- The trust should ensure the service adheres to the Mental Health Act and the Mental Health Act Code of Practice, in particular that patients' medicines are prescribed in line with consent to treatment documents.

- The trust should ensure that care plans are easy to use and understand.

- The trust should continue its work to recruit psychologists as part of the multidisciplinary team.

- The trust should ensure that staff meet its targets for compliance with staff appraisals and staff supervision.

- The trust should ensure all wards follow its governance systems and processes to maintain patient safety, in particular for clinical equipment monitoring, assessment and management of patient risk, and medicines management.

- The trust should ensure that it develops structured quality improvement models to help facilitate improvements and service developments.

Wards for People with a learning disability and autistic people

- The service should ensure that staff follow trust policy on body worn cameras

- The service should ensure that the contents of the first aid box are checked regularly, and items replaced.

- The service should ensure that governance systems and process are fully embedded to ensure that action is taken.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Our findings

Since our previous inspection in July and August 2019, changes had taken place to the board to increase accountability, strengthen clinical leadership and increase capacity. The board appointed the current chief executive officer in October 2020. Alongside this, the trust recruited a new chief operating officer, a new executive director of strategy, transformation and digital and a new chief financial officer.

The EPUT board of directors consisted of 8 executive directors (EDs) and 8 non-executive directors, with no current vacancies. The trust planned to refresh the chair of the audit committee later in 2023.

The executive board had 1 (7%) person from an ethnic minority group member and 2 (25%) women. The non-executive board had 3 (50%) members from ethnic minority groups and 3 (50%) women.

The trust leadership team had a comprehensive knowledge of current priorities and challenges. However, we were concerned by the lack of pace that leaders applied to make improvements in some services. Acute wards for adults of working age and psychiatric intensive care units' inspections from 2019 to current have identified ongoing and repeated breaches of regulation that are yet to be fully addressed. Further to this, examples of poor practice which have been highlighted in the core service report were still being used and evidence of trust policies not being followed. The trust leadership team recognised the need for further work to embed and evaluate policies and procedures, particularly relating to patient safety. Leaders demonstrated commitment and drive to improving the care delivered in underperforming services.

The leadership team created new roles to drive improvement. The trust recruited deputy directors for quality and safety and deputy medical directors. The trust intended to devolve leadership and empower leaders to drive improvements in their care units. The accountability framework implemented in January 2022 supported this approach. Leaders aimed to outline, through the framework, ways in which the care units were held to account on their ability to achieve the trusts strategic objectives and key performance indicators. Leaders held monthly accountability framework review meetings to ensure joined up discussions took place with care units to understand local challenges and successes. The agenda for the meetings monitored performance and challenged under performance.

Leaders planned time to ensure visibility in services. From June 2022 to December 2022 board members completed 130 visits to services across the trust portfolio. During visits leaders spoke with staff about any concerns, observed how staff delivered care and spoke with patients about their experiences of services. Leaders reported to board on visit outcomes. Staff across services spoke positively about visibility of senior leaders. The CEO held 'L50' events with 50 leaders in the trust where they updated colleagues about key messages, challenges, priorities and achievements. There were further opportunities for staff to engage via all staff briefings and 'engagement champion grills'.

Recruitment files demonstrated all appointments to the board had been completed in line with fit and proper person guidelines. More recent appointments demonstrated the involvement of governors and people who use services in the recruitment process.

The trust invested in developing leaders for the future. The RISE programme provided opportunities for staff from ethnic minority groups to develop a range of skills and competencies to support them in advancing their careers. It was open from bands 2 to 8b and provided opportunities from 1 day line manager modules to longer courses offering 5 modules, a quality improvement project and a graduation event. The programme used a blended learning approach and offered a range of development tools from self paced learning to mentoring. The first cohort had completed the programme and an evaluation was complete. Twenty seven percent of the first cohort experienced promotion during their time on the course. The trust recognised that staff not from a ethnic minority groups had requested access to the programme and planned to design further options to promote inclusivity.

Our findings

People appointed to positions of senior leadership had the appropriate skills, knowledge and experience to perform their roles. The members of the executive leadership team had clearly defined roles as leads for delivering the strategic improvement priorities and were actively working on translating this into practice. Members of the executive leadership team spoke about this work with confidence.

The non-executive directors had well defined areas of responsibility and brought a wide range of skills, experience and connections with external bodies. They were able to describe their roles with clarity.

Clinical leadership had been strengthened. The medical director had support from 5 deputy medical directors, having previously having 1. This was the same for the executive nurse. This increased medical leadership's ability to meet with medics working in services and offer increased support. The medical director met with inpatient consultants on a weekly basis to keep informed about the pressure's services faced. The guardian of safe working met with junior doctors regularly and medical staff had access to supervision and external supervisors. Medicines safety and Pharmacy sat under the portfolio of the executive nurse. Medical education sat under the portfolio of the medical director. There were 145 trainee Doctors and 180 students involved with the trust. Once a month the medical director and a deputy medical director held a reflective podcast which engaged 300-400 staff.

Vision and Strategy

In 2021, the trust agreed a new vision and set out "to be the leading health and wellbeing service in the provision of mental health and community care. The executive team presented their 2023 – 2028 strategic plan at public board on 25 January 2023. The strategy sets out the commitment to put service users, families and carers at the centre of everything the trust does and was designed in line with national policies such as the NHS long term plan and the NHS mental health implementation plan. The trust set values of "we CARE, we LEARN, we EMPOWER. The strategic objectives set by the board aim to "deliver safe, high quality, integrated care services, we will enable each other to be the best that we can, we will work together with our partners to make our services better, we will help our communities thrive." The trust vision aimed to "be the leading health and wellbeing service in the provision of mental health and community care".

The trust had four strategic objectives:

We will deliver safe, high quality, integrated care services

We will enable each other to be the best we can be

We will work together with partners to make services better

We will support our communities to thrive

The trust sought feedback from patients, carers, families and system partners during the development of the strategic plan to ensure it captured the needs of the population and they system. The trust engaged with 680 people over 83 engagement events during the development phase.

Our findings

The strategy laid out the priorities for each objective, the trusts commitments to achieving the objectives and ways in which leaders would monitor outcomes. Under the strategy sat local strategies for the 5 'care units': Mid and South Essex Community, North east Essex, Specialist services, Urgent care and Inpatient and West Essex Community. These described local visions and commitments that supported the objectives of the overall trust strategic plan. Care units formed a new operating model for the trust led by multi disciplinary and professional teams.

Wider organisational plans supported the delivery of the strategic plan. Some of these included the 'safety first, safety always strategy' which aimed to consistently deliver safe, individualised care with patients and family at the centre. The trust viewed this strategy as a 'golden thread' throughout the organisation supported by the accountability framework and the cultural work happening in the trust. The digital and data strategy aimed to maximise inclusion and support transformation and improvement programmes and focused on meeting national and system requirements including the requirements set out by the NHS transformation directorate relating to shared care record requirements. The trust also had strategies 'under construction' such as the clinical quality strategy, the working with people and communities strategy and the people and culture strategy, all of which required embedding following their sign off. Executives chaired the strategy steering group which reviewed progress against the delivery outcomes of the strategy.

The trust developed strong working relationships with system partners. The population served by the trust required engagement with 4 integrated care boards (ICB's), 4 integrated care systems (ICS's), 3 local authorities and 6 place based alliances. The trust had also established specific arrangements with other providers of NHS services to work towards their strategic objectives. In North East Essex the community collaborative brought together services providing community health services. This also occurred in Mid and South Essex. In East of England, the regional specialist mental health collaborative brought together specialist mental health services and and the CEO attended to represent the trust.

In Southend, Essex and Thurrock the trust worked with multiple partners and stakeholders from NHS colleagues to the Police to refresh the all age mental health strategy for the area. This required collaborative working arrangements to support its design and implementation.

The trust maintained relationships with local universities to support education and training for students and worked with services in their geographical area such as general practitioners, acute hospitals and community services.

Culture

The trust recognised the need to continually improve the culture of the organisation. Throughout various interviews leaders described the work to ensure staff worked in a culture of learning and not blame. Many of the staff we spoke with during the inspection described work encouraging people to speak up and recent work about challenging racist behaviour.

Following a recent undercover television programme broadcast the trust instigated an internal inquiry to investigate and review concerns raised. Culture featured as a concern for two acute wards for adults of working age. Whilst the inquiry team approached 61 members of staff only 20% of staff engaged with the process. Recommendations from the inquiry included the need for further development of local learning cultures, time to be protected to support developments of team culture and was critical of the 'cultural grip' that failed to assure that behaviours were in line with trust values. The inquiry made primary recommendations that the trust review induction guidance for temporary staff to promote consistency of positive culture, that the trust should review how a culture of psychological safety could be

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embedded to encourage staff to speak out and that local teams featured in the broadcast build relationships with the lessons team to develop their culture of learning. The inquiry team made longer term recommendations for the trust to develop strategic plans to address organisation culture and develop staff confidence in the trusts ability to be open, honest and responsive. The inquiry team presented their findings to board in January 2023.

The trust had an interim freedom to speak up guardian (the permanent post was being recruited to). The role of a freedom to speak up guardian is a person who supports staff to speak up about concerns without the fear of negative consequences. Data collected from the freedom to speak up guardian showed an increase in people raising concerns. In 2022/2023 quarter 1 (April – June) staff reported 44 concerns, quarter 2 (July – September) staff reported 54 concerns and in quarter 3 staff reported 129 concerns. Themes of concerns included bullying and harassment, patient safety, staff safety and inappropriate restraints. The trust also had 10 freedom to speak up champions whose role was to support the guardian in raising the profile of their work. The guardian and champions prioritised visibility and spent time of wards, including attending handovers and night shifts. The guardian delivered themed workshops to staff which linked to themes from reported concerns and had also delivered sessions to staff following the broadcast of an undercover television programme. During December 2022 the guardian purposely reduced their visits to wards to measure visibility versus reported concerns. Reported concerns dropped when visibility decreased. The guardian had direct access to the chief executive office and provided reports to board. The trust employed administrative support for the guardian to support the workload of 129 reports of concerns requiring review and action.

The trust had an equality, diversity and inclusion plan outlined for 2022 – 2023. The plan outlined four strategic pillars: culture and leadership, talent management and acquisition, recruitment and retention and data. Work identified in the plan included 'embed the just culture – civility and respect principles across the trust', 'ensure process for career progression plans are in place for black and minority ethnic staff', 'all leavers will have a "stay" and/or "exit" interview and 'campaign to encourage staff to share their protected characteristics for use within the trust'. The trust outlined ways in which progress against the work would be measured such as: 80% of staff with complete demographic data, 100% of staff leavers to have a recorded exit interview, 5% uptake in career progression initiatives and a reduction of 5% in recorded formal concerns. The plan outlined the goal of improved staff wellbeing making a positive impact on patient safety.

Twenty three percent of staff in the trust were from ethnic minority groups. The workforce race equality standards (WRES) requires NHS employers to take action to ensure that staff from ethnic minority groups have equal access to career opportunities and receive fair treatment in the workplace. Whilst the trust made some improvements in 2022 across 6 WRES indicators, 3 showed a decline in staff experience. Indicators showing improvement included staff from ethnic minority groups in clinical workforce leadership positions (NHS Band 7, 8a and 8d) increasing by 1.5%, as well as staff from ethnic minority groups being more likely to access mandatory training and continual professional development. This was a specific achievement for the trust after being identified as one of the lowest performing trusts in the country for this previously. Although board representation for staff from ethnic minority groups had declined from 2021, at 25%, this remained above the national average of 7.5%. However, indicators which had worsened included the number of staff from ethnic minority groups experiencing bullying and harassment from patients, relatives and staff in the last 12 months and the likelihood of staff from ethnic minority groups entering disciplinary proceedings. The trust refreshed their WRES action plan for 2022/23 based on the required areas for improvement and consulted with stakeholders and the ethnic minority and race equality staff network in September 2022 with a view to develop the plan further and present to board for approval.

The declaration rate for disabled staff had increased by 0.7% from 2021 to 2022, standing at 4%. The workforce disability equality standards (WDES) supports organisations to compare the workplace and career experiences of disabled and non-disabled staff. In 2022, the trust saw an improvement in 11 out of 13 WDES metrics. Disabled applicants were more

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likely to be approved during trust shortlisting processes for roles than non-disabled applicants. This indicator was supported by the work completed by the trust around hiring practices as a disability confident employer and their guaranteed interview scheme. However, the prevalence of disabled staff experience of bullying and harassment was the main area of focus for the trust, having seen a decline in the 2022 results compared to 2021. As with the WRES, the trust refreshed their WDES action plan in consultation with stakeholders and the disability and mental health network for in September 2022, with an updated version to be presented for board sign off.

The equality and inclusion sub committee was in place to steer and guide work required to make progress on the trust's general equality duties. The committee was responsible for monitoring and developing the equality delivery system (EDS2). The EDS2 was designed to support employers embed equality principles into day to day work and improve equality performance. The most recent EDS2 from 2021/2022 recorded the trust as 'achieving' 12 outcomes and 'excelling' in 6 outcomes. The trust excelled in areas such as staff taking up training and development opportunities and having fair recruitment and selection processes contributing to a more representative workforce. However, it was noted that the trust also 'excelled' in staff feeling free from abuse and harassment, bullying and violence, which conflicts with the findings of the WRES and WDES. The trust had 350 staff engagement and equality champions whose role it was to spread the message about equality inclusion. They received training and support for this role and were sponsored by the Executive Director for People and Culture. The trust trained staff in understanding the accessible information standards to ensure that anyone using services with a disability, impairment or sensory loss could get the information they needed in a way they understood. Leaders expected staff to identify and record information relating to communication needs at the earliest opportunity and to review them throughout treatment.

Staff networks existed for staff from ethnic minority groups, disabled staff, LGBT+ staff and staff with caring responsibilities. Executive sponsors supported each network. Staff networks planned and delivered events throughout the year to draw attention to specific topics such as Black History Month and LGBT+ history month.

Recruitment and retention of staff posed a challenge to the trust. Staffing data showed trust wide vacancy rates for registered nurses to be at 21% (1544 full time equivalent out of an establishment of 1958). The vacancy rate for health care assistants was 12% (745 full time equivalents out of an establishment of 850). The trust workforce improvement planning for 2023 – 2024 set out three key workforce priorities: recruitment and retention, temporary staffing and culture. Recruitment and retention was underpinned by 9 actions, examples of which included: clear recruitment processes, job description standardisation, the implementation of 'Time to care' and school/college/university in-reach across the trust geography. Temporary staffing actions included example such as 6 month contracting with agencies and a preferred supplier list and the introduction of an agency to bank policy. Finally, culture actions included examples such as equality, diversity and inclusion educational sessions, leadership development for band 7 and 8a and a rota of employee experience managers on wards. The trust set a deadline of 7 February 2023 for all care units to design action plans to support workforce improvement. The HR director took responsibility for owning the plan, with progress tracked via fortnightly delivery review meetings and assurance gained from the accountability frameworks. The trust were in the early implementation stage of 'Time to care' (TTC) following it commission in June 2022. The program supports frontline staff to identify challenges and implement solutions at the ward level in order to increase time available for direct patient care. This was not yet fully embedded in all services.

The trust recruited 185 internationally trained nurses from a variety of different countries to improve vacancy rates. At the time of inspection 65 were working on wards and the remaining 120 were in progress. The trust offered 3 months pastoral care to internationally recruited nurses in comparison to most other trusts with similar programmes who offered 1 month.

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Staff sickness was above target for the trust (5%). Figures report for January board showed 6% sickness levels across the trust. Although long term absence was less concerning at 3%. The trust reported that 5% of staff sickness related to anxiety, stress or depression. Staff turnover sat at 11% against a national benchmark of 12% for mental health services and 12% for community health services.

The trust recognised staff through staff recognition awards which members of the public could access via their website. There were 5 categories available: hero award – beyond the call of duty, peer to peer recognition, team recognition, leadership award and research, innovation and improvement. The trust put forward any winners of recognition awards into the staff recognition of the year award at the annual quality awards event.

The trust supported staff wellbeing in a variety of ways. The 'here for you' service, delivered in partnership with another NHS trust was award winning and was established in response to the challenges staff faced during and post the COVID-19 pandemic. It provided support for mental health issues, financial issues and practical issues. This was additional support available to staff alongside the employee assistance programme.

Forty two percent of staff engaged in the most recent staff survey, despite the trust arranging access for bank staff. Highlights of the survey showed 89% of staff felt the organisation was compassionate and inclusive. Staff felt trusted to do their job (92%), staff felt they could discuss flexible working (78%) and that leaders took a positive interest in their career (77%). Forty nine percent of staff felt they could meet the demands of their job which was 5% above the average scores nationally. Twenty one percent of staff felt they would probably look for a new job in the next 12 months.

Duty of Candour continued to be upheld appropriately. Complaint and investigation responses included apologies, where appropriate, and demonstrated compassion and transparency.

Governance

Governance processes did not always support the delivery of high quality person centred care. It is recognised that many of the governance process were new and had recently implemented by the trust. The year 2 progress report for the safety strategy was due for board sign off in January 2023 and required embedding across the organisation. The use of live safety dashboards to capture risk and performance issues was a new concept and was still under development. The trust recognised that their pace at implementing new structures and processes needed to increase and it would take time for them to see the benefits reflected in the quality of their services. A full review of governance and leadership was due to take place by the end of the 2023/24 financial year by an external facilitator. The trust did use data that compared current performance to previous months performance to look at how services performed over time, and this was included on the new safety dashboards.

We remained concerned about the trusts ability to use previous inspection findings to drive improvements to patient safety and experience. In acute wards for adults of working age and psychiatric intensive care unit's leaders had not ensured all breaches from 2019 and 2022 inspections had been fully addressed. We reviewed all six breaches during the services inspection and identified ongoing issues with 5. How staff safely and effectively observed patients also remained an issue across services. In continuing to identify these issues, we not only remain concerned about the safety of patients in services, but also question how robust and effective the trusts governance and monitoring systems are when they are not identifying and addressing these issues in between CQC inspection activity.

We asked the trust how they would ensure that they would resolve historical and repeated issues raised by previous inspections across their portfolio of services. Changes made to structures and culture were given as examples. One being the newly appointed deputy directors of quality and safety who oversaw each care unit (5 in total). The people in

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those roles played a significant part in ensuring that quality and governance was consistent across the care units. They chaired the quality and safety meetings which enabled them to take lessons and feedback to trust sub committees such as the quality and governance sub-committee. The roles were new and required time to embed with the most recent recruitment having been appointed in December 2022. Whilst it is recognised the trust are making changes to address issues of quality and safety, we remain concerned about pace when some of these issues came to light from the inspection in 2019.

The structures, systems and processes in place to support the delivery of trust strategy included sub-board committees, care unit meetings and local governance meetings. The director of corporate governance reviewed the governance structures on their appointment and implemented a system framework approach. This enabled the trust to ensure there were programmes of work identified to address any problems identified from assurance processes. Governance leads had defined portfolios and described their priorities.

Papers provided for board meetings contained appropriate information and were of a good standard. Minutes reflected the link between wards and the board. Staff at service level communicated how governance processes worked and gave examples of how change had occurred.

The new accountability framework provided the structures for team, care unit and senior governance meetings. It enabled leaders to share essential information such as learning from complaints and incidents to ensure action could be taken. Although the trust could access a wide variety of data, we could not be assured this was always accurate. Without accurate data we were not assured the trust would always be able to recognise where support may be needed in services to improve the quality of care delivered by staff.

There were arrangements in place to ensure that the trust discharged its powers and duties under the provisions of the Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA).

The audit committee 7 times in 2022/23 and was supported by 3 NEDs. In November 2022 the committee noted that despite policy review staff still did not always adhere to policies and procedures required by the trust. This information came from a 'site visit' report. It was decided that to address this issue executives must take ownership of policy and they must be enforced. This was due to be raised at executive team meeting and an update provided to the committee in January 2023. We were not assured that this action was robust to address the issue of staff not following policy. The trust clinical audit team were responsible for oversight and management of audit across the services. They provided bi-monthly reports on progress of their audit schedule to the clinical governance group and a monthly report to the learning collaborative partnership.

The trust used a quality assurance and quality control IT system. The aim is to take data from ward to board. The areas for quality assurance and quality control are infection, prevention and control, Mental Health Act, medicines management and clinic room care. Information is transferred to a portal where information could be filtered into dashboards and performance reports.

There were discrepancies in information provided to board as assurance via this system compared with data provided at ward level during our inspection. Therefore, we were not assured that the board received accurate assurance all the time. Examples of this includes data around the observation of patients

Following our focused inspection in October 2022 of acute wards for adults of working age, there was a recognition that the process for accessing closed circuit television (CCTV) for assurance was difficult. This process was being updated and needed continued development.

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Management of risk, issues and performance

In January 2021 the trust launched their safety first, safety always strategy following the Health and Safety Executives prosecution. The prosecution related to the North Essex Partnership NHS Foundation Trusts failings to adequately manage ligature risks between 2004 and 2015. The strategy sets out how the trust will focus on seven themes of improvement: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments and governance and information. The trust engaged with medical and corporate staff across the organisation through 1 to 1 meetings, workshops and focus groups in creating the strategy. The strategy year 2 progress report was due to be reviewed with further consultation and brought back to board in March 2023.

Since the launch of the strategy the trust have invested £20 million in their inpatient services addressing environments and safety. This included reducing ligature risks across the estate. In 2022 fixed ligature point incidents reduced by 32%. Alongside the physical changes to environments the trust offered opportunities to staff where they could receive payment for completing training outside of working hours, including the completion of required patient safety training. Six thousand staff members had completed part one of this training. Staff had access to suicide prevention training which worked alongside physical changes to environments with an aim to reduce harm to patients. As of January 2023, 95% of staff had completed dedicated suicide prevention training. Whilst the implementation of the suicide prevention strategy remained on the board assurance framework (BAF) as an 'amber; risk the trust had made key progress including at 19% downward trend n instances of self harm, 95% of patients had a personal safety plan and further trainers for suicide prevention training had been recruited.

The board had a BAF in place which identified key strategic and corporate risks which they scored by priority. In January 2023 the board reported 4 risks rated as 'red' relating to safety, people, demand and capacity and capital. These related to demand for services, national challenges relating to recruitment and retention, COVID-19 long term planning and enough capital being made available to maintain modernisation and essential works. The board rated 4 strategic risks as 'amber'. Corporate risks rated 'red' included issues with staff observing patients (as found by CQC). 'Amber' corporate risks related to training frequencies post COVID-19, suicide prevention, patient safety incidents, medical devices, staff experience and COVID-19 vaccination focus. We were concerned about the pace of issues being addressed on the BAF as many had been present for the last 3 months with minimal movement. NEDs also expressed this concern. The board had been unable to remove any risks in January 2023 and had made an additional entry relating to Pharmacy. Services completed local risk registers which detailed specific risks that applied to their services, however none of the services described how local risks informed what risks the board included in the trust wide risk register. We identified issues with the quality of risk assessments across the services. The quality and frequency of completion varied. These issues had not been addressed by the trust via quality audits and spot checks.

The trust participated in the early adoption of the patient safety incident response framework (PSIRF). This sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The purpose is to develop a culture of learning to improve patient safety. PSIRF does not make a distinction between patient safety incidents and serious incidents, instead it promotes a proportionate approach where a response to incidents should have resources allocated to learning. There was a specific patient safety team dedicated to reviewing safety incidents in the trust. On report of a safety incident the executive assurance group reviewed the information and made decisions about how to progress it. The most reported incident types relevant to patient safety incidents were recorded as patient disengagement, record keeping and documentation and communication. Actions could include a full patient safety incident investigation (PSII), a clinical review, the requirement for a safety improvement plan (SIP) or an after action review. Reviews provided an opportunity for the trust to look at any gaps and share this with local teams to promote a culture of learning. At the time of the inspection there were 10 PSII investigations underway, 3 of which were 'paused' due to ongoing Police involvement. Forty five examples did not meet the criteria for investigation and

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would be directed down other learning avenues depending on decisions by the executive assurance group. We reviewed 5 PSII reports and found that the trust had compassionately involved family members and sensitively addressed all their questions and queries. Family liaison officers supported this process. Staff completed thorough and detailed investigations and the staff leading them had the right qualifications and experience and applied objectivity as they did not work in the service the investigation related to. Investigators sent completed PSII reports back to the executive assurance group for final review and sign off and family liaison officer supported families on receipt of final reports.

The trust invested heavily in PSIRF and maintained significant involvement in the national programme. Initially it was expected that adopting PSIRF would be a 'cost neutral' (meaning no impact on the trusts finances) exercise, despite this not being the case the trust progressed with implementation and made appropriate financial investments into the patient safety team and the resources required. The trust contributed to the design of new safety improvement plans to be used nationally following a review of the practicality and effectiveness of the original template.

The trust invested and implemented a contact free vision based patient monitoring system and an electronic observation platform. This aimed to support clinicians intervene earlier when there were issues with vital signs, risk and cardio-respiratory issues. During previous CQC inspection in October 2022, we identified problems with the trust gaining consent from patients for this system to be used. In response the trust immediately met with all patients on the wards this related to and discussed the system and its use. They reviewed the standard procedure for the use of the system to strengthen guidance for staff about gaining consent. Despite the changes made by the trust there remained issues with observations which we have highlighted in the core service reports. We found reported incidents of staff falling asleep on duty and we observed staff not completing observations in a therapeutic way as required by trust policy. Closed circuit television was available on wards but leader did not have easy access to this to prove or disprove allegations of sleeping on duty. During the well led inspection the trust recognised that this was an ongoing issue to monitor and improve and there had been some more recent changes that required embedding. Examples included reviews of CCTV and the development of 'key point' learning for night staff. The trust were also reviewing the idea of increasing the volume of senior night staff available to provide increased leadership, but all of these changes were in their infancy and newly introduced, despite these issues being highlighted at previous inspections.

The trust had played a significant role in the roll out of the COVID-19 vaccination programme. As of January 2023, the trust delivered over 1.6 million vaccinations and were the only provider in the region to do so. The autumn 2022 booster programme delivered 161,000 vaccinations. At the peak of the pandemic the trust ran up to 16 vaccination centres. They also provided vaccination busses, a wellbeing team that delivered vaccines to hard to reach groups, a team to deliver vaccines to housebound patients. The trust intended to retain their vaccination staff in preparation for any future surge and had plans to support stepping up closed vaccination centres if need required.

There remained issues with restrictive practices across the organisation. Staff restricted patients access to fresh air on some acute wards for adults of working age. We identified this at our inspection in October and November 2022 and some remained in place in January 2023 when we returned. Staff did not base these restrictions based on individual risk assessment and we heard some concerning responses when we asked why they were in place (we raised this to the trust for them to action). The approach to restrictions was inconsistent, some wards restricted patients on a risk basis, some worked in a more restrictive way. Restricted items lists were at a level expected in secure wards on wards that did not require that level of security. We were concerned about how the trust supported and educated staff about restrictive practices based on these findings and it brought into question the audit of restrictive practice that the trust were not aware of the inconsistencies. The trust did have global restrictive practices guidelines in place which required staff to monitor and review global restrictions to ensure they were in place for the shortest amount of time; however, this was not something staff described to us at ward level.

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The trust had made progress in reducing the use of prone restraint, which was an issue identified at their last well led inspection. The trust reduced prone restraints by 27% at the end of 2022. One of the deputy directors for quality and safety led work around reducing restrictive practice. They had been in post for 3 months. Immediately they ensured that those staff who led on restraint became certified and became members of the national restrain reduction network. This will ensure that the trust meet national standards for staff training in restraint along with interventions that should be tried before restraint, such as de-escalation. As of November 2022, 91% were up to date with TASI (therapeutic and safe interventions) training against a target of 95%. The trust experienced challenges with restraint training during the COVID-19 pandemic but were working towards pulling training back from an 18 month renewal (which was agreed nationally) to a 12 month renewal. The trust had arranged multiple training events throughout the coming year to produce enough capacity for staff to attend. If monitoring of restraint increased the TASI team based themselves on wards to observe staff teams' practice and provide support. This had a notable impact in reducing the use of restraint. In January 2023 staff successfully de-escalated 61% of reported incidents avoiding the use of restraint.

Improvements were in progress to increase the safety of patients in relation to sexual safety. The trust required all services to work with patients to produce a sexual safety charter for each service. This provided the opportunity for staff to explain what sexual safety meant to patients and come up with ways they could feel safe and protected in their services. Staff displayed sexual safety charters across the services. Staff used the opportunity to encourage patients to speak up if they had concerns and ensured patients knew how to make a complaint.

Medicines optimisation and management across the trust required improvement. Pharmacy workforce challenges affected the quality and sustainability of medicines across the services. Pharmacy teams operated with a 45% vacancy rate overall. Of 25 vacancies, 14 remained as open adverts with no applicants. Organisational restructures and reporting lines meant that Pharmacy teams felt removed from operational decision making and morale was low. We identified issues with medicines management on wards and the capacity of the Pharmacy teams impacted their ability to audit and support teams with compliance. The trust continued to advertise their vacancies but had trouble recruiting. The trust added Pharmacy resource to the board assurance framework in January 2023. They proposed a risk score of 20 (high).

The health and safety team ensure regular audits of buildings and facilities and reported to the health, safety and security committee. Wards had local health and safety champions to further support compliance with health and safety legislation.

The trust recognised the challenges faced with capacity of acute wards for adults of working age and psychiatric intensive care units. In December 2022 the average length of stay was 74 days and although this had reduced from November 2022 (91 days) it remained above the benchmark. The trust discharged 79 patients in December 2022, 29 of which were patients who had been in hospital for 60+ days. The trust set up weekly consultant led meetings to clinically review all patients ready for discharge and those with stays over 60 days. The trust flow and capacity team managed inpatient capacity. The team had plans to implement various work projects to address the capacity issues and pressures on the services. The trust ensured they met with system partners on a regular basis to discuss flow and pressure and to work towards solutions for patients who had experience delayed transfers of care. Pressures with capacity meant bed occupancy was at 92% for December.

The trust saw an increase in out of area placements in December 2022. Performance was rated by the trust as inadequate at 1722 days. There were two wards in their inpatient portfolio that were capped on the number of

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admissions they could take following previous CQC inspections: a decision made by the trust. The trust placed 24 new patients out of area in December 2022 and returned 27 patients to Essex services. This left 56 patients out of are in total for December 2022. The trust recognised it would be challenging to meet the target set by NHS England/Improvement of 0 patients being out of area by March 2023.

Performance scorecards indicated that access to Psychology was inadequate (trust rating). This related to first meaningful contacts in the community, although there had been improvements in people waiting for therapy following assessment.

The NICE (National Institute for Health and Care Excellence) and clinical audit report from December 2022 provided an update to the board about how well services implemented best practice guidance and an update on the progress of clinical audits. The report referred to a lack of clinical time available to staff to undertake audit and progress implementation of guidance.

In January 2023 the trust reported to board that safer staffing levels were inadequate on their quality and performance scorecard. This related to day qualified staff fill rates which reported at 94%. Mitigation recorded included the introduction of twice daily situational report (SitRep) calls to review staffing needs across services and work towards a 7 days forward view of any staffing challenges. It was recorded that in the previous 2 months the trust target had been achieved in this area, but the rating would remain inadequate until the target was met for 3 months consecutively. Staffing fill rates below 90% applied to 22 wards which was an increase from the previous performance. There were also 13 wards where there were more than 10 days where shifts remained unfilled. In January 2023, fill rates were at 94%, having improved for the last 2 months. Board papers did not identify wards with concerning staffing levels or record conversations by the executive team that showed their plans to address this. The trust told us that their Board would not discuss this level of detail and it would be captured at ward level. In acute wards for adults of working age and psychiatric intensive care unit's there remained high use of bank and agency staff which meant patients did not experience regular staff who knew them and their needs well. On Galleywood ward from February 2022 to October 2022 leaders filled 66% of shifts with temporary staff. There also remained issues with filling shifts at all. For the same time period, Kelvedon ward had 64% of shifts not filled by qualified staff. Staff in the services described challenges with staffing and ways in which they attempted to resolve this, but we were not able to see the grip the board had on this issue when they focused on trust wide figures alone, which are impacted by those services with good staffing data.

In December 2022 the use of temporary staffing breached the trusts targets. There were 1039 breaches of agency cap rates and 338 breaches relating to shift frameworks (meaning too many agency staff featured on one shift). There were 231 times where both the agency cap rate and shift framework was breached. The trust held 13 vacant consultant posts, some of which the trust covered with locum staff but other relied on internal staff cover. The proportion of temporary staff used was 10% across the trust in December.

The board planned to agree and launch a new physical healthcare strategy in April 2023, a further example of a 'new' strategy. The previous strategy was dated 2020 – 2022. In order to monitor physical health within the trust there was a physical health sub committee which reported to the quality committee. The committee had worked on identifying gaps in physical healthcare provision to inform the development of the new strategy. The committee reported positive performance for physical health issues such as resuscitation and physical health deterioration. Physical health leads worked to establish positive working relationship with primary care nurses to ensure patients with mental health problems could access physical health support.

The performance and finance committee provided comprehensive updates to the board about the trusts financial position. As at month 9 of 2022/23, the trust was reporting a £1.3m year to date deficit and forecasting a year-end break-

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even position. There were concerns about the growing underlying deficit position which has moved from c£6m to c£11.8m over the last 3 years, this was reported monthly to the finance and performance committee. The finance team was currently being restructured and the new structure was expected to be implemented before the end of the 2022/2023 financial year. The new structure would introduce finance business partners to support the Care Units. The chair and NEDs and members of the finance team made it clear that there was enthusiasm for the move to the trust being operationally and clinically led rather than financially led. Care Units would be 'corporately enabled' and frontline care was the priority rather than a strategy driven by the financial position of the organisation. Other initiatives included Time to Care, the Safety First Safety Always Strategy and the Accountability Framework. We heard frustration from some NEDs about the pace of change being slower than they had anticipated. The Audit Committee will continue to seek assurance on the impact of these initiatives as they are introduced and embedded.

Information Management

The trust faced challenges with electronic patient records and used 7 different systems across their services dating back to the merger in 2017. Whilst the trust had developed interim measures to mitigate the risks associated with this (such as the health information exchange - a system to support record sharing), we were concerned this issue had lacked pace as the trust were in a current position of starting to work towards a single patient record system 6 years post-merger. Whilst recognising the trust had now secured external funding for this it had taken a long time to prioritise, particularly as themes and trends from investigations and Coroners reports continued to highlight this as an ongoing issue. Not all staff were able to use all systems, therefore there was a risk that key clinical information could be missed. It was described that it would be likely that it would take a further 12 months (2024) to identify a system to be brought in before any type of implementation would begin.

The trust did not use electronic prescribing and medicines administration (EPMA). There was a working group in place and a plan to present a business case to the board in March 2023. It was expected it would take 18 months to implement.

The executive director of strategy, transformation and digital heled the senior information risk officer position and the medical director held the role of clinical information officer. The trust had a chief information officer and a deputy chief information officer.

The trust data strategy was in draft format and had not yet been signed off by the board. The aim of the strategy was to empower people to use data to make informed decisions by providing a user-friendly service with single view of data that would be accurate. The implementation of the strategy was forecast over 3 years. The trust recognised their previous data strategy was not fit for purpose and required refreshing to best support staff working with patients in an effective way.

The trust described the need to have access to better quality, accessible information. We found issues with data quality in core service inspections and found issues with how accurate the information was. We were concerned about the quality of data the trust had to be assured about quality and safety. The trust introduced live dashboards, but these were in development stage and were not being used regularly. Concerns over the quality of data had been raised by the NEDs in board meetings.

The risk of cyber-attacks featured on the risk register and was rated as 'red' by the trust. Steps taken to mitigate risk included the purchase of new mobile phones where the older model provided some vulnerabilities, the same approach

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was taken with other computing devices. The trust recruited a cyber assurance manager, due to start in February 2023. By March 2023 the trust intended to complete recommendation from a cyber security internal audit and develop a business continuity plan and disaster recovery for each electronic system. The trust did not have cyber security accreditation but were looking towards this on completion of recruitment to their cyber team.

Engagement

The trust had a head of patient experience and volunteers and a director of patient experience, co-production and participation. Their roles focussed on putting patients, families and carers as the centre of services by ensuring they were engaged and consulted with. The trust also had a patient experience team responsible for monitoring feedback and organising engagement events to ensure the trust provided positive experiences. The trust were considering the recruitment of patient participation leads, but this was in early stages and no plans were in place.

The involvement strategy described the need to move away from 'tokenism' to ensure that involvement was not just a 'tick box exercise' and that it had meaning. The strategy was created with the views of the public, stakeholders and people with lived experience of services. Five distinct roles featured as part of the strategy and these included: member, volunteer, ambassador, governor and partner. Two key objectives featured in the strategy: increase and elevate public involvement and engagement across the trust and breed a culture that values patient experience through involvement.

The patient experience team developed multiple ways for people to provide feedback on their experiences by working with local teams to understand what fitted their demographic. This included the use of text messages, quick response (QR) codes, paper ballot boxes and forms. The work on creating a variety of feedback methods contributed to an 800% increase in feedback from August 2022 – January 2023. Work was ongoing to ensure that patients and people who use service featured as a key stakeholder. The 'your voice' community provided challenge and feedback to the board and the trust launched 'I want great care' in January 2022. The patient experience annual review from November 2022 demonstrated positive results for involvement including 92% growth in the recruitment of volunteers (from 126 in 2021 to 243 in 2022) and a 720% growth in recruitment to the lived experience team (from 10 in 2021 to 82 in 2022).

Communication systems such as the trust website and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used.

There were some issues with response times to complaints that required attention, particularly those that had been received under the 'old' complaints system. Their new complaints process went live on 1 January 2023 and was co-produced with people who had made complaints about services before. The trust captured their views on what was positive about the process and where it was frustrating so they could design a process that would address those points. A dedicated complaints team oversaw the complaints process. Administrators logged complaints on the system and a dedicated complaint liaison officer (CLO) attempted to contact the complainant within 48 hours of the issue being logged. The team requested support from clinical advisors to support with investigations but the responsibility for completion was with the CLO. Complaint investigations opened with a record of conversations with the complainant, ensuring their concerns and issues were the focus of the report. Staff gave complainants the opportunity to decide how they would like to be updated, what desired outcomes might be and set expectations about timescales early in the process. Upon closure of complaints staff logged outcomes and shared learning and sent a satisfaction survey to the complainant. The team had received little response, but it was recognised that this was a process in its early stages. To be assured of the quality of the process and final response, a random 10% of complaints were reviewed by NEDs. At the time of the inspection, there were 118 'open complaints' which had been received prior to the new process being started. Three were over 12 months old, the oldest being logged in August 2021. When looking into the delay for the response it related to an open patient safety incident which ran alongside the complaint. We were not assured that the

complaints team and the patient safety team had developed effective working relationships to ensure people did not experience a delay in response when something went wrong. The last contact made with the complainant was in April 2022: 9 months prior to our inspection taking place. 31 complaints were over 6 months old. Nineteen complaints had been received under the new process, 3 of which had been closed.

The trust sought to actively engage with people and staff in a range of equality groups. Governors held non-executive directors to account for the performance of the board.

Care group leaders engaged with external stakeholders such as commissioners and Healthwatch. The trust undertook a partners' survey to understand how they could increase their confidence in the trust and were acting on the findings.

Learning, continuous improvement and innovation

The trust formed a transformation team in March 2021, initially to support the 'safety first, safety always strategy'. Since its formation the team have taken on further responsibilities to support positive change in the organisation. Examples included: ligature risk reduction and the development of the mental health emergency department. The transformation team were responsible for embedding a consistent end to end change methodology to capture all proposed changes, supported by governance from the transformation steering group.

In April 2022 the trust launched a transformation steering group (TSG). The purpose of the TSG was to review initiatives, projects and ideas from across the organisation. The TSG was made up of senior leaders and subject matter experts. Staff presented ideas through a single 'front door'. The 'front door' acted as a triage process to capture the change required and make decisions over how to progress, such as fast track or to proceed through change methodology. As of January 2023, the TSG approved 30 submissions through the 'front door'.

Quality improvement initiatives required embedding further at ward and service level. Staff in the services struggled to describe examples of changes made via quality improvement methodologies, which is reflected in the core service reports.

The perinatal mental health service is one of the only services in the country to provide appropriate care for bariatric patients in a room with specially adapted facilities. In 2021 the service received an excellent peer review from the college centre for quality improvement (CCQI) against the community quality standards. The perinatal mental health services were one of the best performing services in the country providing positive outcomes for those who use their service.

The trust launched a neuromodulation service on 7 December 2022 which was the first of its kind in the East of England. The service provided the latest treatment for treatment resistant depression such as vagal nerve stimulation.

The trust was due to open a mental health urgent care department (MHUCD) which would look to support the increasing pressures in the Mid and South Essex system. It would provide an alternative to local emergency departments. It would provide a bespoke facility for adult patients and was due to open 13 March 2023. The trust also had urgent care response teams (UCRT) whose focus was to treat people in their own homes, which included care and nursing homes, and avoid hospital admission. Between January 2022 and August 2022 3519 admissions were avoided through UCRT support. Between the same time period 5063 attendances at accident and emergency had been avoided. Patients with physical health problems had access to virtual, if appropriate and safe, which was another programme of work designed to reduce admissions to hospital. West Essex had created 66 virtual physical health patient beds that were delivering some early successes. The trust were considering how they might expand a virtual ward system to patients with mental health problems.

Our findings

The trust had strong working relationships with Anglian Ruskin University to support innovation and research that would benefit services and the people who use them.

Research was important to the trust. They had a dedicated research and innovation team who worked with clinicians, partner organisations, the commercial sector and The National Institute for Health Research (NIHR). The trust had 15 ongoing research studies, some examples included: tackling chronic depression and attitudes to voices. The research team had academic links to 12 universities across the country.

Wound care specialists from the trusts launched a pilot scheme using digital technology to improve care for patients with pressure ulcers and other wounds. Staff used a mobile application to measure, assess and monitor wounds. The application also built 3D wound scans. This supported the accurate recording of wounds to support monitoring and treatment. The application received positive feedback from patients.

The trust had seen success with awards. Two services won awards in the positive practice in mental health awards – for addressing inequalities and for integration of physical and mental health. Clinical team leads had won the Cavell star award. Two team were announced as winners at the NHS Parliamentary awards. The health service journal awarded the trust (along with their partner trust) an award for workforce initiative. The trust was recognised at the building better healthcare awards for improving patient environments and enhancing safety. Our health heroes awarded the trust for most progressive integrated care workforce programme.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔← Jun 2023	Requires Improvement ↓ Jun 2023	Good ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Rawreth Court	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Clifton Lodge	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Overall trust	Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Rawreth Court

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019

Rating for Clifton Lodge

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022	Requires improvement Jul 2022
Wards for people with a learning disability or autism	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Acute wards for adults of working age and psychiatric intensive care units	Inadequate →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement →← Jun 2023	Inadequate ↓ Jun 2023	Inadequate →← Jun 2023
Wards for older people with mental health problems	Requires Improvement →← Jun 2023	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good ↑ Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023
Forensic inpatient or secure wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Long stay or rehabilitation mental health wards for working age adults	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Community-based mental health services of adults of working age	Requires Improvement ↓ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023	Requires Improvement ↓ Jun 2023
Mental health crisis services and health-based places of safety	Requires Improvement →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023
Substance misuse services	Good ↑ Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Good →← Jun 2023	Requires Improvement →← Jun 2023	Good ↑ Jun 2023
Community mental health services for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for older people	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health inpatient services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community end of life care	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Good Oct 2019	Outstanding Oct 2019
Community health services for children and young people	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community-based mental health services of adults of working age

Requires Improvement 🟠 ⬇

Is the service safe?

Requires Improvement 🟠 ⬇

Our rating of safe went down. We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Observation of the environments and review of the ligature risk assessments confirmed this.

All interview rooms had alarms and staff available to respond.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations.

All clinical areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Review of the cleaning records in the patient's areas on each site confirmed this.

Staff followed infection control guidelines, including handwashing. In response to rising cases of Covid-19, the trust had reintroduced the wearing of face masks in clinical areas.

Staff made sure equipment was maintained, clean and in working order. "I am clean" stickers visible on clinical equipment.

Safe staffing

Managers, staff, and patients told us they had enough staff, who knew the patients and received appropriate training to keep them safe from avoidable harm. The number of patients on caseloads was not too high to prevent staff from giving each patient the time they needed. There were no waiting lists to access service. When managers used temporary bank and agency they were block booked to work in the service and knew the patients well.

Nursing staff

Managers, staff, and patients told us they felt they had enough staff in the service to keep patients safe from avoidable harm, and caseloads were not too high.

Community-based mental health services of adults of working age

Data at November 2022 showed the service had 33% vacancy rate (74 posts out of a total for 224) across all staff grades, professions, and teams. While we recognised this was a high vacancy rate across the service, the impact was minimised because the service used regular known, block booked, bank and agency staff to fill vacancies. Managers and staff confirmed that recruitment was getting better, bank and agency staff were good and because they were considered as part of the permanent staff team they received the same training, had access to the same information and attended the same meetings which ensured consistency. Patients and family members we spoke with did not identify this as a major issue for themselves.

Managers used a recognised tool to calculate safe staffing levels. The service had 224 staff across 20 teams in the trust. The number and grade of staff matched the provider's staffing plan.

The service had reducing rates of bank staff. Data for the period June to November 2022 showed bank staff rates for additional clinical staff, (which included psychologists, occupational therapists, social workers, healthcare assistants and recovery workers), had reduced from 25% to 13%. While bank staff rates for qualified nursing staff had reduced from 11% to 6%.

The service had stable rates of agency staff. Data for the period June November 2022 showed agency staff rates for additional clinical staff, had stayed constant at 62% and for qualified nurses had risen from 35% in June 2022 to 36% in November 2022.

Managers limited their use of bank staff in favour of known, blocked booked agency staff when required. Managers ensured that all bank and agency staff had full induction to the service and the teams they were working in. Temporary staff were involved in team training sessions, team meetings and service developments. Bank and agency staff we spoke to told us they were happy in the teams and felt a sense of ownership and commitment to the teams they worked in. Staff and patients told us they knew all the bank and staff they worked with and related to them as they would any other colleagues.

Managers supported staff who needed time off for ill health. Sickness rates across the service remained constant between 6% and 7% for the period May to October 2022. Managers told us that if the absence was short then any appointments scheduled for the clinician's days of absence were reallocated to another worker. Alternatively, and if the appointment was not very urgent, staff contacted those patients to see what support they might need during the period of absence. For long term absence, the clinician's case load was reallocated to other team members and patients were advised if this needed to happen.

Data showed that the service had a stable turnover rate of 7% between May and October 2022.

While individual caseloads were well managed, in some team's caseloads were slightly higher than the recommended numbers. In 16 out of 20 teams the overall caseloads had reduced while in the remaining four teams' overall caseloads had remained stable.

Data we received from the trust showed that team and individual case load numbers had improved significantly between 2017 to 2018 and continued to reduce slightly or remained stable between 2018 and October 2022. Staff we spoke with told us that caseloads in the recovery and wellbeing teams ranged from 28 – 35 cases per care co-ordinator, the recommended number was 35 per person. In the first response teams, individual caseloads ranged from 26 – 32 per care co-coordinator with the recommended number being 20 per person. However, we found no evidence that this impacted on patient care, and patients told us they usually got the time they needed with key staff.

Community-based mental health services of adults of working age

Medical staff

The service had enough medical staff. Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the teams they worked in.

Staff could get support from a psychiatrist quickly when they needed to. Medical staff contributed to the on-call duty roster and covered for each other where possible for periods of leave or sickness.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. Mandatory training compliance across teams in the service ranged from 100% in the Basildon and Brentwood first response teams to 82% in the Southend recovery and wellbeing team. Thurrock recovery and wellbeing team was an outlier at 69% data we received did not explain why Thurrock team should be an outlier. However, post inspection the trust confirmed that all staff who needed to be, were now booked onto courses to bring their mandatory up to date.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training included preventing suicide training 94%, clinical risk for register staff 88% and clinical risk for non-registered staff 91% as required.

Managers monitored their team's performance in mandatory training using information on their organisations dash boards. Managers alerted staff via e-mail when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. Most staff worked with patients and their families and carers to develop crisis plans. We saw policy and practice guidelines explaining how waiting lists were to be managed. Staff monitored patients on the psychologists waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

The trust had clinical risk assessment policy and procedures in place along with guidelines for good documentation.

We reviewed 34 patient risk assessments across 8 teams we visited in the service. Staff undertook a full risk assessment for each patient and operated an ongoing risk management process using a recognised tool. Staff developed risk assessments in collaboration with patients, family, and friends. Most records we reviewed, 29 out of 34, showed staff updated risk assessments regularly, including after any incident. Risk assessments showed that staff encouraged positive risk taking and least restrictive options.

However, 4 patients' risk assessments at Colchester early intervention psychosis team, that were reviewed in April 2022 should have been updated in October 2022, at the time of our visit in November 2022 they still showed a review date of April 2022. We did see that the manager explained that due to a previous care co-ordinator leaving and new one taking

Community-based mental health services of adults of working age

over there had been a delay in updating the documentation. Though we saw evidence that staff discussed risk at weekly MDT meetings, daily safety meetings and in the minutes of MDT meetings. Staff we spoke with appeared to have good knowledge of the patients in their care including any risks they presented with. We saw no evidence of impact on patient care.

Staff recognised when to develop and use crisis plans and advanced decisions according to patient need. We saw evidence of six advanced decisions as part of our review of 34 patient records.

Management of patient risk

We reviewed 34 patient risk management care plans. The trust had a clinical safety management policy and procedures in place.

Risk management plans showed that patient risks were clearly identified, and appropriate plans were in place to address those risks including plans to address any deterioration in mental wellbeing.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us they had standard practice for any patients, family, or friends to take in case of mental ill health or physical health deterioration. This was to either ring the team duty worker in office hours or the CRISIS team 24/7 who would then be able to advise based on the level of risk present. In case of extreme urgency, the process was to ring 111. If a patient presented to accident and emergency mental health liaison workers carried out triage and assessment of their needs.

When a patient care co-ordinator was not available another member of staff was allocated to continue with any planned visits or other actions. All the teams had duty systems in place, this meant that any patient or their family and friends needing help, advice or support could ring the team and staff formulated a suitable plan for the patient, family and friends.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when signs or symptoms of risk increased.

Staff followed clear personal safety protocols, including those for lone working. Staff carried alert alarms that were connected to a central 24/7 hub where any calls or alerts were responded to immediately. The alarms also allowed for quick access to emergency help such as paramedics or police when required. The alarms had a listening facility allowing the staff member to alert someone in the response team to listen into the clinician and patient conversation where the staff member had identified an element of potential risk.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Data at October 2022 showed that 90% of staff had completed safeguarding adults' level 3 including Mental Capacity Act, Deprivation of Liberty safeguards and Prevent and 83% staff had completed safeguarding children level 3 including Looked after children and Prevent. Prevent training is designed to make sure that when we share a concern of a vulnerable individual who may be being radicalised, the referral is robust, informed and with good intentions, and that the response to that concern is considered, and proportionate.

Community-based mental health services of adults of working age

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and when necessary, made changes based on the outcomes. Such as improving links and communication processes with community drug and alcohol teams and mental health liaison workers in accident and emergency departments.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Most records were clear and up to date. However, patient's historical information was not always easily available to all staff.

The trust used 3 different electronic patient recording systems across the county. Staff told us this made access to historical information difficult when patients transferred between teams in different parts of the county. This meant that important information about patients could be missed as the 3 systems did not interface with each other.

The trust had been working towards an integrated electronic recording system since their merger in 2017 but this had still not been achieved. The trust needed to address the issue urgently.

Staff worked well within teams, across services and with other agencies to promote safety including correct and timely use of systems and practices around information sharing.

All records were stored securely.

Medicines management

Staff did not always follow trust systems and processes when prescribing, administering, recording, and storing medicines. Although staff regularly reviewed the effects of medicines on each patient's mental and physical health.

The trust had systems and processes in place to safely prescribe, administer, record and store medicines. However, staff did not always follow these processes. For example, 2 of the 20-community prescription and administration records for intramuscular antipsychotic depot injection we reviewed did not have signed informed consent.

Staff did not always store and manage all medicines and prescribing documents in line with the provider's policy. We found 2 expired depot injections in a medicine's cupboard, this was raised with the staff member present and the medicines were immediately removed and disposed of.

We found 3 gaps in the November 2022 recording of medicines fridge temperatures at Basildon recovery and wellbeing team; 4 gaps in the November 2022 recording at Rayleigh recovery and wellbeing team and 5 gaps North Essex Tendering Specialist Community Mental Health team, Colchester. The above issue was raised as a should in 2018.

Community-based mental health services of adults of working age

However, we also saw that in response to the 2018 report findings at Tendering the clinic room and fridge used temperature sensors on the fridge and in the room. This sent an alert to the team if room/fridge temperatures went out of range. Staff we spoke with were not sure if they needed to continue checking the temperatures daily as they were now using the sensor system. Managers had not given official guidance around this.

We found 1 doctor's prescription pad, at 1 team base the Basildon recovery and Wellbeing team, which was not kept securely as per the providers policy. At our previous inspection we had recommended the provider should ensure there were systems in place to audit the security of blank prescription forms. The doctor confirmed that the system in place was for all doctors to regularly check their FP10 prescription pads for completeness and to keep the pad secure, but on this occasion the doctor had omitted to do this.

Medicines advice and supply was available, and an on-call pharmacist was available outside of core working hours. The pharmacy team visited when possible and remote support was offered in between these visits. The pharmacists told us that due to pharmacy staff shortages the team could not visit as often as they would like to, however this did not have impact on patient care and staff were able to access pharmacy advice vis telephone when required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff told us that patients could raise concerns about their medicines, and these would be considered and reviewed.

Staff reviewed the effects of each patient's medicines on their physical health in accordance with National Institute for Health and Care Excellence (NICE) guidance. After issuing an initial prescription, staff completed review appointments to check for medicine dose adjustments and side effects.

Staff only gave small quantities of prescribed medicines to control behaviour, especially where medicines were prescribed as required. We saw examples of daily reviews of the use of these types of medicines and that prescribing was stopped when it was felt that it was no longer needed.

Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

The service had a good record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

We reviewed incident records and saw that staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

Community-based mental health services of adults of working age

Data for the period 01 December 2021 – 30 November 2022 showed that across all 20 teams the service had 2,543 incidents reported. The service reported no never events. Managers categorised and investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff understood the duty of candour and 98% of staff had completed duty of candour training. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers and psychologists debriefed and supported staff, patients, and their family and friends as necessary after any serious incident

Staff received feedback from investigation of incidents, both internal and external to the service, usually via email bulletins or one to one discussion if the staff member was personally involved.

Staff met in team meetings to discuss the feedback and look at improvements to patient care. There was evidence that managers had made changes because of feedback. Such as improved communication between general practitioners and community mental health staff and revised reporting protocols between hospital mental health liaison workers and the community mental health teams.

Managers shared learning with their staff about never events that happened elsewhere using the same systems as above.

Is the service effective?

Good 🟢 ➜ ⬅

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients, families, and friends to develop individual care plans and updated them as needed. **Most care plans reflected the assessed needs, were personalised, holistic and recovery oriented. However, we found 5 care plans at Basildon recovery and wellbeing team did not have discharge plans or goals or notional discharge dates.**

We reviewed 34 care plans across 8 out of 22 teams visited in the service. Not all care plans had discharge plans, goals, or notional discharge dates. We found 5 care plans at Basildon recovery and wellbeing team did not have discharge plans or goals or notional discharge dates. Managers in this team had not ensured that staff understood the significance of discharge planning at an early stage of treatment, and how important recording discharge plans was to the patients care pathway. This meant that without identified goals for discharge and no discharge plans staff and patients would not know what they were aiming to achieve in treatment or where their future care pathway would take them.

Staff completed a comprehensive mental health assessment of each patient. All patients were allocated a care coordinator.

Community-based mental health services of adults of working age

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. The trust included "make every contact count physical health screening" mandatory training across the recovery and wellbeing teams and data showed that 95% of staff were up to date with this training.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly carried out physical healthcare reviews and blood monitoring under the Care Programme Approach and updated care plans when patients' needs changed.

However, we observed patient review meetings and saw minutes of multidisciplinary team meetings and doctors' letters that did cover all areas of care and they were personalised and holistic. The manager explained that due to a previous care co-ordinator leaving and their case load being held by other people in the team pending permanent reallocation updating documentation with the quality and level of detail was not as robust as it should be.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. This included cognitive behavioural therapy (CBT), supportive psychotherapy, family therapy and eye movement desensitisation and reprocessing (EMDR). Skills training return to work and education programmes, dialectical behaviour therapy (DBT) informed therapy and Schema Therapy.

Staff delivered care in line with National Institute for Health and Care Excellence guidance. The service was working towards the new NHS England Community Mental Health Framework for Adults and Older People. A new place-based community mental health delivery model, with a completion date of March 2023.

Staff made sure patients had support for their physical health needs, either from their general practitioner or community services. The service had physical healthcare nurses and work was underway to secure more physical healthcare services for people with mental ill health in general practice and primary care settings.

Staff encouraged patients to live healthier lives by supporting them to take part in healthy living programmes, such as smoking cessation, healthy diet and exercise, work, education, and leisure programmes.

Staff used recognised rating scales and outcome measures including patient reported outcome measures (PROMS) and clinician reported outcome measures (CROMS), Health of the Nations Outcome Scales, Model of Human Occupation and Recovery Star.

Staff used technology to support patient care where appropriate and if patients wanted this as an option. Such as face time, zoom, language line, and healthy living digital applications.

Community-based mental health services of adults of working age

Staff took part in clinical audits, benchmarking, and quality improvement initiatives. Managers used results from audits and what they had learned during the COVID pandemic to make improvements. Such as offering text and telephone reminders about appointments, face time and zoom remote consultations digital progress letters via secure e mail, and flexible working times for staff. This was in addition to more traditional telephone and written correspondence.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of each patient. This included community psychiatric nurses, general registered nurses, recovery and support workers, occupational therapists, psychologists, doctors, and employment facilitators as well as peer support workers.

Managers made sure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff including bank and agency staff a full induction to the service before they started work. The induction program was comprehensive and included a full orientation to the team the staff member would be working in including opportunities to shadow experienced colleagues.

Managers supported staff through regular, constructive appraisals of their work. The trust had an appraisal policy and procedure in place. Data at October 2022 showed that 75% of staff were up to date with annual appraisal.

Managers supported staff through regular, constructive managerial and clinical supervision. The trust had a supervision policy and procedure in place. Data at October 2022 showed that 83% of staff were up to date with clinical and managerial supervision.

Psychologists and occupational therapists also received profession specific supervision from more senior colleagues, and we saw evidence of case specific specialist training and peer supervision based on case study within the teams.

The trust supported permanent medical staff to develop through yearly, constructive appraisals of their work. All medical staff had updated their accreditations and received supervision from profession specific supervisors.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. We saw from the minutes of team meetings that they were well attended. Staff who could not get to team meetings had the option of joining via video link and staff told us that minutes from meetings were easily accessible.

Managers identified any training needs their staff and peer support workers had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. We saw evidence of specialist training sessions within the teams we visited. Psychologists and doctors told us they operated an open-door policy and always made themselves available to give advice and support to staff with queries about treatment care or more complex patients.

Managers recognised poor performance, could identify the reasons, and dealt with these.

Community-based mental health services of adults of working age

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

We observed 3 multidisciplinary meetings where staff discussed patients' risk and any required changes to their care and risk plans. Staff told us these meetings were planned, prioritised, and rostered into their diaries, each week. We saw all staff present engaged with the discussions, were open and frank with each other, listened to each other and made notes of the outcomes and decisions made.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation, including inpatients' teams, crisis and home treatment teams, safeguarding teams, primary care, and specialist therapy services. Care co-ordinators were invited to all team meetings.

Staff had effective working relationships with external teams and organisations, including adult social care, social, education and employment providers.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust offered separate training for registered staff and non-registered staff. Data at October 2022 showed 89% of registered staff had completed this training and 93% of non-registered staff had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

We reviewed five records where patients were subject to a Community Treatment Order, staff completed all statutory records correctly.

Community-based mental health services of adults of working age

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of the five principles. Mental Capacity Act and Deprivation of Liberty Safeguards training was included with Safeguarding adults' level 3 and Prevent training. Data at October 2022 showed that 90% of staff were up to date with this training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture, and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 🟢 ➔ ⬅

Our rating of caring stayed the same. We rated it as good

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

Community-based mental health services of adults of working age

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. This was demonstrated through observations of staff and patient interactions and in speaking with patients their families and friends.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help, such as employment support services, housing services and debt management services.

Staff understood and respected the individual needs of each patient. We heard this when staff discussed patients in MDT meetings.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans and recorded this in the patient record.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. This included translation line, large font for written information, and written information in other languages as well as English.

Staff involved patients in decisions about the service, when appropriate. Patients told us they had not liked the term carers, and following discussions with the managers and staff, the term was changed to family and friends rather than carers.

Patients could give feedback on the service and their treatment and staff supported them to do this. We reviewed 34 patient feedback forms from the previous 9 months and saw the results of 3 recent patient feedback surveys. Most of the comments in these documents were positive.

Staff supported patients to make advanced decisions on their care. We saw evidence of this in six patients care records.

Staff made sure patients could access advocacy services. Two patients and one carer told us they had accessed advocacy services. There were posters around the public parts of the team bases, explaining who the advocates were and how to access them. Staff knew about advocacy services in their areas.

Staff informed and involved families and friends appropriately and only after patients had given permission.

Community-based mental health services of adults of working age

Involvement of families and carers

Staff supported, informed, and involved families and friends. We saw in daily care notes how staff had contacted family and friends, with the patient's permission, when needing to arrange appointments, checking how they were coping, and enquiring on the whereabouts of their loved one.

Staff helped families to give feedback on the service. The trust had introduced family and friend's liaison workers to work across teams. Their role was to engage with family and friends, act as a source of information, arrange family and friends support and education sessions and run the family and friends support groups.

Staff gave family and friends information on how to access the carer's assessment.

Is the service responsive?

Requires Improvement 🟠 ⬇

Our rating of responsive went down. We rated it as requires improvement.

Access and waiting times

We found a significant number of patients had experienced longer than expected periods of time in treatment in the recovery and wellbeing part of the service. However, the service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.

We found 37% of people using the recovery and wellbeing part of the service experienced longer than expected times in treatment across all recovery and wellbeing teams. There should be more support to move people on in their recovery journey in a timely way to achieve their full potential and allow wider accessibility to the service. We determined this figure based on the number of patients using the service for longer than 5 years. The longest period in treatment was 13 years at Basildon recovery and wellbeing team. This meant that if patients experienced longer stays in mental health services than they need then they could become overly dependent on clinical services, and not able to achieve their full potential for recovery and independence. However, neither staff nor patients and family we spoke with raised this as an issue.

Operational policy suggested that patients could expect to be in treatment for between 6 months and 3 years. However the policy also recognised that some patients may need to stay in treatment longer than this if they were receiving medicines that could only be administered via the community mental health team because they required ongoing and frequent blood tests and monitoring. This did not appear to impact on patient flow as there was no waiting list for access to the community mental health teams.

Data at November 2022 showed the number of treatment periods exceeding 5 years across the Recovery and wellbeing part of the service ranged from 15% (32 out of 219) in Rochford and Rayleigh to 33% (297 out of 905) in Southend. Other teams had 30% (72 out of 239) at Castle Point; 27% (139 out of 512) at Basildon; 25% (54 out of 214) at Brentwood; and 24% (107 out of 524) at Thurrock.

Community-based mental health services of adults of working age

Managers told us that patients were in treatment for longer than expected periods of time. This was primarily due to staff's reluctance to discharge patients once active treatment had been completed, for fear of destabilising patients with discharge to wider community services. Some staff also felt that they needed to retain patients who were on Clozapine and depot medicine regimes. We were told that this was because of a culture and reluctance for general practitioners to accept patients with a severe or enduring mental health diagnosis. Managers told us this issue was long standing and despite several trust initiatives, and high-level discussions with commissioners and general practitioners the situation had not resolved. Managers also told us that the latest initiatives put in place in 2019 were delayed due to COVID-19 and the pressures on primary care because of this. However, we heard from two team managers how they hoped this situation would change once the new community mental health framework for adults and older adults came into being during 2023. This national framework set out guidance and expectations for closer and more joined up working between secondary community mental health services and primary care services, including general practice, to speed up flow through the community mental health system, and implement more shared care practice.

We did not find these longer than expected periods in treatment in the other community teams in this core service. Such as the first response, access and assessment, and home treatment teams, because patients who required ongoing community support were transferred to the recovery and wellbeing service. While other teams in this core service such as early intervention in psychosis teams were required to work to clear national guidelines and there was a clear pathway of discharge to recovery and wellbeing teams or to general practitioners for patients at the end of this treatment phase.

The service was able to assess urgent referrals quickly when required, and staff saw all non-urgent referrals within the trust target time. The early intervention and psychosis service met all the assessment and treatment targets as set out in National guidance for early intervention and psychosis services. Patient flow through the service was good.

However, the service did have waiting lists for individual therapy, primarily specialist psychology input such as family therapy and integrated psychotherapy. The average waiting time for individual psychological therapy ranged from 4 weeks to 2 years. Staff we spoke with confirmed that this was due to insufficient numbers of psychologists in the service as a whole and a national shortage of psychologists wanting to work in the NHS.

The service used systems to help them monitor waiting lists and support patients on those lists. All patients on waiting lists were well supported and monitored during their waiting time. Patients waited on average 4 weeks for assessment to the recovery and wellbeing teams, and new referrals to the specialist teams were seen within the stated time frames for the type of service they were accessing, and in line with National Institute for Health and Care Excellence guidelines.

Staff supported patients when they were referred, transferred between services, or needed physical health care. The service followed national standards for transfer.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. They used face time and zoom for people who found it difficult to have face to face conversation, staff agreed to meet patients in places of their choosing subject to safety and lone working policy. Staff used text as well as telephone and letter to make and confirm appointments. The service developed outreach projects to meet vulnerable people and joint working with drug and alcohol teams.

Data for October 2022 showed the service offered 14,558 appointments that month. Appointments offered had risen steadily since January 2022 and remained stable throughout May to October 2022.

Community-based mental health services of adults of working age

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. During October 2022, 8% of the 14,558 planned appointments were cancelled by staff and 12% by patients. Data showed this was a steady decease month on month since August 2022.

Staff tried to contact people who did not attend appointments and offer support. During October 2022, the service saw a did not attend rate of 12%. The number of did not attend appointments had decreased month on month since August 2022. Patients had some flexibility and choice in the appointment times available between 8.00am and 6.00pm. Appointments ran on time and staff informed patients when they did not. Out of hours all patients knew how to access help and support usually through the first response teams.

The facilities promote comfort, dignity, and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy, and dignity.

We looked at the clinical areas of 6 team bases and 7 clinics. The service had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients' engagement with the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

The service could support and adjust for people with disabilities, communication needs or other specific needs. Managers tried to keep patient facing clinical areas on the ground floors of buildings whenever possible. There was level access to ground floor areas and working lifts to the clinical areas on upper floors. There were identified parking facilities for mobility scooters and blue badge holders, and posters advertising easy read information and hearing loop for those patients with sensory deficit.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the patients could understand the information more easily. We saw posters advertising the facilities available for people with mobility, communication, or sensory needs.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could access interpreters or signers when needed. Staff also used language line and staff who were bilingual and happy to interpret were easily identifiable.

Listening to and learning from concerns and complaints

Community-based mental health services of adults of working age

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Data for the period June to November 2022 showed this core service received 84 complaints and 25 compliments. We saw 82 complaints were categorised, investigated and outcomes recorded, along with learning points where required. A further 2 recent complaints were awaiting processing.

Patients, families, and friends told us they knew how to complain or raise concerns. We saw information in the foyers and waiting rooms of clinics explaining how to make a complaint.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints, identified themes, and made changes to the service based on outcomes. An example of one of themes was waiting times for consultants and psychologists were considered too long.

Managers shared feedback from complaints with staff and learning was used to improve the service. Examples included administration staff to check daily care notes and multi-professional team decisions when responding to patients' enquiries, and staff to routinely ask patients for updated contact details rather than just relying on patients to inform staff of any changes.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 🟠 ⬇

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders we spoke with had the skills, knowledge, and experience to perform their roles. All leaders we spoke with said they felt supported to fulfil the role and responsibilities of their leadership role.

Within the teams we visited there was a cohesive leadership team including consultant psychiatrist and senior clinicians who were able to advocate for the service internally and externally.

Leaders had good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Managers told us about the trust's clinical leadership development programme, to help support succession planning and staff development within the organisation. Managers positively considered this.

Community-based mental health services of adults of working age

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. We saw posters around the buildings explaining the trust's values.

Staff could describe the trust's values and their role to provide quality care and treatment was key to achieving the values and goals.

Culture

The culture in the Adults community mental health service was positive.

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. Staff e spoke with were aware of the freedom to speak up guardian.

Three staff and 2 managers told us that they did not have too many challenges with recruitment or retention of staff because this service was a good service to work in.

Managers respected staff autonomy and encouraged staff to develop their knowledge and skills by offering enhanced training opportunities such as family therapy, other specific therapy training and clinical leadership training. Two managers told us they felt the service had a lot of credibility within the trust, which helped to retain staff, even through the COVID pandemic.

Staff had access to the trusts Occupational Health service and the "Here for You" psychology service. There was also a range of other wellbeing initiatives including 1 to 1 staff support focussed on wellbeing, wellness planning and range of standalone staff wellness events such as Mindfulness and sleep clinics.

The trust provided support for managers to manage staff sickness and this was outlined in the trusts sickness absence policies.

Staff we spoke with knew about the trusts whistle blowing policy and how to use it.

The trust operated two staff recognition and awards schemes. The quarterly recognition awards where nominations were accepted from staff, patients, service users and the public. There are 5 categories a staff member can be nominated for including Hero Award – Beyond the Call of Duty; Peer to Peer Recognition Award; Team Recognition Award; Leadership Award and Research, Innovation and Improvement Award. The second scheme is known as the quality and excellence awards nominations are accepted from staff and there are 18 categories. Managers advised that while both of these award schemes were disrupted due to Covid, they will be holding an annual awards ceremony on 5 July 2023 (the 75th anniversary of the NHS) for the first time since the Pandemic.

Governance

Our findings from the other key questions demonstrated that while there were clear governance processes in place, managers did not always use these effectively to manage discharge from the recovery and wellbeing teams, or record keeping. Some managers did not use the audit process to good effect when looking at the quality care records.

Community-based mental health services of adults of working age

We found 37% of patients using the recovery and wellbeing part of the service experienced longer than expected times in treatment. Data up to end of October 2022 showed discharge planning and implementation was an issue across all the recovery and wellbeing teams. There was not enough emphasis on discharge and moving patients away from dependence on the team. There was not enough work with general practitioners to support and enable them to take back patients on depots. limits patients' recovery and could potentially make the service less accessible to others.

However, managers told us they expected this situation to improve once all the teams had adopted the new the new NHS England - Place-based, community mental health framework for adults and older adults in March 2023.

Not all care plans had discharge plans, goals, or notional discharge dates. We reviewed 34 care plans across the 8 teams we visited. We found at Basildon recovery and wellbeing team 5 care plans did not have discharge plans or goals or notional discharge dates. Managers had not ensured that staff understood the significance of discharge planning at an early stage of treatment, and how important recording discharge plans was to the patients care pathway. This meant that without identified goals for discharge and no discharge plans staff and patients would not know what they were aiming to achieve in treatment or where their future care pathway would take them.

Managers had not used record keeping audits to good effect. We saw that 4 risk assessments at Colchester early intervention in psychosis team, (out of 34 risk assessments reviewed across the service), had not been updated since April 2022. We also saw that 5 care plans at Colchester recovery and wellbeing team, (out of 34 care plans reviewed across the service), were not holistic or personalised and held minimal detail.

While the service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trusts mediction safety officer post had been vacant for an extended period. No in-depth medicines incident analysis was being undertaken to provide a monthly medicines incident updates at governance committees for further distribution across the trust. We were not told what the contingency plans were for this vacant post.

Management of risk, issues, and performance

While teams had access to the information, they needed to provide safe and effective care and used that information to good effect, the trust used three different electronic recording systems that did not link with each other.

The trust used three different electronic patient record systems that did not link with each other. This made finding all that information time consuming and not dependable. This meant that when patients transferred between teams using different electronic systems, historical information had to be manually uploaded into archive files. This meant that not all historical information was available in a timely manner and there was potential for information to be missed in the uploading process. The inspection team found it difficult and time consuming on occasion to track a patient care where they had transferred from one electronic system to another. However, the health information exchange (HIE) remained in place to support record sharing between teams.

Within teams' managers had systems and processes in place to identify and address any risk issues as soon they arose. There were local risk registers that linked to service risk register, which fed into the trusts clinical risk meetings. Staff were careful to monitor any risk to patients and knew how to escalate concerns to managers.

Information management

Community-based mental health services of adults of working age

Patients' information was stored securely on electronic data bases. However as noted above the trust used three electronic systems that were not integrated.

The service and the trust had business continuity plans in place to ensure that if normal business were interrupted for any reason staff could continue to provide safe care and treatment for patients.

Managers used information gained from findings following their investigations into complaints and serious incidents to make improvements to their service as reported above.

All managers attended the trusts clinical governance meetings where information and best practice was shared and disseminated across the services. Managers then met with their staff teams to share the key messages from these meetings.

The trust emailed individuals personally to ensure that all staff received the same key messages at the same time from the senior management team.

The trust had a staff newsletter that was sent to all staff via e mail and displayed in team bases. This helped to ensured that staff felt part of an organisation and not just part of one team or service.

Engagement

Managers actively engaged with other local health, integrated care boards, commissioners, and social care providers to ensure that services were provided to meet the needs of the local population.

Managers from the service participated in the work of the local transforming care partnership.

Managers were engaging with primary care colleagues in preparation for adoption of the NHS England Community Mental Health Framework for Adults and Older People.

Learning, continuous improvement and innovation

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers we spoke with were committed to continuous improvement and innovation within their service.

Managers engaged in a range of quality improvement programmes. We saw evidence of monthly quality improvement meetings, where any new action plans were agreed and monitored. Such as revised communication processes with family and friends of patients using the service. Routine introduction of video appointments as well as face to face appointments.

We saw the minutes from a range of local clinical governance meetings had been designed to ensure that good practice was shared across the service and to ensure that where there were any challenges to delivering quality services, these could be addressed and resolved.

Community-based mental health services of adults of working age

We saw evidence that staff engaged in a range of audits using the information they gathered to make improvements. Such as management of shared clinics in team bases and revised communication processes with patient, family, and friends.

We saw evidence of quality improvement projects that managers and staff were involved in including the review of access and waiting times, team skill mix and enhanced therapy training programs and introduction of carers liaison workers.

Wards for older people with mental health problems

Requires Improvement ⬤ ➔ ⬅

Is the service safe?

Requires Improvement ⬤ ➔ ⬅

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff monitored the wards each day to identify any risks or repairs that were needed. Wards carried out a comprehensive annual health, safety and security inspection.

Staff could observe patients in all parts of the wards. The wards had installed convex mirrors to improve visibility at blind spots covering communal areas and corridors. Not all wards had CCTV in place. Henneage Ward and Tower Ward had CCTV covering communal areas and corridors. Meadowview had CCTV covering the ward entrance. Staff on this ward reported they had access to body-worn cameras if needed to support patients who presented with increased risk. Beech Ward, Gloucester Ward and Kitwood Ward did not have any CCTV in place. Beech Ward had vision-based patient monitoring system which enabled the staff to monitor patents' vital signs without entering their rooms. Staff on Beech ward said the system was highlighted to patients on admission and consent gained. Monitoring of rooms could be switched off if required. Staff increased the frequency of observations for patients assessed as being at risk.

All wards complied with guidance on mixed sex accommodation. Male and female patients had separate areas for bedrooms and bathrooms, and female patients had access to female only lounges. Staff and patients confirmed that patients were not placed in rooms that required them to walk past member of the opposite sex to reach toilet and shower rooms.

Staff knew about any potential ligature anchor points and most staff mitigated the risks to keep patients safe. Staff were able to identify ligature risks and said these were discussed as a team in team meetings and away days. Each ward had completed a ligature risk inspection audit. Each audit included a comprehensive list of ligature risks, an indication the severity of risk and details of action the ward manager and staff should take to protect patients. Action included increased observations by staff and ensuring offices, staff rooms, meeting rooms, laundry rooms and shower rooms were locked when they were not in use. However, on Beech Ward one of the showers was found to be unlocked. This shower room was listed in the ward's ligature risk inspection audit as needing to be locked when not in use. This posed a risk to patient safety as staff were not complying with the ward's ligature risk mitigation processes. This was highlighted to staff at the time and the room was locked.

Staff had easy access to alarms and patients had easy access to nurse call systems. On all the wards, staff carried personal alarms. Call buttons were installed in all bedrooms. Emergency call buttons were installed in bathrooms.

Wards for older people with mental health problems

Maintenance, cleanliness and infection control

Ward areas were clean, maintained, well furnished and fit for purpose. Patients said, and we observed, wards were kept visibly clean. Staff and patients told us that any faults or repairs were identified and addressed.

Staff made sure cleaning records were up-to-date and the premises were clean. Domestic staff were cleaning the ward throughout our inspection. Domestic staff signed cleaning rotas to confirm they had cleaned all areas of the ward.

Staff followed infection control policy, including handwashing. The service had standard operating procedures for hygiene, cleanliness and infection control. Staff followed infection control principles including handwashing and the use of personal protective equipment if required. Each ward had completed an audit to assess compliance with the requirements for infection prevention and control, hand hygiene, the environment and clinical practices. All wards had at least 85% or higher compliance at their last audit.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. Clinic room observations confirmed this. Staff had access to emergency equipment. If medicines were required out of hours, staff could access these medicines via an on-call pharmacist. All the wards had an examination couch and scales.

Staff checked, maintained, and cleaned equipment. Staff attached stickers to equipment showing when it had last been cleaned and when it was due to be calibrated. Staff on most wards checked the emergency equipment daily in line with the trust's protocol. However, on Henneage Ward and Meadowview Ward emergency equipment was not always checked in line with this protocol. The trust's protocol on checks for the resuscitation bag stated the defibrillator must be checked daily to ensure that the machine is 'rescue ready'. On Henneage Ward the defibrillator was not checked on five individual days during September 2022, October 2022 and November 2022. When the emergency equipment was not correctly checked and/or checks were not recorded this posed a potential risk to patients as staff could not confirm the equipment was 'rescue ready'.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff with the right qualifications, skills,

training and experience to keep patients safe and to provide the right care and treatment. Staff described the wards as being calm, safe and patients received consistent care that met their needs.

The majority of wards had low vacancy rates. As of November 2022, Beech Ward's total staff vacancy rate was 9%, Gloucester Ward was 7%, Meadowview Ward was 6%, Henneage Ward was 6%, and Tower and Kitwood wards were 5%. These vacancies had been covered by locum, bank and agency staff. Meadowview and Gloucester wards had just appointed staff to their nursing vacancies, while the other wards' vacancies were out to recruitment. Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff and patients confirmed locum, bank and agency staff were regular and knew the patient group and the individual patients. Patients confirmed they

Wards for older people with mental health problems

knew most of the staff on the wards. However, patients reported that sometimes activities did not take place when the service was short staffed. For example, on Henneage Ward, patients reported a lack of meaningful activities when the ward was short staffed. The service was aware of this and a new activities co-ordinator has recently been recruited to support staff in facilitating activities for patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Each ward had introduced a competency checklist for all staff working on the wards, including bank and agency staff. This checklist included assessment of competencies for patient observations, the procedure for rapid tranquilisation, and ligature risk awareness.

Managers supported staff who needed time off for ill health. Staff said managers supported them to return to work after illness in ways they were comfortable with.

Ward managers could adjust staffing levels according to the needs of the patients. Managers could increase the number of staff on the ward if there was a high level of acuity or there were patients assigned to enhanced observations.

Patients had regular one- to-one sessions with their named nurse. Ward staff met each morning to allocate staff to specific engagement throughout the day. Support workers and nurses were assigned to facilitate leave and escort patients to appointments whenever necessary.

The service had enough staff on each shift to carry out any physical interventions safely. Staff on all the wards could call for assistance from colleagues on adjacent wards if extra staff were needed to carry out physical interventions.

Staff shared key information to keep patients safe when handing over their care to others. Staff discussed any changes in patients' needs, support and presentation at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. This information was also documented in patients' care records.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. All wards had a consultant and a duty doctor cover. Patients said they were able to see the consultant and doctor when needed. Staff reported there was always sufficient medical cover. Staff said they would call an ambulance if a patient needed urgent medical attention.

Managers said they could arrange locums when they needed additional medical cover and all locum staff would have a full induction before starting their shift.

Mandatory training

Most staff had completed and kept up-to-date with their mandatory training. Overall staff achieved 95% compliance with mandatory training. The service achieved a 75% compliance rate or greater for all mandatory training except for Tower Ward in grab bag training and Beech ward in physical health screening training at 71%. At the time of the inspection Tower ward staff were at 59% compliance for grab bag training. Grab bag training familiarises staff with the content and application of emergency equipment that is kept within the grab bag such as bag valve mask, nebuliser mask and an anaphylaxis kit. Managers were aware of their teams training needs. Managers said they took this into account when planning the ward staffing and ensured each shift had the appropriate skills and knowledge mix. Training

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was discussed in team meetings and supervision. Staff said training availability was significantly reduced during the COVID-19 pandemic. The service had re-introduced face-to-face sessions since the pandemic restrictions had eased although staff felt the training access had not yet fully returned to adapted to the return to business as usual as the COVID-19 pandemic eased.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training sessions were provided either in person or virtually. During the COVID-19 pandemic virtual sessions replaced face-to-face sessions as training availability was reduced. The service had recently re-introduced face-to-face sessions since the pandemic restrictions had eased. Staff they were informed when their training was due. They felt confident carrying out their roles and applied training to their practice. They were fully supported to carry out any additional required training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training courses included basic life support, immediate life support, moving and handling, safeguarding, medicines management and the management of actual or potential aggression.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. However, not all wards accurately recorded Do Not Attempt Cardiopulmonary Resuscitation information. Also, not all staff maintained trust standards when observing and interacting with patients.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. When patients first arrived at the ward, a doctor and nurse completed an initial risk assessment. A more comprehensive risk assessment was completed within 24 hours of admission. These risk assessments were regularly updated. Staff on each ward confirmed patients' Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information and recorded this within their patient records. Patients who provide DNACPR information completed a DNACPR hardcopy form which was stored on the ward. The DNACPR information and form was often completed in another service and this information was transferred with the patient referral and/or admission. The DNACPR information was also recorded in the patients' records and added to the patient whiteboard in the staff office. However, on Tower Ward, of the 8 patients that had DNACPR information, for 4 of these patients their DNACPR information on the patient whiteboard and/or in their patient records did not match with the hardcopy DNACPR information in the service DNACPR folder. This posed a significant risk to patients should a patient be resuscitated when their preference was to not be resuscitated or vice versa. This was highlighted to staff at the time. The ward manager immediately reviewed the DNACPR information for all of the patients who had provided DNACPR information and confirmed the information in the DNACPR hardcopy forms was correct and immediately updated the patient whiteboard and patients' records for the 4 patients where the information was incorrect.

Staff used a recognised risk assessment tool. Risk assessments were recorded on a standardised form in the electronic patient record. This form included the patient's risk history, potential mental health and physical health risks and mitigation to reduce the likelihood of incidents occurring. Staff also used standardised risk assessments to assess risk areas such as malnutrition, skin integrity and falls.

Management of patient risk

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Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff shared key information to keep patients safe when handing over their care to others. Shift changes, handovers and multidisciplinary meetings included all the necessary key information to keep patients safe. Staff in multidisciplinary team meetings discussed individual patient's needs and demonstrated an understanding of each patient. Staff on the ward met each day to discuss any changes to patients risks and to assign risk management activities to each member of staff.

Staff identified and responded to any changes in risks to, or posed by, patients. All patients presented complex risks in relation to their mental health. Many patients also had significant physical health risks. In relation to mental health, patients presented with risks of self-harm and aggression. Staff managed these risks through prescribing anti-depressant or anti-psychotic medicines and by assigning staff to conduct enhanced observations of the patient. Staff provided personal care to patients that required it along with support and encouragement to eat and drink. Staff monitored physical health risks through frequent observations, blood tests, electro-cardiograms and referrals to specialist services such as physiotherapists and dieticians. Staff monitored the physical health of patients regularly using the observation chart for the National Early warning Score 2 (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult patients. Staff were trained in the use of the NEWS2 chart to identify deteriorating patients. Staff said they were confident about using it and escalating issues as appropriate. Staff knew where the emergency grab bag was kept. Falls risk assessments were completed when required and updated after any subsequent falls.

Staff could observe patients in all areas. Staff checked all patients every hour. When patients presented a heightened level of risk, this was increased to 4 observations within the hour or constant observations. However, not all staff maintained trust standards when observing and interacting with patients. This compromised patient safety as the patient was not being observed appropriately. The review of CCTV on Henneage ward also showed one staff member reacting in an uncaring and punitive manner toward an unwell patient during an incident where the patient threw a pen. On review of the incident report the language within it was also punitive and uncaring.

Use of restrictive interventions

Levels of restrictive interventions were low. Ward managers explained that staff rarely used restraint due to the frailty of patients. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. If restraint was used, it would involve standing or seated restraint. None of the patients had received rapid tranquilisation. The service did not place patients in seclusion. The trust had policies and procedures which reduced the need for restraint. Staff kept records that showed that staff used de-escalation techniques to avoid the use of restraint. Electronic incident reports included information on how patients were supported when restrained with details that including length and type of restraint and debriefing for patients and staff.

Although the ward did not use rapid tranquilisation, staff were required to be aware of how to carry this out safely and conduct physical observations after the injection. This formed part of the competency checklist for staff working on the wards.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. Compliance with mandatory training on safeguarding at level two and level three for adults and children ranged between 75% and 100% compliance across the wards.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Examples included situations where staff thought patients may be at risk of financial abuse, and instances of patients being assaulted by other patients, Staff addressed the risks of abuse by implementing safety action plans which included actions such as increasing patients' observation levels and asking the local authority to investigate allegations.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were confident in identifying and making safeguarding referrals and knew who to inform if they had concerns. We observed a multidisciplinary team meeting that discussed safeguarding in a holistic manner and included reflections on areas such as the patient's cultural norms.

Patients said they felt safe on the wards. Staff understood their responsibilities to ensure that patients were protected from bullying and harassment. Patients and carers reported they could report any concerns to ward managers and staff at meetings or confidentially in one to one discussions.

Staff access to essential information

Staff had access to clinical information and it was easy for them to update clinical records – whether paper-based or electronic.

Patient records were comprehensive and all staff could access them. Records relating to patients' care and treatment were stored on an electronic patient record. Staff recorded hourly observations and food and fluid charts on paper. These were stored in the nurses' office and uploaded to the electronic records. Staff were able to access paper and electronic records quickly.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic records could be accessed by anyone working within the trust.

Records were stored securely. Staff needed to enter a personal identification name, a password and an identity card in order to access the electronic patient record.

Medicines management

Staff did not always follow the service's systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe, administer, record and store medicines safely. The trust had systems and processes in place to safely prescribe, administer, record and store medicines. These processes were not always followed by staff and governance arrangements were not robust enough to identify and improve systems. For example, on one ward medicine was prescribed for an individual that needed to be taken at least 30 minutes before food and other medicines. However, this was prescribed and administered at the same time as other medicines. We pointed this out and the doctor changed the timings. We saw records for patients whose medicines were given covertly. There were no instructions on the drug charts for staff to follow when administering these medicines. Medicine records

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were not always complete, and medicines reconciliation was not always updated when patients were transferred from different care setting. On Gloucester ward, we saw a large quantity of a patient's own medicines stored in a cupboard without being checked, recorded and reconciled when patients were transferred to the ward from other health care settings.

Medicines were stored safely and securely. Each ward had a dedicated clinic room with air conditioning and remote temperature monitoring of ambient room and fridge temperatures. Some wards also conducted daily physical checks to provide additional assurances. Medicines cabinets were locked when not in use and only accessible to authorised staff. Controlled drugs were stored securely and checks of these were conducted daily.

Medicines advice and supply were available, and an on-call pharmacist was available outside of core working hours. Pharmacists visited wards when possible and at some sites, remote support was offered due to pharmacy staff shortages. Ward staff knew the routes to contact pharmacy if required.

Staff reviewed each patient's medicines regularly. However, pharmacists did not provide specific advice to patients and carers about their medicines. Pharmacists or medicines management technicians attended the ward weekly on some of the sites, to screen prescription charts. On other sites, prescription charts were screened by the pharmacy team remotely using a specific Application. This Application allowed the pharmacist to review the medicines chart remotely in real time.

Staff stored and managed controlled drugs in line with the provider's policy. The service held controlled drugs (CD) on site. These were checked regularly and managed safely. They also completed regular CD audits which were shared with the ward's managers. Fridge and room temperatures were monitored centrally by estates, and we saw evidence of action being taken if out of range. Also, some ward still completed a physical daily temperature check.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When patients were admitted, an attempt was made to take baseline blood and electrocardiogram readings. All staff had completed their mandatory training in medicines management.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, the trust Medication Safety Officer post has been vacant for an extended period, therefore no in-depth medicines incident analysis in being undertaken in order to provide a monthly medicines incident update at governance committees for further distribution across the trust.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was administered to manage agitation or aggression, medicines were appropriately prescribed and monitored. Staff we spoke with understood the requirements within the policy. Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

There had been 11 serious incidents on the wards in the 12 months before the inspection. Four incidents involved the unexpected death of a patient. Two of these deaths were a result of patient self-harm, and 2 were a result of physical health issues. At the time of the inspection each of these incidents were being reviewed by the trust's serious incident

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investigation process. Of the remaining serious incidents in the 12 months before the inspection, 4 involved patient falls, 2 involved injuries to patients from unknowledge causes and 1 involved a physical illness. In all instances, staff completed a report of the circumstances surrounding the incident within 48 hours, referred the matters for a more comprehensive investigation.

Reporting incidents and learning from when things go wrong

The service managed most patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff recorded incidents relating to slips, falls and aggression. Staff had completed all incident forms appropriately. Managers had reviewed and signed off all entries on the incident record.

Staff understood the duty of candour. They were open and transparent, and patients said staff discussed and explained incidents when things went wrong.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff and patients met to discuss the feedback and look at improvements to patient care in business and community meetings, and the clinical improvement groups.

There was evidence that changes had been made as a result of feedback. For example, on Meadowview ward following an unwitnessed fall of a patient while on enhanced observations the ward manager met with all staff to review observation competencies, the level of observations was discussed in subsequent safety huddles and staff meetings highlighting the importance of knowing patients' whereabouts at all times. This incident was shared across the wards via their lessons learnt processes. Supervision records and team meeting minutes showed discussion of incidents.

Is the service effective?

Requires Improvement 🟠 ⬇

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected patients' assessed needs, were personalised, and recovery oriented. However, some care plans were extremely long which made them difficult to use.

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Staff completed a comprehensive mental health assessment of each patient either on admission. A doctor assessed the physical and mental health of each patient when they were admitted. The initial assessment typically involved recording the circumstances surrounding admission, a mental state examination and an assessment of any risk the patient presented. All patients had their physical health assessed soon after admission and regularly reviewed during their time on the wards. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included close and regular monitoring of blood samples, heart rate, oxygen saturation and respiration, urine tests, temperature, weight monitoring and electrocardiograms.

Staff developed a care plan for each patient that met their mental and physical health needs. There was some variation in the quality of care plans in place for patients, but most met their mental and physical health needs. However, on Gloucester ward, the patient care records system created extremely long care plans for patients with complex needs. For example, one patient had a care plan of 134 pages. Care plans were live documents with staff updating them as patients' needs and risks changed. In the patient care records system this created a rolling document for each care plan. This made it difficult to find recent updates and current information. This could cause delay in accessing important information about the current needs of patients. Staff said they found these long care plans documents difficult to use and understand. Patients on Gloucester ward were not familiar with their exact care plans but were aware of their support needs and how staff supported them with these.

Staff regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team reviewed every patient each week and regularly updated each patient's care plan.

Most care plans were personalised and recovery-orientated. Care plans showed that patients' and carers' views were recorded and addressed a range of issues such as medicines, safety, psychological needs, physical needs, social inclusion, social networks and community services and support.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit and benchmarking.

Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. Patients were supported with their care and treatment at a pace that was comfortable to them. This meant the pace of support was set in partnership with the patient and their carers. Staff used non-pharmacological approaches during the first weeks of admission to establish whether there were particular triggers to the patient's behaviour or whether behaviour was random. Doctors prescribed mood stabilizers for patients with poor impulse control. When patients' symptoms included physical aggression, and non-pharmacological interventions had not been successful, doctors prescribed promethazine. The reasons for prescribing this were recorded in the patient's records. As a last resort, doctors prescribed a low dose of antipsychotic medicine. Doctors prescribed acetylcholinesterase to patients with dementia to increase communication between nerve cells in the brain which in turn helps to temporarily reduce symptoms. In addition to pharmacological interventions, the service offered interventions to promote cognition stimulation, independence and wellbeing such as occupational therapy and music and drama therapy.

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Staff identified patients' physical health needs and recorded them in their care plans. Staff completed physical observations including blood pressure, pulse, oxygen saturation and respiration, for each patient every day. Staff also provided a comprehensive range of physical health assessments and treatments according to patients' needs. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, for patients at risk of malnutrition staff completed food and fluid charts and supported patients at mealtimes. Due to the importance of nutrition and health eating mealtimes were protected times of the wards with most staff focused on assisting patients with meals.

Staff made sure patients had access to physical health care, including specialists as required. Each ward had access to specialists that included dietitians, diabetes nurses, physiotherapists and tissue viability nurses. These specialists met with patients to support their care and treatment and worked with staff to upskill their knowledge and support for patients. The wards referred patients to neurologists for specialist assessments where required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included discussions with patients about diet, exercise and smoking cessation. Staff were able to give advice and refer patients to specialist services if needed.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. for example, the occupational therapists used the model of human occupation screening tool.

Staff took part in clinical audits and benchmarking. Managers ensured staff carried out a range of audits to check that staff followed good practice guidance. For example, there were audits of care plans, risk assessments, and escalation of physical health observations. Managers and staff met monthly to compared local audit results and learn from each other. Managers used results from audits to make improvements with development areas being addressed through reminders, training and supervision.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff. Managers supported most staff with appraisals and regular supervision to review and reflect on practice and skills.

The service had access to a range of specialists to meet the needs of the patients on the ward. This included consultant psychiatrists, doctors, nurses, occupational therapists, drama and music therapists and physiotherapists. However, full access to psychological support was limited across the service due to psychology vacancies. Managers were aware of this need and recruiting for these posts. The wards also had access to diabetes nurses, speech and language therapists, podiatrists, dietitians, and tissue viability nurses.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff were experienced and qualified to work with older people. All staff, including bank and agency staff, were required to complete competency checklists covering areas such as observations, awareness of ligatures, and fire safety.

Managers gave each new member of staff a full induction to the service before they started work. Staff were supernumerary for their first two weeks when they join the service to allow time for them to complete their corporate induction, be introduced to the ward and spend time shadowing more experienced colleagues.

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Managers supported most staff through regular, constructive appraisals of their work. Staff had a performance appraisal each year and planned their professional development for the following year. The trust's target was 90% for staff completing annual appraisals. As of October 2022, only Henneage ward at 69% and Ruby ward at 50% had not achieved the 90% target. Without regular appraisals staff were at risk of not being fully supported and developed in their professional role which in turn could impact of the quality of care for patients. Senior leaders were aware of the trust's data on staff appraisals and were supporting wards to make the completion of the appraisal procedure easier for staff and managers. Staff felt that appraisals were an important part of continuing professional development as it allowed them to reflect on their current performance and progress and to set goals for their future development.

Managers supported most staff through regular, constructive clinical supervision of their work. The trust's target was 90% for staff completing regularly supervision. The trust collected data on their staff supervision targets, and this showed for Kitwood ward for August 2022 their completion rate was 67%. For Tower ward for August 2022 it was 62% and for September 2022 it was 67%. For Henneage ward for October it was 69%. Managers were aware of their wards' supervision compliance. They said they had been prioritising staff supervision recently. For October 2022 all wards showed a completion rate between 86% and 100%. Most staff said they found supervision with their managers very helpful. During supervision sessions, staff talked about their clinical support and challenges at work along with administrative matters such as leave and sickness. Staff said they could discuss new opportunities and personal development. Without regular supervision staff did not get a one to one space to discuss work and personal issues which in turn impacts of the quality of care for patients.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Staff attended regular business meetings. At the meetings staff discussed activities on the wards, complaints and compliments, learning from incidents and audits.

Managers made sure staff received any specialist training for their role. Staff said there was an extensive range of mandatory, essential and specialist training on offer to develop their professional competence. Staff said they had completed additional professional development courses in understanding dementia and Alzheimer's disease.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff made sure they shared clear information about patients and any changes in their care. Staff held daily nursing handovers and multidisciplinary team handovers to discuss any incidents, any changes to patients' levels of risk and assigned duties across the multidisciplinary team for that day. We observed strong communication and team working during meetings and discussions attended by a variety of clinical and non-clinical staff. Staff valued these meetings. Staff felt they supported learning across their teams and encouraged holistic care.

Ward teams had effective working relationships with other teams in the organisation. We saw evidence that patients had been referred to, for example, dieticians, diabetes nurses and speech and language therapists and advice had been received and incorporated into patient care.

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Ward teams had effective working relationships with external teams and organisations. For example, ward managers held a 'safety huddle' with other managers from across their region. This meant that managers had a good understanding of any incidents or challenges across the directorate and they could provide support for each other.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. They received training on the Mental Health Act and knew how to access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service adhered to the requirements of the Mental Health Act. Patients' records did not show any unlawfully detentions.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. These policies and procedures covered information for patients, emergency detention, holding powers, renewals of detention, leave and discharge.

Patients had access to information about independent mental health advocacy. Advocacy details were displayed on the wards. Advocates visited the wards regularly. Staff offered the advocacy service to all detained patients. Written information about the trust's services stated that patients could talk to an advocate if they had concerns about the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff took steps to ensure that patients understood the provisions of the Act under which they were detained and advised patients and carers of their rights to apply to a tribunal in respect of their detention. These discussions were recorded in the patient's care records. Staff also ensured that patients who were subject to enhanced observations were aware of the reasons for this.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff reviewed the arrangements for leave at the multidisciplinary handover meeting each day.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Patient records included certificates of second opinion and records of discussions with the patient by the responsible clinician, following the visit of second opinion appointed doctors. However, staff did not always review consent to treatment forms to ensure that they were in line with agreed guidance. For example, on Kitwood ward we saw one instance of a patient being prescribed medicines which was not in line with the Mental Health Act certificate of second opinion treatment form. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There were 159 Deprivation of Liberty Safeguards (DoLS) applications submitted between December 2021 November 2022 across the all of the wards for older people with mental health problems. The service's safeguarding team managed and tracked all DoLS applications and authorisations. Staff made applications for a DoLS order only when necessary and monitored the progress of these applications. The service's DoLS data showed one instance on Roding ward where staff submitted a DoLS application after the previous DoLS authorisation had expired. This DoLS authorisation ended on 20 April 2022, and the application was submitted on 22 April 2022. The individual was deprived of their liberty safeguards unlawfully for two days. Applications for DoLS authorisation can be submitted 28 days in advance of previous authorisations expiring.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. The policy covered the key principles of the Act, assessments of capacity and roles and responsibilities of staff. Staff could access the policy on the trust's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could get advice on the Mental Capacity Act from colleagues in the Mental Health Law Office.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, an assessment of mental capacity included details of the information provided to the patient to help them to understand the reasons for proposing additional nutrition supplements.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Consultant psychiatrists assessed and recorded the capacity of patients in relation to their admission. Further capacity assessments were also recorded in relation to other decisions such as treatment, and staff giving information about the patient to carers. Doctors recorded assessments of mental capacity on a standard form on the electronic patient record.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff sought support from families and people from patients' communities to help them understand patients likely wishes, culture and history.

Is the service caring?

Good 🟢 ➡️ ⬅️

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

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Staff were discreet, respectful, and responsive when caring for patients. We observed staff supporting patients with gentle encouragement at mealtimes. During meetings, we saw that staff were warm and friendly. Staff had a very good understanding of patients' lives, the things they liked and didn't like, and their social circumstances outside the hospital. Staff and patients were happy to laugh and chat together. Most patients were positive about the way staff interacted and supported them. Patients and carers said staff were respectful, attentive, non-judgemental and caring, and tailored care to individual needs. Patient also reported staff provided help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly and were responsive to their needs.

Patients were treated with care, compassion, kindness, dignity, calmness and respect by staff. Staff interactions with patients were professional, sensitive and always appropriate. Staff spoke respectfully about patients and had in-depth knowledge of their personal needs and preferences and took the time to establish productive relationships. Staff were discreet, respectful, and responsive when caring for patients. They did not ignore or reject patients with requests, they responded respectfully each time. Patients said staff listened to how they were feeling and supported them to understand their care. They found staff were always friendly, honest and open with them.

Staff supported patients to understand and manage their own care treatment or condition. Staff understood and respected the individual needs of each patient. They adapted their approach to each individual and worked with patients' individual preferences. Discussions about patient leave were person-centred and involved reasonable adjustments to accommodate patients' particular needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients, although none remembered a time when they had had to do it. Several of them said they would be very confident about raising it directly with the staff member themselves, but they would tell manages as well.

Staff followed policy to keep patient information confidential. Staff understood the importance of patient confidentially. Patients felt staff were suitably discrete when communicating. Wards with whiteboards containing patient information were closed when not in use. We observed no instances of staff discussing patient information in patient areas.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. **They ensured that patients had easy access to independent advocates.**

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. A member of staff met with each patient and their carers on the first day of their admission. They explained the aims and purpose of the ward.

Staff involved patients in their care planning and risk assessments. The multidisciplinary team met with each patient once a week to discuss their care and treatment. Staff went through care plans with patients and/or carers.

Staff made sure patients understood their care and treatment and supported patients to make decisions on their care. The multidisciplinary team held meetings with patients each week. During these meetings they asked patients how they were feeling, talked about observations and discussed the schedule for medication and support. Staff said when patients did not have the capacity to engage with meetings, they worked closely with patients' families and carers to communicate with patients and gain a better understanding of patients' lives and preferences.

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Patients could give feedback on the service and their treatment and staff supported them to do this. The service had feedback posters on display around the wards. These included quick response (QR) codes that allowed patients to complete a quick survey about the ward. Wards held regular community meeting for patients. At these meetings, patients gave feedback on ward safety, the quality of food, the environment and activities. Staff also sought feedback in one to one session with patients.

Staff made sure patients could access independent mental health advocacy services. Advocacy services were available for patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Patients' carers were positive about the service. Relatives said they found staff very supportive. They said staff always asked how they were and provided updates on their family member. Carers said they met with doctors and that staff were always happy to answer any questions they had.

Staff helped families to give feedback on the service. Staff encouraged feedback directly and directed carers to the feedback posters on the wards.

Is the service responsive?

Good 🟢 ⬆

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Bed occupancy was above 85% on most the wards. However, Kitwood ward's bed occupancy was low, on average around 65%.

Managers regularly reviewed length of stay for patients and worked with staff to make sure they did not discharge patients before they were ready. Patients were not moved between wards during an admission episode unless it was justified on clear clinical reasons or it was in the best interest of the patient.

When patients went on leave there was always a bed available when they returned. The service did not admit new patients to bedrooms assigned to patients on leave.

The service had no out-of-area placements at the time of the inspection. Any of out-of-area placements were reviewed each day in the 'safety huddle' for each region.

Wards for older people with mental health problems

Staff did not move or discharge patients at night or very early in the morning. All discharges were planned to ensure the patients were discharged to an appropriate setting.

Discharge and transfers of care

The service had a low number of delayed discharges. Managers ward kept a list of patients whose discharge was delayed due to non-clinical reasons. Staff said most delayed discharges were due to the accommodation or care provision in the community. This meant that arrangements had to be made for appropriate accommodation and/or ensuring appropriate support was in place before individuals could be discharged. Making these arrangements could cause delays.

Staff carefully planned patients' discharge and worked with local authorities, care managers, care coordinators and commissioners to make sure this went well. Service leads and managers monitored and reviewed upcoming and delayed discharges at regularly meetings. Actions and recommendations were discussed and implemented to support discharges. Staff said when there were delays this was generally due to partner organisations finding it difficult to find suitable resources to meet a patient's complex needs.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could have hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. Across all wards patient bedrooms appeared personalised. Staff across the wards did not lock patients' doors unless requested, or if there was a specific risk such as a patient prone to repeatedly wandering into the wrong room. Patients said staff were responsive to requests to lock and unlock their bedrooms.

Patients had a secure place to store personal possessions. Patients could store valuable items in a safe or secure lockers in the nurses' office or the cashier's office.

Staff used a full range of rooms and equipment to support treatment and care. The wards all had a lounge area, dining room, occupational therapy kitchen, activities room and a therapy room.

The service had quiet areas and a room where patients could meet with visitors in private. Most wards had a designated quiet room. Patients could meet with visitors in the quiet rooms, meeting rooms, the lounge areas or the ward gardens.

Patients could make phone calls in private. Patients could use the ward telephone in private. Patients also had access to their own mobile phones.

The service had an outside space that patients could access easily. Ward garden areas were locked as these required staff supervision due to ligature risks. Patients said that staff always opened the garden doors and supported patients when they wanted to access outside space.

Wards for older people with mental health problems

Patients were supported with hot drinks and snacks. Patients were able to make hot drinks and snacks on Beech ward and Gloucester ward which supported patients with functional conditions such as schizophrenia. However, on Meadowview, Tower and Kitwood wards which supported organic conditions such as dementia staff supported patients in making hot drinks and snacks as patients' conditions and poor motor function could create difficulties for patients.

The service offered a variety of good quality food. Wards displayed menus for lunch and dinner. For each meal, patients had options for starters, main courses, side dishes, salads, sandwiches and desserts. Patients said the standard of the food was good.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as interest activities and family relationships.

Staff helped patients to stay in contact with families and carers. Patients said staff supported in maintaining contact with families and carers. Most patients had their own mobile phone. Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Wards displayed information about local charities that provided support for older people.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Staff assessed each individual and completed a full assessment of patients when they were admitted. Staff provided the service in a way that met the specific needs of each patient.

Wards were dementia friendly and supported disabled patients. Wards had clear, large print signage and photographs of staff. Signs were clear, in bold face with good contrast between text and background, fixed to the doors they referred to, at eye level and well lit. Handrails were colour coded to designate male areas and female areas. Wards were well-lit and made as much use of natural light as possible. Floors were not highly reflective or slippery. The trust had an action plan in place for the continuing environmental works for Kitwood ward to further improve the dementia friendly environment. All the appropriate fixings and fixtures were in place but the painting and decorating were yet to be completed. This was due to be finished by March 2023.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Wards displayed information on the Mental Health Act, advocacy, how to complain, encouraging feedback, charities providing support for older people, how to cope with loneliness and information for carers.

The service was able to meet the diverse cultural, religious and linguistic needs of patients in the service. The service had information leaflets available in languages spoken by the patients and local community. This included information about mental health conditions and medicines. Patients and relatives could request information in different formats such as 'easy-read', large print, braille and other languages for patients who did not have English as their first language. Managers made sure staff and patients could get help from interpreters or British sign language interpreters to ensure patients and their families were fully included in care planning.

Wards for older people with mental health problems

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Each ward provided food that was halal, kosher and vegetarian. For patients with specific dietary needs, wards could provide food that was gluten free, easy to chew and high energy.

Patients had access to spiritual, religious and cultural support. Cultural and religious needs were addressed in care plans. Patients had access to religious leaders who visited the wards. Multi-faith rooms were available for use by patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients across the service told us that they were aware of how to make complaints. As well as the formal complaints process and raising issues directly with staff and managers, patients had the opportunity to raise issues in community meetings and in one to one sessions. Patients reported that in most cases staff responded promptly to any concerns raised.

Staff understood the policy on complaints and knew how to handle them. The trust had a complaints policy that all staff could access through the intranet.

Managers investigated complaints and identified themes. Between November 2021 and November 2022 there were 19 formal complaints in areas such as clinical management of mental health, attitude of staff, communication, and systems and procedures. All complaints were fully investigated. Themes were reviewed and learning points explored regardless of whether complaints were upheld. Six complaints were resolved locally, 2 were not upheld, 4 were partially upheld, 1 was fully upheld and 6 were still in the investigation process.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Actions points stemming from complaints were completed and followed up at the appropriate level. For example, in relation to one complaint all staff received additional training in the correct process for homeless patients and how to ensure that they were referred for assessment of their eligibility for social housing under the Homelessness Reduction Act 2017.

The service used compliments to learn, celebrate success and improve the quality of care. Staff routinely reviewed both complaints and compliments at team meetings.

Is the service well-led?

Good 🟢 ➡️ ⬅️

Wards for older people with mental health problems

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders, including ward managers and matrons, were experienced in health and social care. Ward managers had a very good understanding of their patients. This included knowing about the circumstances surrounding the admission for each patient, their social circumstances, their risks, their current treatment plan and the plans for their discharge. Senior managers in the regions spoke positively about their ward managers and the leadership they provided at a clinical level. Modern matrons worked closely with the ward managers and knew the patients and staff well. Managers were able to clearly explain how they led the wards and worked with their staff teams to ensure the quality of the service. Staff said that managers were both approachable and supportive.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The values of the trust were, "we care, we learn, we empower". Staff applied this in their work through the care they demonstrated to patients, their respect for patients and colleagues and the overall inclusivity shown to a everyone from very diverse communities. Staff were aware of the October 2022 Channel 4 Dispatches programme highlighting extremely poor care and support in the trust's acute inpatient services. Staff said they were disgusted by the way in which some staff behaved and conducted themselves in the footage. Staff said they came together as teams to discuss and reflect on the footage. Patients said they had not witnessed any mean or abusive behaviour from staff and felt staff in the wards for older people with mental health problems service showed competence, and strong compassion and care in their support.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff from all backgrounds and professions were proud of their work, felt positive and reported good staff morale. All staff showed passion and commitment to providing high quality patient care. Staff described strong staff teams that worked well together and supported each other. Staff described an open culture where everyone was encouraged to share their views. They felt respected by managers and peers**.** There were opportunities for career development. For example, some healthcare assistants were training to become registered nurses. Staff said they would have no hesitation in raising concerns with their manager or other supervisors. Staff were aware of the whistleblowing policy and freedom to speak up guardian.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at team level and that performance and risk were managed well.

Wards for older people with mental health problems

Governance and decision making were led in each borough by the executive nurse. The executive nurse met with the matrons, who then met with the ward managers each week to discuss action plans and compliance with operational standards. Risks were managed well. Care and treatment were consistent with national guidance. Feedback from patients and carers was positive. All wards carried out a programme of audits to monitor areas such as care and treatment records, staffing levels, staff supervision and appraisals. However, not all wards fully applied the trust's governance system and processes around clinical equipment monitoring, assessment and management of patient risk, and medicines management.

Management of risk, issues and performance

The service managed risk well. Risk registers accurately reflected risks identified by staff. Action was taken to mitigate risk.

Risk management was comprehensive and recognised as the responsibility of all staff. Each ward had a risk register and ward managers were aware of the key risk areas on their wards. The risks were discussed at team meetings. Staff carried out appropriate tests to measure the level of risk and took appropriate action to address this. This included the assessment and management relating to nutritional intake, falls, tissue integrity and diabetes. Risks relating to mental health were managed through medication, therapeutic engagement and enhanced observations. Each day ward teams reviewed the risks for their wards and patients. The ward teams knew the patients well. They were well informed about incidents and used the multidisciplinary team meetings to discuss any changes to patients' care or new insights into their presentation. There were systems in place to monitor risks associated with patients' physical health and any issues were quickly picked up and addressed.

The service had contingency plans for emergencies which wards reviewed as part of their risk registers. Wards carried out regular health and safety monitoring, including regular emergency simulations and fire drills.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The information used in performance management and delivering quality care was consistently accurate, reliable, timely and relevant.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was provided to meet the needs of the local population.

Managers engaged actively other local service providers to ensure that older people experienced good quality care on discharge. The service was transparent and collaborative with local health partners about performance. They were open and honest about the challenges and the needs of the population and felt comfortable in feeding back to system partners.

Learning, continuous improvement and innovation

All staff were committed to continual learning and improving services.

Wards for older people with mental health problems

The service did not use any structured quality improvement models to improve and develop the service. However, managers and staff were clearly committed to improving the service and responded to feedback from patients, carers and staff. A framework of meetings was in place which facilitated sharing of learning from incidents, complaints and safeguarding across the service.

Mental health crisis services and health-based places of safety

Good ● → ←

Is the service safe?

Requires Improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. We reviewed the environment of 5 crisis and home treatment teams and 4 health-based places of safety. Two of the health-based places of safety were being refurbished but one was almost complete. Each area had an environmental risk assessment that included a ligature risk assessment. These were detailed and covered all risks. Risks were RAG (red, amber, green) rated and mitigation for each risk was included. In the Home First West health-based place of safety they included photos of the red rated risks. The service was in the process of refurbishing the health-based places of safety. We saw evidence that ligature risks will be reduced further as part of this process, Chelmsford site that was almost completed.

All interview rooms had alarms and staff available to respond. Staff in all locations had access to pinpoint alarms that would alert staff if assistance was required. There were panels located throughout the building which showed staff exactly where the alarm was activated.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. We reviewed the clinic rooms at all 5 locations. All clinic rooms were equipped with all necessary equipment for staff to complete physical examinations. Each location also had grab bags available for staff to take so they were able to complete physical health checks whilst visiting patients in the community.

All areas were clean, well maintained, well-furnished and fit for purpose. We completed a tour of each location. All locations were clean and well maintained. Rooms used for meeting patients were well furnished and fit for purpose.

Staff did not keep cleaning records. However, cleaning staff were on duty each day and ensured the environments were clean and tidy.

Staff followed infection control guidelines, including handwashing. Staff had access to hand washing facilities and there was disinfectant hand gel for staff to utilise at each location.

Staff made sure equipment was well maintained, clean and in working order. Staff put labels on equipment when they cleaned it to show that it had been cleaned and when it was due to be cleaned next. We reviewed the calibration records for equipment and saw that staff kept it well maintained.

Mental health crisis services and health-based places of safety

Safe staffing

The service had enough stuff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Staff told us that they were often short staffed, however they did not feel that the service was staffed unsafely. Managers told us they had regular bank staff who knew the service and the patient group and were able to work as part of the team. This enabled managers to ensure that any staff shortages did not affect patient care. We reviewed the duty rotas for 3 months, which showed that shifts were covered with bank staff where possible. If the team were short staffed, then staff would look at the workload for the day and offer lower risk patients telephone contact. The Health Based Places of Safety had staff allocated to attend each day should a patient require the service.

The service had high vacancy rates. The service had an overall vacancy rate of 30% for the past 6 months. The Crisis Resolution and Home Treatment Team East had a vacancy rate of 35% and the Crisis Resolution and Home Treatment Team West had a vacancy rate of 36%. Managers at these locations told us that recruitment was particularly challenging due to their proximity to London where potential staff could earn higher wages.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Each team had access to regular bank staff who were familiar with the service and patient group. Regular staff would also do extra hours on the bank to support the service and ensure patient care was not compromised due to unfamiliar staff. We reviewed the duty rota's which showed that the bank staff worked regular hours.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers ensured that new bank or agency staff completed an induction. This included shadowing a regular member of staff on shifts to ensure they were competent.

The staff turnover rate for the service was 2% for the past 6 months. However, the crisis resolution and home treatment team east had a turnover rate of 6.5%. This was below the trusts target of 12%.

Managers supported staff who needed time off for ill health.

Levels of sickness were high. The service had an overall sickness rate for the past 6 months of 9%. This was above the trusts target of 5 %. The crisis resolution and home treatment team east had a rate of 7% and the crisis resolution team west had a rate of 8%. However, the home first team west had a sickness rate of 21%.

Medical staff

The service had enough medical staff. Each team had a consultant psychiatrist and a staff grade psychiatrist. All teams also had junior doctors available for support.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

Mental health crisis services and health-based places of safety

The service could get support from a psychiatrist quickly when they needed to. Staff had easy access to a psychiatrist when required. Psychiatrists were based with the teams and could be accessed when required. Psychiatrists would see patients within 24 hours of referral to the home treatment teams.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The overall compliance rate for the service was 88%. However, the Home First West team's compliance rate was 74%. The Home First West team had 17 out of the 32 mandatory training courses that fell below 75% compliance.

Care certificate training for health care assistants was 57%. The Home First East team only had a 50% compliance, Home First Mid team had a 33% compliance and the Home First West team had 0% compliance with care certificate training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The mandatory training programme contained up to 33 different training courses covering a range of topics. These included safeguarding adults and children, Mental Capacity Act and Mental Health Act training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 25 care records across the Health Based Places of safety and the Crisis teams. Records showed that staff completed a risk assessment as part of the initial assessment process. Staff used the trust's risk assessment tool which covered a variety of risks. Staff completed detailed risk assessments that covered all identified risks, including historic risks.

Staff could recognise when to develop and use crisis plans according to patient need. Staff completed crisis plans during the assessment process. Staff told us that that they would usually complete the crisis plan as part of their initial home visit.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Staff RAG rated each patient's risk daily. This meant that staff could respond quickly to deterioration in patient's health and could increase support where necessary or refer for admission to hospital.

Staff followed clear personal safety protocols, including for lone working. We reviewed the lone working policy for the service. Staff followed the lone working policy to maintain their safety. Staff had access to lone working devices which they could use to get assistance while in the community if they were at risk or required assistance. These devices alerted staff from an outside organisation who would then attempt to make contact and could call the police if required. The devices had GPS location signals so the staff at the outside organisation could send help to the right location.

Mental health crisis services and health-based places of safety

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were mainly up to date with their safeguarding training. The overall compliance rate for safeguarding adult training was 90%. However, the Home First East team had a compliance rate of 79% and the Home First West team had a compliance rate of 71%. Safeguarding children compliance was 93% overall. Staff we spoke to were able to explain how they recognise and report abuse when they have concerns.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We spoke to 24 staff of different grades who were able to explain and give examples of how they protect people from abuse and harm. Staff demonstrated good knowledge of the providers safeguarding policies and procedures.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they would make a referral to the Trust safeguarding team who would triage the referral before passing it on to the local authority if required. Staff told us they could contact the safeguarding team for advice and support and could access safeguarding supervision if they had a complex case.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The trust had an electronic recording system that was accessible to all staff, including bank staff.

When patients transferred to a new team, there were no delays in staff accessing their records. As all staff had access to the electronic information system there were no delays in accessing information.

Records were stored securely. The electronic record system only allowed staff to access the information they had a right to access.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had systems and processes in place to safely prescribe, administer, record and store medicines. We reviewed the process of all teams and found that these were being followed in 4 out of the 5 teams. However, these processes were not always followed by staff in the health-based place of safety in Rochford, and governance arrangements were not robust to identify and improve systems. We found an out of date, controlled drug in the controlled drugs cupboard, which staff immediately destroyed in line with the trust policy on destruction of controlled drugs. Staff had not completed the stock check since July 2022.

Mental health crisis services and health-based places of safety

There was an illicit drug, that staff had removed from a patient, in the controlled drugs cupboard. Staff had documented this in the controlled drugs book, but and had not followed the trust's policy and had not removed it since June 2022. Staff were informed of this and when we visited the following day, no action had been taken to remove it. Staff did act later that day to dispose of this in line with the trusts policy.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients saw a doctor on admission to the service who reviewed their medication. Patients only received support for a short period, so staff arranged for a review of medication if there were concerns or if the patient was experiencing side effects.

Staff completed medicines records accurately and kept them up to date. We reviewed 25 medication records. Staff completed records accurately and there were no gaps in signing for medication.

Staff mostly stored and managed medicines and prescribing documents safely. However, in the crisis resolution and home treatment team east the doctor kept his prescription pad in an unlocked drawer in an unlocked office.

Staff learned from safety alerts and incidents to improve practice. The trust shared a lesson's learned newsletter with staff which contained information on medication incidents and alerts.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff would monitor patient's for over sedation on every appointment. If staff felt that a patient was overly sedated, they would refer them to the doctor for a medication review.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute of Health and Care Excellence (NICE) guidance. Staff had access to a grab bag containing physical health monitoring equipment to monitor patient's physical health in line with the NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. We spoke to 24 staff who were aware of what they needed to report as an incident and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had not had any never events. We reviewed the incident report data and found the service had not reported any never events in the past 6 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed incident reports and investigations which showed that staff were open and honest and fed back the results of investigations to patients and their families.

Mental health crisis services and health-based places of safety

Managers debriefed and supported staff after any serious incident. Managers told us they could get support from the psychology team who would facilitate debriefs after serious incidents. Staff told us they would hold more informal debriefs after incidents within the service.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incident reports demonstrated patient and family involvement. They were detailed and thorough and identified lessons to be learned.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from lessons learned during team business meetings. We reviewed the business meetings for the past 3 months and only found 2 examples of where lessons learned were discussed. The trust did produce a lesson's learned newsletter. We reviewed an example of this. It was very detailed and included lessons learned from both community and inpatient. It also highlighted good practice that was identified.

Is the service effective?

Good 🟢 ➡️ ⬅️

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. We reviewed 25 care records and found that staff completed a thorough and detailed assessment of each patient prior to treatment within the teams. Assessments cover a range of areas including past and present mental health history, current triggers, risk history, support networks and social circumstances.

Staff made sure that most patients had a full physical health assessment and knew about any physical health problems. Staff booked patients in to be seen by the doctor within 24 hours of assessment. The doctor would complete a physical health check as part of their initial assessment. Care records showed that staff were completing physical health checks and monitoring. However, we reviewed 4 care records in the Home First West Team and found staff were not completing regular physical health monitoring.

Staff developed a care plan for each patient that met their mental and physical health needs. Care records showed that staff completed care plans for each patient. However, in 11 out of the 25 care records we reviewed (4 care records in the Home First West and 7 care records home first east team), the care plans were not individualised. We saw evidence that care plans had been copy and pasted from one care plan into another. Care records the home first east team showed crisis plans were all the same with just the name changed. Staff told us this was due to their treatment plans being very similar for each patient such as, once or twice daily visits initially, and this would reduce once the patients risk would reduce.

Mental health crisis services and health-based places of safety

Staff regularly reviewed and updated care plans when patients' needs changed. Care records showed that staff updated care plans when necessary. Patients were only supported short term so staff would update care plans if needs changed.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Staff told us that psychology was limited within teams due to the short-term nature of their work, and that they could access psychology input for more complex cases. However, staff could refer to community services for psychological support as well as access specialist groups such as personality disorder focus groups.

Staff delivered care in line with best practice and national guidance. Managers explained that the service reviewed the National Institute for Health and Care Excellence (NICE) guidance Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults. Staff told us they followed NICE guidance on the use of anti-psychotic and anti-depressant medication.

Staff made sure patients had support for their physical health needs, either from their GP or community services. We saw evidence in the care records of staff referring patients for support with their physical health such as electro-cardiograms and blood tests.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff used the National Early Warning Scale to monitor and assess patient's physical health. Staff also used the Health of the Nation Outcome scales to monitor patient's mental health severity and improvement.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. We reviewed the audit processes and saw that staff engaged in several clinical audits including record keeping, clinical audits, caseload audits and environmental audits.

Managers used results from audits to make improvements. We reviewed the audits for the past 3 months. We saw evidence that the managers would ensure action was taken to make improvements where the audits highlighted an issue.

Skilled staff to deliver care

Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients. However, teams did not routinely offer psychology as teams did not have psychologists as part of their teams as patients were only supported short term, however, staff could refer to community services if required.

Mental health crisis services and health-based places of safety

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The service had a range of staff with differing skills and experience. Staff was made up of band 5 and band 6 nurses as well as occupational therapists and social workers. Staff had access to specialist training to improve their skills. Health care assistants could undertake training to become a band 4 assistant practitioner.

Managers gave each new member of staff a full induction to the service before they started work. Staff were expected to complete the trusts induction programme before starting work in the team. This included completing mandatory training. Once this was complete staff would then have to shadow an experienced staff before they lone worked.

Managers supported staff through regular, constructive appraisals of their work. We reviewed the appraisal rates for each team. The overall compliance for the service was 88%. However, the home first east team had an appraisal rate of 75 %.

Managers had not always supported staff through regular, constructive clinical supervision of their work. We reviewed the supervision rates for each team. The overall compliance rate for the service was 75%. The Home First West team had a compliance rate of 58%, the home first team east had a compliance rate of 74% and the crisis resolution and home treatment west team had a rate of 62%. This meant that staff were not receiving appropriate support and that any issues with performance may not be identified.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Each team had monthly business meetings. Managers would share the minute to these meetings with all staff so if staff were unable to attend, they could keep up to date.

Managers made sure staff received any specialist training for their role. Staff were able to access specialist training to enhance their skills. This included phlebotomy and nurse prescribing training.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff could arrange meetings when required to discuss patients care. Staff would arrange a multidisciplinary meeting prior to discharge and include all professionals involved in the patients care to ensure a safe transfer of care.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff included all professionals involved in the patients care in discussions and decisions regarding the patients care and treatment. This ensured all staff involved with the patient was kept up to date.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff compliance with Mental Health Act training for all teams was 89%. However, the home first team west had an overall compliance rate of 61%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff told us that if they required advice regarding the Mental Health Act, they would speak to the team manager or the Mental Health Act administrators. Staff told us they have Approved Mental Health practitioners in the team who would also provide support and advice.

We reviewed the Mental Health Act documentation in the Health Based Places of Safety. We found the staff were complying with the Mental Health Act Code of Practice and that patients were discharged within 24 hours.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. Staff provided patients with information on how to access advocacy support.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed. We saw evidence in patients records that staff identified if they were subject to Section 117 rights under the Mental Health Act.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. OR Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff received training in the Mental Capacity Act as part of their safeguarding adults training. Staff overall compliance for all teams was 90%. However, the home first team west had a compliance rate of 71%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff were able to tell us their responsibilities regarding the Mental Capacity Act and how they would always assume a patient has capacity and that if they were concerned and if they thought a patient did not have capacity to make a decision, they would arrange a capacity assessment.

Staff knew where to get accurate advice on Mental Capacity Act. Staff told us they would speak to the team manager to get advice regarding the Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Mental health crisis services and health-based places of safety

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff told us that if a patient did not have capacity to make a decision, they would arrange a decision meeting and involve all those involved in the patients care, including family and carers to ensure the patient's wishes, feelings and culture were respected.

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve.

Is the service caring?

Good 🟢 ➡️ ⬅️

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We spoke with 12 patients who told us that staff always treat them with respect and dignity. Patients felt valued by staff and that staff were kind and responsive to their needs. We attended 4 appointments in patients' homes and saw that staff were very kind, caring and compassionate.

Staff gave patients help, emotional support and advice when they needed it. Staff provided patients with contact details for the service as well as the out of hours service, so patients could get the advice and support when needed.

Staff supported patients to understand and manage their own care treatment or condition. Staff provided patients with support and guidance to manage their condition so as to avoid hospital admission. We saw evidence in the care records of a patient who had been assessed as requiring hospital admission. The team was able to support the patient to learn coping skills and they avoided the patient having to be admitted to hospital.

Staff directed patients to other services and supported them to access those services if they needed help. Staff supported patients to access other services such as psychology services and community recovery cafes for support.

Staff understood and respected the individual needs of each patient. We attended 4 appointments in patients' home and saw that staff were respectful of patients in their homes. Staff demonstrated a good understanding of individual patient's needs.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Mental health crisis services and health-based places of safety

Staff followed policy to keep patient information confidential. Records were electronic and staff could only access information they had a right to access.

Involvement in care

Staff in the mental health crisis teams did not always involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. We reviewed 25 care records and found that 10 were not individualised or did not show involvement of the patient. Staff explained that due to patients being in a mental health crisis it was often difficult for them to be involved in writing their care plan when they first start treatment with the team. We reviewed survey results from January 2022 to November 2022 and saw that there was a 92% satisfaction rate with involvement in care.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We found evidence in care records of staff getting support to communicate with a deaf patient using a signer.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff provided patients with information on how to give feedback in the service they have received. This included a code that patients could scan to access to an online survey and provide feedback.

Staff made sure patients could access advocacy services. Staff provided patients with information on how to access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff offered families and carers a carers assessment to assess their needs and what support could be offered. In the Home First West team staff could refer carers to local charitable organisations who ran carers groups and a telephone service. In the crisis resolution and home treatment team west, staff could refer carers to a support group or to 1 to 1 support. They also had a carer's link worker whose role was to provide support and guidance to carers,

Staff helped families to give feedback on the service. Staff provided families and carers with information on how to give feedback on the service they have received. This included a QR code which gave patients access to an online survey to provide feedback. We reviewed the survey results from January 2022 to November 2022 and found the service had an 80% satisfaction rate.

Mental health crisis services and health-based places of safety

Is the service responsive?

Good 🟢 ➔ ⬅

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service had clear criteria to describe which patients they would offer services to. However, due to the lack of available beds the teams would have to support patients in the community who had been assessed as meeting the criteria for admission. We found evidence in the incident report log for the past 6 months of 74 patients who were being supported in the community because staff could not access a bed when required. Of the 74 patients waiting for admission 22 had been assessed under the Mental Health Act as requiring detention and were having to be managed in the community. We saw evidence of patients having to wait over 2 weeks for admission to hospital. This meant that staff were managing very high-risk patients in the community and that the team's caseloads were high. We reviewed the case loads for all teams. Staff in the East Essex crisis and home treatment team told us their maximum case load was 25. All other teams were operating above their case load maximum. The home first west team had a caseload of 33 which was 8 over their maximum. The home first east team had a case load of 40 which was 10 over their maximum. However, caseload sizes could be flexible depending on the risk rating of the patients they had on their caseload.

All other teams were operating above their case load maximum. The home first west team had a caseload of 33 which was 8 over their maximum. The home first east team had a case load of 40 which was 10 over their maximum. Staff would provide intensive support to manage high risk patients who were waiting for a bed to become available. We saw evidence in the care records of patients who were waiting for a bed, but the Home first teams had managed to reduce the risk so that they were discharged from the team without having to be treated in hospital.

The trust set and the service met the target times seeing patients from referral to assessment and assessment to treatment. Staff would assess patients within 24 hours and if suitable for the service they would be accepted immediately for treatment. Patients in the Health Based Places of safety were assessed and discharged within 24 hours.

The crisis team had skilled staff available to assess patients immediately 24 hours a day seven days a week. All teams worked 7 days a week. Patients had access to the 24-hour crisis line, out of hours should they need support. The trust also had an accident and emergency liaison team who would assess patients who arrived at the accident and emergency department needing mental health support. We spoke to one the managers of the liaison teams who explained the service and how they linked with the home treatment team.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. We saw evidence in the care record of when staff had tried to engage with a patient who was reluctant to seek support. Staff visited the patient at different times of the day to try and make contact. They also tried phoning at different times. When this was unsuccessful, they wrote to the patient and asked them to make contact. If staff had significant concerns due to the risk of the patient, they would call the police and request a welfare check.

Mental health crisis services and health-based places of safety

Patients had some flexibility and choice in the appointment times available. Patients could state their preference of either morning, afternoon or evening visits. Staff would always accommodate this where possible. Staff would also offer telephone contact if they were unable to facilitate a visit at an appropriate time for the patient.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff would only cancel appointments when necessary due to staff shortages caused by sickness. If staff were unable to visit, they would offer the patient telephone support instead.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Staff supported patients through their transition back to their care coordinators or GP. Staff would liaise with care coordinators and plan discharge with them to ensure a smooth transition between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Each team had private rooms at their location so they could see patients on site if the patient preferred. The rooms were comfortable and promoted privacy and dignity.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff were able to refer patients to get support to access work and education opportunities. Staff would also offer flexible appointment times to enable patients to continue working or studying.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff supported patients to access a range of support networks including the recovery café and therapeutic groups in the community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments, for disabled people and those with communication needs or other specific needs. All teams had access to rooms with disabled access to use should they be required for a patient with disabilities. We saw evidence of staff using a sign language interpreter to assess a patient with a hearing impairment.

Mental health crisis services and health-based places of safety

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff had access to a variety of information on treatments, local services, rights and how to complain. Staff could access the information in various formats including different languages and large print.

Managers made sure staff and patients could get hold of interpreters or signers when needed. We saw evidence in the care records of staff utilising interpreters to communicate with patients whose first language was not English. We also saw evidence of staff using signers to assess a patient with a hearing impairment.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff provided patient's, relatives and carers with information on how to complain and what to expect should they need to complain.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke to were able to tell us the complaints process and what they would do if someone made a complaint to them.

Managers investigated complaints and identified themes. We reviewed the complaints for the past 6 months and saw that the crisis teams had received 6 complaints. Staff had investigated and responded to all complaints in line with the trust's policy. Staff investigated complaints thoroughly and wrote to complainants with the outcome and information on how to appeal the outcome. Staff identified lessons learned from complains and actions to take to make improvements.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared lessons learned from complaints with staff during handovers and team meetings. The trust also published a lessons learned newsletter with details of complaint outcomes and lessons learned from complaints throughout the trust.

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 🟢 ➡️ ⬅️

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. We spoke with 5 team manages. They all demonstrated good knowledge and awareness of their teams and were all experienced. Staff told us they were visible, and they could approach them anytime with any concerns or general advice and support. Managers demonstrated good knowledge of the patients and the current risks the team were managing.

Mental health crisis services and health-based places of safety

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. Staff were aware of the trust's values of we care, we learn, we empower, and explained how these were demonstrated in their work.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. All staff we spoke to told us that they felt supported and valued. Staff felt that they had opportunities for career development as they could undertake specialist training to develop their skills and knowledge. The trust had an equality and diversity policy. Staff felt that the trust followed the policy, and this was reflected in how staff were treated.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. Managers in 4 out of the 5 teams used the results of audits to monitor the performance of the services and make improvements. However, in the East Essex Crisis Resolution and Home Treatment Team they did not have robust governance systems to monitor medication management. Managers had not identified that staff were not completing controlled drugs stock checks which would have identified an out of date medication.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff attended daily handover meetings and weekly multi-disciplinary team meetings where patient information and risks were discussed. Staff would also share information on changes to patients care and treatment plan. All staff had access to the records system, including bank staff. The risk register was up to date and included patients being managed in the community whilst waiting for a bed.

Engagement

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting. The service worked with the police and the local acute urgent care services. The services had police liaison teams who supported police in the community with assessing people in the community who may be suffering with a mental health crisis and supported them to get the most appropriate support. The services had a team who supported the local urgent care centres with assessing patients who presented in urgent care with mental health care needs.

Learning, continuous improvement and innovation

Staff did not provide any evidence or information of ways the service used quality improvement methods to make improvements to the service people received.

Acute wards for adults of working age and psychiatric intensive care units

Inadequate 🔴 ➔ ⬅

Is the service safe?

Inadequate 🔴 ➔ ⬅

Our rating of safe stayed the same. We rated it as inadequate.

In the 2019 inspection safe was rated as requires improvement. We currently rate safe as inadequate.

Safe and clean care environments

Not all wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Patients' observations were not carried in accordance with trust policy. There was limited measurement and monitoring of safety performance.

Safety of the ward layout

At the November 2022 CQC visit, staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We reviewed the ward ligature risk assessment which included a risk score coupled with a RAG (green, amber and red) rating risk score and description of the actions taken as mitigation. Managers had mitigated ligature risks. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff could not observe patients in all parts of the wards due to the layout of the buildings. However, patients were supported with daily observations. Closed-circuit television camera monitoring was present on wards with an overview of the communal and corridor areas. All wards had curved mirrors placed around the ward to assist staff with patient observations. In addition, the trust had an electronic system which including cameras and sensors in patient's bedrooms. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity- based alerts, warnings and reports on risk factors. This was known as a contact-free patient monitoring and management system. There were large numbers of patients that required observations to help keep them safe. Some staff on wards used handheld electronic device to record patients' observations. Staff completed patient observations which were later reviewed and signed off by managers.

At the October 2022 CQC inspection of two wards Willow ward and Galleywood ward, we identified staff not following policies and procedures for patient observations and engagement; and staff falling asleep when undertaking patients' observations. The trust was required to make improvements. At the November 2022 visit staff across the inpatients service had undertaken observation training in line with trust patient's observation policy. Agency and bank staff new to the service, were not allowed to undertake patient observations until they had completed the observation training. Senior staff on wards would ensure new staff received the training and this was now part of staff induction and included training videos. On Willow ward and Galleywood ward managers introduced plans for a therapeutic engagement quality improvement plan to aid staff with patient observations. We saw on Willow ward poster wipe boards in patients' bedrooms, with talking points, prompts and ideas from patients for staff to consider when completing observations. Managers told us staff were meeting with patients weekly to review developments.

Acute wards for adults of working age and psychiatric intensive care units

On the November 2022 CQC visit despite the trust taking some steps to follow up ongoing risks; four patients on Kelvedon ward said when they were on enhanced observations staff did not engage with them. On Willow ward two patients said they had seen temporary staff asleep during their night observations. Some patients from Galleywood and Ardleigh wards told us temporary staff had gone to sleep when they should have been observing them. The trust was aware of incidents where staff were sleeping on duty and were monitoring this. Managers reported that they did not have immediate access to closed-circuit television camera monitoring to check incidents, advising that access could take up to 14 days. Following the November 2022 inspection, the trust told us they had reviewed the list of staff members who could access closed-circuit television camera monitoring. The trust were undertaking a pilot to give appropriate staff direct access to CCTV and body worn camera footage to test using this routinely for learning. The trust reviewed who was part of the pilot and extended this to service managers and matrons from the 9 December 2022. The pilot was due to complete in quarter 4 and recommendations made.

At the October 2022 CQC inspection of two wards Willow ward and Galleywood ward. Staff had identified a blind spot in the garden at Galleywood ward. Staff had reduced the associated risk by keeping the garden locked. This meant that patients could only access the garden under the supervision of staff. At the November 2022 CQC visit the risks had not been addressed in the Galleywood ward garden area. The garden area remained locked, and patients had to ask staff to access the garden area.

On the November 2022 CQC visit, we visited Cherrydown ward and Grangewater wards, both were mixed sex wards. The wards had complied with guidance with mixed sex accommodation. On Peter Bruff a mixed sex ward, staff told us about a mixed sex breach two months ago, when a female patient had been found in male bedroom. Staff had reported this as an incident. One patient on Peter Bruff ward said the female lounge doubled up as a quiet room and was routinely used by male and female patients. We fed back to the ward manager for immediate action.

On the November 2022 CQC visit, most staff had easy access to alarms and most patients had easy access to nurse call systems. Visitors were provided with alarms when visiting their relative. At the October 2022 inspection of two wards Willow ward and Galleywood ward we found Willow ward had nurse call systems in the bedrooms but not on Galleywood ward. Staff used the contact-free patient monitoring and management systems as an additional safety tool to use when appropriate and were supplementary to clinical observations.

Maintenance, cleanliness and infection control

On the November 2022 CQC visit not all ward areas were clean, well maintained, well-furnished and fit for purpose. We saw Chelmer, Stort, Galleywood Grangewater, Cherrydown, and Kelvedon wards were exceptionally clean. The Galleywood ward manager arranged regular checks of the ward with a staff from estates to identify any maintenance issues. Grangewater, Cherrydown, Kelvedon wards had recently been refurbished.

However, on Christopher psychiatric intensive care unit the windows were dirty. The glass surround inside and outside the nurses' station were grubby with food stains. Christopher's psychiatric intensive care unit were at the beginning of a refurbishment plan which was due for completion in March / April 2023.

On Cedar ward, the environment was not therapeutic, the décor was worn and gloomy. The patients lounge on Cedar looked bare, with chairs lined up. Patients were unable to see outside their bedrooms due to privacy film on windows. We observed the extra care shower room was dirty and bedroom 12 toilet were visibly dirty. The dining room sink, and bin were dirty. Staff had not always stored food safely. For example, we found that cheese had not been covered in the

Acute wards for adults of working age and psychiatric intensive care units

fridge. The Cedar ward main garden was stark with a large amount of litter and a large puddle had formed from the recent rainfall. We saw a separate therapy garden for patients to access that was very small. Estates were looking at the robustness of doors throughout the wards. Doors were scheduled for change over to keypads so patents could use a fob card to access their bedrooms. In the interim, patients had to request access to their bedrooms during the day.

On Ardleigh ward there were some maintenance issues. The tumble dryer had broken down 23 November 2022 and awaiting priority urgent repairs. The digital video disc player (DVD) was broken in the patient's main lounge. A communal toilet door was missing and broken in July 2022 and awaiting repairs (due 28 November 2022). In the patients' lounge noticeboards had been removed and left marks on walls with unpainted areas. Indoor and outdoor windows were dirty.

On Hadleigh psychiatric intensive care unit the environment was sparse and awaiting refurbishment. Staff said the ward was cold, and female staff said they could not wear warm long sleeves due to infection control issues.

On Peter Bruff ward, the ward environment looked worn and needed refurbishment. Some ward walls were damaged. Bedroom seven (bariatric bedroom, bathroom) had an unpleasant smell, due to the drains. Managers told us they had to keep chasing up repairs to be completed. The communal room walls were bare. The staff had lockers but there were no staff rest areas. Staff would have to go off the ward for their breaks.

Patients on Stort and Chelmer wards did not have access to their own garden. The garden is an adjoining garden off the ward.

Staff followed infection control policy, including handwashing. Staff washed their hands when in the clinic room. We saw staff wore personal protective equipment when needed. We saw cleaning stickers on items in bathrooms and clinic rooms.

Seclusion room

On the November 2022 CQC visit, we saw the seclusion room at Ardleigh ward which was shared with another hospital ward. The Ardleigh seclusion room allowed clear observation and two-way communication. They had an ensuite. We saw a portable clock broken with a sticky label on that identified the clock was to be replaced. The seclusion room door had a built-in privacy blind, with a key to access the blinds that could not be located. A set of spare keys were later found during the inspection. The seclusion room needed repair the floor was marked and peeling, and walls had scribbled pictures drawn on them and were marked, the inside of the seclusion room door was scuffed and marked. Managers told us the seclusion room had been identified for refurbishment. The estates team had recently visited to make repairs, but at that time a patient was using the seclusion room, so were unable to proceed with works.

The seclusion room at the Christopher's psychiatric intensive care unit was refurbished in September 2022. The seclusion rooms allowed clear observation and two-way communication. It had a toilet and clock that patients could see. The seclusion room had safe bedding, toilet and washing facilities, heating and ventilation.

Staff told us on Peter Bruff ward the de-escalation suite was not used regularly but had been used for seclusion. There was no clock in this area.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All equipment, including the crash bag, was clearly labelled and all items were well within their expiry dates.

Acute wards for adults of working age and psychiatric intensive care units

At the October 2022 CQC inspection on Willow ward and Galleywood ward the trust had not ensured ligature cutters were consistently accessible for staff. We saw improvements at the November 2022 CQC visit. Across all wards ligature cutters packs had been made accessible to staff and located in clinic rooms and nurses' stations. Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. There were frequent staff shortages and poor management of agency staff which increased risks to patients.

Nursing staff

During the October 2022 CQC inspection on Willow ward and Galleywood ward we found there were very high levels of vacancies and sickness amongst nursing and support staff across both wards. This meant that there were many different temporary staff working on the wards that were not familiar with the patients.

At the November 2022 CQC visit improvements had not been made since the last inspection, the service continued to not have enough nursing and support staff to keep patients safe. Staff on all wards visited, told us they had staff vacancies. The service had high vacancy rates. Cherrydown, Peter Bruff and Galleywood wards had high registered nursing vacancies whole time equivalent 6.4, the highest healthcare assistant vacancies were at Christopher's psychiatric intensive care unit at 7.9 and Willow ward 6.3.

During the inspection we found areas of the service had high rates of shifts filled by bank and agency nurses and healthcare assistants. Data from the trust February 2022 to October 2022 showed shifts filled by agency and bank staff were high for agency staff on Galleywood ward at 66%. The lowest for agency staff was Grangewater ward at 32%. For bank staff the highest was Grangewater ward at 68% and the lowest was Galleywood ward at 34%.

The service had shifts not filled by bank or agency staff. Data from the trust February 2022 to October 2022 showed for qualified staff Kelvedon ward had the highest with 64% shifts not filled and the lowest for qualified staff were Hadleigh with 36% shifts not filled. For unqualified staff the highest number of shifts not filled were for Ardleigh ward with 64% and the lowest were Kelvedon ward 36% shifts.

Managers limited their use of unfamiliar bank and agency staff and requested staff familiar with the service. Managers said they booked long term agency staff and bank short term contracts across wards to ensure consistency of staff. However, six patients on Willow and Kelvedon wards told us at evenings and weekends temporary staff didn't know the ward and patients well.

Data showed a large number temporary qualified and unqualified staff worked on wards. It was unclear from staff data which temporary staff knew the patients and wards. We sampled ward rosters for November 2022 for three wards Willows, Peter Bruff and Galleywood. Data showed Galleywood had the highest use of qualified temporary staff, 63 per month, this averaged two temporary staff per day. The highest use of temporary unqualified staff was Peter Bruff ward at 390 staff per month, which averaged at 14 staff per day. Followed by Willow ward temporary unqualified used at 333 per month with an average of 12 staff per day. The trust told us the temporary workforce were made up from a mixture of permanent staff doing additional shifts, staff block booked or well known to the ward and as a last resort would use unfamiliar staff.

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Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates for some wards. The service target turnover rates were 12%. Data from the trust from November 2021 to October 2022 showed Ardleigh ward at 20% with a higher turnover rate. The data showed Cedar ward had a consistently high turnover rates between August to October 2022 at 23%. Ardleigh wards turnover rates were highest in January at 25% and February and March 23%. Hadleigh psychiatric intensive care unit had no staff turnover between Nov 2021 to March 2022 and remained low April to October 2022 between 4% to 5%.

Measures had been put in place to reduce staff turnover rates with a 5% uplift payment for substantive staff at Christopher's psychiatric intensive care unit and Haleigh psychiatric intensive care unit. A new clinical site manager was now available out of hours and weekends to support leadership across core service locations. International nurses were deployed to increase nursing substantive nursing levels. The trust had introduced pilot twilight shifts on wards to support teams covered by unqualified staff.

Managers supported staff who needed time off for ill health. The trust provided for staff an employee assistant programme and *Here for YOU- psychology support*, and fast track physiotherapy support.

Levels of sickness were high. The trusts target sickness rate was 5%. However, staff sickness absence levels across urgent and inpatients care were 11%. Cedar ward showed the highest sickness levels with sickness ranging from 42% (Nov 2021 42%) to 22% (October 2022). Sickness levels on Chelmer ward followed, with sickness levels ranging from 27% (January 2022 to 17% (October2022). Stort ward sickness levels had been lower, between 1% to 14% and in October 2022 5%. The trust told us in early 2022 up to October 2022 there were Covid-19 outbreaks which impacted on staff sickness levels.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients, however there were frequent staff shortages and poor management of agency and locum staff.

There were enough staff on each shift to carry out any physical interventions safely.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. A seven day a week rota included a nominated doctor and senior manager on call. Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift. Staff were supported by a speciality doctor who worked up to five days a week on wards.

Mandatory training

At the October 2022 CQC inspection Willow ward and Galleywood ward staff were not up to date with mandatory training. At the November 2023 visit Willow and Galleywood ward training compliance rates were between 77% to 92%.

Not all staff completed and kept up to date with their mandatory training. Out of the twelve wards visited, four wards were not up to date with their mandatory training. Training data showed mandatory training compliance rates for some wards less than 75%. CQC view mandatory compliance rates of 75% or below as non-compliant. The trust staff training

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target rate was 85%. We found low training rates on Stort ward for fire compliance 73% and Cherrydown 71%. On Ardleigh ward prevention management of violence and aggression 73%, level 3 Looked after children and PREVENT 71% and fire compliant 63%. Peter Bruff ward for Mental Capacity / Deprivation of Liberty & PREVENT 71% and safeguarding children 43%.

Staff said training availability was significantly reduced during the COVID-19 pandemic.

Staff also received essential training. Training included diabetes level 1 & 2, engagement and supportive observations, preventing suicides by ligatures, moving and handling and positive cultures.

Staff told us bank and long-term agency staff were provided mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Manager received regular staff training compliance reports.

Assessing and managing risk to patients and staff

Not all staff assessed and managed risks to patients and themselves well or followed best practice in anticipating, de-escalating and managing challenging behaviour. Opportunities to prevent or minimise harm are missed. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff did not assess, monitor or manage risks well to patients who use the services. Staff used a recognised risk assessment tool. We examined 60 risk assessments across twelve wards. We found 16 (26%) risk assessments were not complete or updated regularly including after an incident. However, managers told us patients' risk assessments should be reviewed weekly as part of ward reviews at multidisciplinary meetings, after the daily review of patient observations and following incidents.

On Willow ward we looked at six risk assessments, none of these had been completed. One patient had been admitted on 17 November 2022 (with five days on the ward), however there was no evidence that a risk assessment had been completed on admission. The patient had an incident recorded of head banging, but the date had not been recorded and there had been no review of risk after the incident. The patient had been restrained on 21 November 2022; however, the risk assessment had not been updated following the incident. Three other risk assessments had been partially completed but were not updated regularly. One patient had an eating disorder, but there was no evidence of weight monitoring and body mass index information. A skin integrity assessment had not been completed.

On Cedar ward we looked at three risk assessments, of which two were not completed. One patient had been on the ward for 45 days with a risk assessment dated July 2021. A risk assessment for this patient had not been completed upon admission. A second patient's records indicated that the patient had been admitted to the ward 7 November 2022. However, other records showed the patient were admitted 779 days ago. The patients risk assessment was not completed upon admission.

On Galleywood ward we looked at three risk assessments with two not up to date. One patient had transferred from another ward 04 August 2022. Their risk assessments had not been updated since 15 October 2022. We saw the patient

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had taken an overdose on the same date 15 October 2022, but the risk assessment had not been updated to reflect this, and there was no evidence that the patients' enhanced observation changes. A second patient was given rapid tranquilisation 27 October 2022, but this was not recorded as an incident. There was no documented review of risk after the incident.

On Stort ward we looked at six risk assessments for three patients, however there had been no regular updates. The three patients' risk assessments had not been reviewed for between twelve days to one month. On Chelmer ward we examined six risk assessments with five not updated weekly.

On Peter Bruff ward we looked at four risk assessments. One was completed. We saw on one patient's records dated 3 - 16 November 2022 had raised eight sexual safety concerns. The risk assessments and care plan had not been updated following the concerns We found for another patient risk assessments included sexualised behaviours. The patient was later transferred to a single sex ward.

We examined six risk assessments on Christopher's psychiatric intensive care unit. All six risk assessments were updated regularly including after an incident. One patient had declined the vision-based patient monitoring system monitoring. It was difficult for staff to locate consent within the patient's electronic records. Staff told us the trust were developing a record to be added to the existing patients care records specifically for vision-based patient monitoring system consent and ongoing consent.

We looked at twelve risk assessments at Kelvedon ward and Grangewater wards. All risk assessments were comprehensive updated regularly including after an incident. We found records written in the patient's voice.

Management of patient risk

On the November 2022 CQC visit we found safety was not a sufficient priority. Some staff did not always know about risks to each patient and acted to prevent or reduce risks. On Willow, Cedar and Peter Bruff wards staff did not always know about risks to each patient and acted to prevent or reduce risks. Staff did not always identify and responded to any changes in risks to, or posed by, patients.

On Willow ward, one patient had left the ward by moving through two air locks and forced opened the main outer door into the car park. Staff found the patient and returned to the ward. A previous incident of the same type had been recorded.

On Willow ward a male staff member was observed holding a female patient's hand as they escorted them to a health appointment. It was unclear if the staff member understands about potential risks and professional boundaries. This issue was immediately raised with managers. The female patients care plan were followed up and reviewed by the inspection team.

Staff followed procedures to minimise risks where they could not easily observe patients. We saw the sensor alerted staff on Ardleigh ward when one patient's oxygen levels had dropped in her bedroom. Staff immediately checked the patient and summoned medical attention.

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Not all staff followed trust policies and procedures when they needed to search patients to keep them safe from harm. Patients on Willow, Cedar and Hadleigh ward had pat-down searches in the corridor (which is part of the air lock). Pat-down search is where a staff member pass their hands over the body of a clothed person to detect prohibited or restricted items. On Cedar ward security staff carried out security checks with patients. The Cedar ward manager had identified a room to use as the patient search room and was waiting final environmental changes with estates.

At the October 2022 CQC inspection the trust were required to take immediate steps to review and reduce all blanket restrictions on wards. On the November 2022 visit we found concerns around blanket restriction and restrictive practice. We raised the concern with the trust around blanket restriction during the CQC visit 4 to 5 January 2023 for Willow ward, one staff said they continued to search patients for security checks before they come on the ward in the main doorway area. Another staff member said they searched patients on the ward in the locker area and used the metal detector without clear rational or assessment.

Ardleigh ward had a patient search room near the main entrance. This was shared with an adjoining acute ward. The search room included locked storage for patient's tobacco and lighters and a pod to temporary store any illicit drugs. We saw a list of prohibited of items on display, but this was different to lists displayed around wards. Managers told us the trust were in the process of reviewing a standard list of prohibited of items.

Use of restrictive interventions

At the October 2022 CQC inspection for Willow and Galleywood ward the trust were required to take immediate steps to review and reduce all blanket restrictions, restrictive practices on wards. On the November 2022 CQC visit we found high levels of restrictive interventions on some wards. On Willow, Cedar, Peter Bruff, Galleywood and Ardleigh wards there were restrictions where patients had to ask staff to access the garden, bathrooms, beverages areas.

On the November 2022 CQC visit, the door to the Willow ward garden was locked and the manager was unwilling to accept this was a restriction. On the CQC visit to Willow ward 4 to 5 January 2023 we saw improvements around this aspect. The garden door was unlocked and monitored by staff. Patients could access the garden area anytime. A staff member was rotated hourly to the garden area and supported patients when they accessed the garden. We observed the nurse on garden duty in the garden talking with patients while they vaped and were popular with patients.

On the October 2022 inspection Galleywood staff had identified a blind spot in the garden area and reduced the risk by keeping the garden door locked. At the November 2022 CQC visit some improvements had been made. Staff had received garden competency training and were aware of blind spot in the garden. The Galleywood ward garden remained locked, and patients had to ask to access the garden area with one patient and one staff member only.

On the November 2022 CQC visit on Peter Bruff ward the manager told us that as the ward was an assessment ward the restrictions were necessary, and they did not believe it to be restrictive practice. On Peter Bruff ward the garden area is accessible to patients every two hours at set times until 23:00 hours. Four patients said they would like to go out to the garden when they wanted to. We reviewed this during the visit on 4 and 5 January 2023. Staff told us they thought that as the ward was an assessment ward the restrictions were necessary and was not restrictive practice despite this being raised as part of the letter of intent sent to the Trust.

On Willow, Hadleigh and Cedar wards, patients could not access the beverage areas for hot and cold drinks and snacks, instead must ask staff. On the CQC visit 4 to 5 January 2023 to Willow and Cedar wards we saw some improvements, patients could access drinks and snacks in the dining area.

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On Christopher psychiatric intensive care unit, the hot water dispenser had tested too hot and so was no longer in use. On Ardleigh the beverage room had not been in use for three weeks following an incident where a patient had self-harmed and scalded themselves with the hot water dispenser.

Eleven patients from Cherrydown, Kelvedon and Hadleigh wards told us the coffee provided was caffeine free, and staff encouraged them to be in bed by midnight to aid good sleep hygiene.

Most wards had a fob key system. The fob key is the small handheld remote-control device that controls a remote keyless entry system to patients' bedrooms. On Willow ward staff told us the fob door key system had been fitted 22 November 2022 during the inspection but wasn't operational at the time of inspection. On Cedar ward the fob key system was fitted 22 November 2022 so patients could access bedrooms.

On Grangewater ward there was a designated garden area for the ward accessed by patients, three staff were required to escort patients outside. There was a shared garden scheme in place with hourly access for all patients. Patients we spoke with said that hourly access to the garden was sufficient.

On Grangewater ward patient's status were informal, however patients told us they would have their "leave discussed with matron." The matron informed us that all patients were admitted informally to the ward and that they would not be allowed to leave the ward for the first 72 hours, despite the fact that the patients were informal and free to leave at any time. Six patients told us there were unhappy with how the matron and staff worked with them as informal patients.

We saw lists of prohibited of items that varied ward to ward. Some wards displaced posters- What are the blanket rules. Staff across wards were unsure of standard items that were restricted. However high-risk items on the prohibited list were seen on the ward for example plastic bags, bars of soap and pens. On Chelmer and Stort wards we saw one patient with a plastic bag, which were a prohibited item.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw trust data from 1 December 2021 to 23 November 2022 across wards there were 753 restraint incidents. The highest were on Willow ward with 228, the most in August with 52 incidents. Christopher's psychiatric intensive care unit second highest with 143 incidents the most incidents in January 2022 with 27. The lowest restraint incidents were Chelmer ward with 24.

During the same time period (1 December 2021 to 23 November 2022), across wards there had been 22 incidents of prone restraint. Prone restraint is when a patient is lying chest down on their front during restraint. The highest number of prone restraints were on Christopher's psychiatric intensive care unit (13) and the lowest Ardleigh, Cedar, Chelmer, Peter Bruff with one prone restraint each ward. The remaining wards had none.

Not all staff followed NICE (National Institute for Health and Care Excellence) guidance when using rapid tranquilisation. We saw trust data from 1 December 2021 to 23 November 2022 across wards there were 299 incidents of rapid tranquilisation. The highest incidents were on Willow ward with 132. There were high incidents in three months January 29, April and August 22 incidents. Christopher's psychiatric intensive care unit had a total 52 incidences with October nine incidences.

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There were ten incidences of rapid tranquilisation on Galleywood ward. One patient was given rapid tranquilisation 27 October 2022. However, this was not recorded as an incident and there had been limited post tranquilisation patient monitoring. During the inspection the patient made an allegation (to the CQC team) of a sexual inappropriate incident post rapid tranquilisation. We passed this to the ward manager to take immediate action. The ward manager immediately raised a safeguarding referral and reviewed the care plan and risk assessment.

When a patient was placed in seclusion, not all staff kept clear records and followed best practice guidelines. We examined one set of seclusion records for a patient in Christopher's psychiatric intensive care unit and found records were accurately recorded. However, on Peter Bruff ward one patient had been secluded, but no seclusion records were commenced on the start date (12 November 2022) or when the patient left seclusion (13 November 2022).

Trust data from 1 December 2021 to 23 November 2022, showed that across wards there were 88 incidents of seclusion. On Christopher's psychiatric intensive care unit there had been a total of 32 incidents of seclusion between 1 December 2021 to 23 November 2022. In February there were ten incidents of seclusion. Ten incidents of seclusion took place in February 2022. Stort ward had a total of ten incidents of seclusion. Willow, Grangewater and Galleywood wards all had a total of one incident of seclusion. Overall, we saw the incidents of seclusion were reducing in December 2021 with ten incidents of seclusion to November 2022 with two incidents of seclusion.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation. Trust data from 1 December 2021 to 23 November 2022 across wards there were 11 incidences of long-term segregation. Peter Bruff ward had four and the remaining wards ranged from nil to two long-term segregation incidents.

The trust was piloting body worn cameras on Ardleigh ward. Four staff were using body worn cameras on the day of our visit. Managers planned to review footage of incidents for the purpose of learning and professional standards. The footage would be used to identify patients and staff safety incidents and safeguarding concerns.

Staff told us systems were in place to monitor the use of restrictive practices at weekly ward rounds, multidisciplinary meetings, incident audits, professionals' meetings, monthly consultants' meetings. Data provided by the trust did not provide adequate plans or evidence of learning from events or action taken to improve safety it's unclear how effective systems were in reducing restrictive practices across wards.

Safeguarding

Not all staff were up to date with safeguarding adults and children training. There was insufficient attention to safeguarding adults. Staff do not always recognise or respond appropriately to abuse.

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff kept up to date with their safeguarding training. Training included safeguarding adults and safeguarding children. Across wards safeguarding compliance rates ranged from 43% to100%. The trust mandatory training compliance rate target were 85%. Three wards were below the trust target. Peter Bruff ward safeguarding children 43%, Cherrydown ward safeguarding adults 78% and Cedar ward safeguarding adults and children 83%.

Most staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

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Staff followed clear procedures to keep children visiting the ward safe. Children were allowed on wards but must be agreed in advance with the multidisciplinary team.

Some staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust provided safeguarding data from December 2021 to November 2022. There had been 183 safeguarding referrals. The highest referrals were on Galleywood ward with 31, followed by Willow ward with 26, Grangewater one referral and Kelvedon ward had none.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

On Christopher's psychiatric intensive care unit, we saw patient notes were comprehensive and of a good standard. The trust used six different electronic systems at locations that staff could access.

Managers said they monitored patients care records to ensure they were detailed and up to date. However, we did not see this across all wards. We saw some risk assessments and care records were not completed or updated regularly.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw new patients admitted to wards clinical records were appropriately shared with the new team caring for the patient.

Records were stored securely. We saw patients' records were held electronically and managed securely.

Medicines management

Not all staff used systems and processes to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Not all staff followed systems and processes in line with trust policy, when safely prescribing, administering, recording and storing medicines. We visited seven ward clinic rooms and found gaps in following different aspects of best practice across wards. We saw evidence of patients not receiving their medicines as prescribed, including antipsychotic medications such as Clozapine, Lithium and Sodium Valproate. On Hadleigh ward we saw that a patient missed four doses of Lithium. This resulted in low therapeutic levels and led to the medication having to be recommenced and re-titrated again. On one occasion, we observed a staff member signing a patients' medicine chart in retrospect after finishing the medicines administration round.

Where rapid tranquilisation by an intramuscular medicine was used, this was only as a last resort. Staff understood the importance for post dose physical health monitoring which was to be taken every hour for the first four hours. However, staff were uncertain with regards to trust guideline for physical observation in the first hour of administering rapid tranquilisation medicine. Comments ranged from 5 minutes to 30 minutes. Records we reviewed showed that there were some gaps in records.

Medicines advice and supply were not always available. An on-call pharmacist was available

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outside of core working hours. Ward staff knew the routes to contact pharmacy when required but would prefer more clinical pharmacist involvement on wards which was lacking due to pharmacy staff capacity issues. For example, on Ardleigh ward staff told us that on one occasion, the insulin dose had been missed as insulin had not been delivered by pharmacy team.

Staff checked Mental Health Act consent to treatment documents before giving a medicine. We reviewed patient's treatments against those authorised on consent to treatment document. These were correct and in line with the consent to treatment documents.

We looked at 15 prescription charts on Chelmer ward. There were staff signatures missing on six patients' prescription charts with a total of 20 signatures missing.

On Ardleigh ward one patient told us they were awaiting antibiotics for a urinary tract infection for four days. The same patient told us their insulin had not been provided. We reviewed their medicine records and found 13 November 2022 insulin was signed as given but administered to the patient on the 11 November. Insulin was due on the 13 November but given on the 12 November. There was missed dose on the 21 November. Staff told us that on one occasion, the insulin dose had been missed as insulin had not been delivered by pharmacy team. We were unable to find information recorded about the urinary tract infection, but staff confirmed the information was correct. The manager agreed to take immediate action to support the patient with their medicines and diabetic care.

On Ardleigh ward permanent staff hold their own key and fob key to the clinic room and on occasions had taken keys home. This may potentially compromise the safety of the clinic room.

Staff reviewed patient's medicines regularly but did not provide specific advice to patients and carers about their medicines. Pharmacist or medicines management technician attended the ward weekly to carry out medicine's reconciliations and screen prescription charts (either on site or remotely using the PANDO APP). Pharmacists did not attend ward rounds and only spoke to patients directly when doing medicines reconciliation, but no patient education was undertaken. Medications were discussed by the consultant in ward rounds and when prescribing.

Staff stored and managed the majority of medicines and prescribing documents in line with the provider's policy. The service held controlled drugs stocks on site. These were checked regularly and manged safely. However, we found illicit drugs brought in by patients in the CD (controlled drug) cupboard had not been documented. Fridge and room temperatures were monitored centrally by estates, and we saw evidence of action having been taken if out of range. Some wards also carried out a physical daily temperature check. However, on Cedar ward fridge temperatures had not been recorded on three occasions, 5, 6 and 27 November 2022.

Most staff followed current national practice to check patients had the correct medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. When patients were admitted to the ward, an attempt was made to take baseline blood and electrocardiogram (ECG) readings. Monitoring was attempted when changes were made to medication in line with NICE guidance. All staff had completed medicines management training as part of the Trusts' mandatory training.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, staff told us there had been an increase in medicines related incidents reported on the trust reporting system. It was not clear the reason behind this. However, the trust medications safety officer post had been vacant for an extended period. Therefore, no in-depth medicines incident analysis had been undertaken to provide a monthly medicines incident update at governance committees, for further distribution across the trust.

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Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. When a medicine was administered to manage agitation or aggression (rapid tranquilisation), medicines were appropriately prescribed however, monitoring was not in line with trust policy. Staff used rapid tranquilisation as a last resort on wards.

Staff we spoke with could describe what they would do when someone refused their medicines and lacked mental capacity.

Track record on safety

The provider did not measure and monitor safety well.

Reporting incidents and learning from when things go wrong

Staff did not manage patient safety incidents well. When concerns were raised the approach to reviewing and investigating causes were insufficient. There was limited measurement and monitoring of safety performance. However, some managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

For this core service, there was little evidence of learning from incidents or action taken to improve safety. Opportunities to prevent or minimise harm were missed. Patient incident data from the trust showed between December 2021 to November 2022 a total of 5691 incidents. Of these, there were 3849 patient safety incidents. Actions were taken with all incidents with lessons learnt documented in 1167 (30%) with 13 serious incidents reported. Incidents with no harm 3057 (79%), 660 (17%) low harm, 32 (1%) moderate harm, one severe harm and five deaths. Ninety-four (2%) incidents were not graded.

There were 1651 incidents non patient safety incidents: 1207 (73%) no harm, 375 (23%) low harm and 30 (2%) moderate harm. One death was listed. The trust data showed action taken and lessons recorded for 466 (23%). Thirty-eight (2%) incidents were not graded. Incidents not graded would be due to the incident being open at the time of data extraction.

Trust data identified top lessons learnt types: Self-harm 1201 (21%), moving handling 772 (14%), assault physical 758 (13%), assault verbal 389 (7%) and anti-social behaviour 444 (8%). The trust identified types of lessons learnt: Education at service level 132 (32%), clinical care 105 (25%), communications 33 (8%) and environment 39 (9%). We did not see detailed plans of lessons learnt.

Staff did not always follow trust guidance and report all incidents. On Christopher's psychiatric intensive care unit staff had not reported racial abuse. The CQC inspection team observed on eight separate occasions during a two-hour period a patient being racially abusive towards several staff. We observed staff and managers ignoring the patient's behaviour. We asked staff if managers took any action and were told this type of behaviour was seen "regularly and normal" and no action were taken to report or escalate. On 4 to 5 January 2023 CQC visit, staff on Willow, Cedar, and Peter Bluff said any reports of racial incidents would be discussed at handovers and escalated with ward managers. However, staff were still not reporting these as incidents despite new guidance being issued from senior leaders, following the inspection in November 2022, that racial abuse should be reported as an incident.

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Staff had not always reported serious incidents clearly and in line with trust policy. On Peter Bruff ward we found examples where staff had not reported incidents. On the 2 November 2022 another patient had been taken to A&E for a hand injury. Staff had not recorded this as an incident. On the 9 November 2022 the same patient had become stuck in an air conditioning unit. The patient was subsequently released by the fire services with no injuries. This had not been recorded as a serious incident.

The trust provided data from 1 June 2022 to 23 December 2022 with incidents of staff sleeping on duty. The trust had recorded action taken and lessons learnt. In total there were 20 incidents. The highest number were on Willow ward; 5, Ardleigh; 4 and Peter Bruff 3 incidents. One of the 3 incidents of staff sleeping on duty were on Peter Bruff ward (23 July 2022). A patient reported a staff member had fallen asleep during their level 3 observations. (This is an enhanced observation with the patient kept within line of sight whereby the staff member can observe, engage with, and maintain contact with the patient to ensure their well-being, safety, and safety of others). Although records showed the incident of staff sleeping on duty had been raised as an incident, the close circuit television monitoring records had not been viewed and managers had not taken any action. Other wards had reported between none or one incident of staff sleeping on duty. The data showed there were four other incidents for Basildon Hospital, but the name of the ward had not been recorded.

Managers told us that lessons learnt around actions to mitigate staff sleeping on duty, was reflected in one of four training videos on the intranet for staff to watch and improve their practice. Safety action alerts were available to staff with lessons learnt including themes- self harm, record keeping. We also saw an alert about staff sleeping on duty.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff could attend weekly debriefs and had support from a psychologist. Managers encouraged staff to take part in reflective practice following any incident.

Managers investigated incidents. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. Managers held quality improvement meetings where they shared lessons learned with staff. They recorded this in meeting minutes. Staff could access safety actions, alert notices and lessons learnt on the trust intranet with identified themes used to improve care. Staff discussed incidents at staff handovers and huddles. We saw lessons learnt bulletins and staff had an icon on the intranet desktop to view lessons learnt bulletins past and present.

Managers did not always make changes and improvements in safety specific to this service. The service had close circuit television monitoring across inpatient wards. Managers can request to view close circuit television monitoring following a patient incident, but this may take up to 14 days for a request to be processed. A register of requests was maintained.

We sampled incidents on close circuit television monitoring for Peter Bruff ward 5-21 November 2022. We found several incidents which staff had not reported. On the 17 November a patient had threated a staff member on the ward, no incident had been recorded. On the 17 November a staff member were seen texting on their mobile phone near a patient. Managers had told us staff were not allowed to bring their mobiles phones onto the ward. No action had been taken. On the 18 November a patient were found with a bladded article and had threatened to hurt staff. On the 20 November the same patient were observed to be very unwell. The patient was seen by the duty doctor and attended A&E. No incident had been reported. On the 18 November another patient had repeatedly showed self-harming behaviour, no incident had been recorded.

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We sampled incidents on the close circuit television monitoring for Willow, Grangewater and Cherrydown wards during the November 2022 CQC visit . We saw staff took appropriate action and sensitively engaged with patients throughout interventions.

Is the service effective?

Requires Improvement 🟠 ⬇

Our rating of effective went down. We rated it as requires improvement.

At the previous 2019 inspection effective was rated good. We currently rate effective as requires improvement.

Assessment of needs and planning of care.

Not all staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Not all care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

At the November 2022 CQC visit, not all staff completed a comprehensive mental health assessment of each patient either on or soon after admission. Not all patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We reviewed 60 care plans across 12 wards. We found 24 (40%) care plans were not complete or reviewed regularly. Not all care plans had been regularly reviewed and updated when patients' needs changed. Most care plans were personalised, holistic and recovery orientated and included 'My care, My recovery' plans.

On Willow ward we looked at seven care plans. We saw care plans were reviewed regularly but there were gaps on three care plans around physical health care and physical health care checks. On Cedar ward we looked at three care plans. The three care plans were not reviewed regularly and did not fully meet patient's needs. One patient had recently been on a community treatment order and recalled to hospital and had been receiving treatment without written consent. We raised this with managers and staff immediately met with the patient and gained the patients consent during our visit.

On Galleywood ward we looked at four care plans. Two care plans were up to date and reviewed regularly. Two care plans had some gaps around recovery and strengths and goals; and no care plan after rapid tranquilisation incident 27 October 2022.

On Ardleigh ward we looked at six care plans. Five care plans were complete and reviewed regularly. One care plan had gaps with no reviews for regular insulin checks and recording events around antibiotics for a urinary tract infection. The patient had a history of restrictive diets and purging episodes and were historically under the outpatient eating disorder service in May 2022 but had lost contact. The patient did not have a restrictive diet care plan. The matron said they would take immediate action and make a referral to the eating disorder service; and follow up the antibiotics for the patient's urinary tract infection.

On Peter Bruff ward four care plans were not updated regularly when patients' needs changed. We saw on one patient's records dated 3 -16 November 2022 eight sexual safety concerns listed and no recorded action taken. On the 27 October 2022 a patient was holding hands with a staff member. During the inspection we saw the same patient holding hands with a staff member. Providing "hand support" was included in the patients care plan.

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On Hadleigh psychiatric intensive care unit, Stort and Cherrydown wards care plans were reviewed regularly, personalised holistic and recovery orientated. On Stort ward six care plans did not record patient involvement. On Cherrydown ward one care plan did not include a specific care plan for an existing medical condition.

On Kelvedon, Grangewater, Chelmer wards care plans were personalised holistic, and recovery orientated, complete and reviewed regularly, however all care plans were difficult to follow and up to 46 pages long.

On Christopher psychiatric intensive care unit. All five care plans were complete, personalised, holistic and recovery orientated, complete and reviewed regularly. One care plan was written to a high standard with evidence of robust wellbeing and safety plans.

At the October 2022 CQC inspection at Willow ward and Galleywood ward the trust were asked to make improvements around the contact-free patient monitoring and management system. This system helped clinicians to plan care and intervene proactively by providing them with location, activity -based alerts, warnings and reports on risk factor. Not all patients had provided consent upon admission or were aware of the systems in their bedrooms. The trust told us that they assume implied consent for this system to be used and they required staff to record if a patient declines.

On the November 2022 CQC visit we looked for evidence of patient's consent to contact-free patient monitoring and management system on Willow, Galleywood and Peter Bruff wards; we were unable to locate consent within patients' records sampled.

On Christopher's psychiatric intensive care unit one patient had refused consent. Staff took a long time to locate the refused consent in the patient's care records. There was no record of ongoing consent being sought.

Staff said the trust were developing a record to be added to the existing patients care records specifically for ongoing consent to the contact-free patient monitoring and management system. We sampled ward welcome packs for Kelvedon and Ardleigh wards and did not see any information around contact-free patient monitoring and management systems. However, wards displayed posters with brief information about technology to monitor patients' vital signs.

Best practice in treatment and care

Not all staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Most staff identified patients' physical health needs and recorded them in their care plans. Staff used NEWS 2 (a system of physical health monitoring scoring the physiological measurements that are routinely recorded at the patient's bedside). However, we saw a lack of physical health care monitoring in some patients care plans.

Most staff made sure patients had access to physical health care, including specialists as required. We saw examples of food and fluid charts for some patients.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw patients with specific dietary needs being met.

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Staff used technology to support patients. Staff used handheld device to record patient observations. However, these devices were not available to staff across all wards. The trust provided contact-free patient monitoring and management systems, but systems were not fully embedded for recording patient's ongoing consent.

The service participated in clinical audit, benchmarking and quality improvement initiatives which included staff sleeping during patient observations, care plans, medicines safety, and patient experience. The results of monitoring were not always used effectively to improve quality.

Skilled staff to deliver care.

The ward teams mostly included or had access to a range of specialists required to meet the needs of patients on the wards. However, there were no psychologists on Willow and Cedar wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

At the November 2022 CQC visit, wards had access to a range of specialists to meet the needs of the patients on the ward, this included a consultant, junior doctor, matrons, psychologists, nurses, occupational therapists, occupational therapy assistants, healthcare assistants and activity coordinator. Social workers were also available across some teams. However, there were no psychologists on Willow or Cedar wards. Registered staff told us they needed psychology input to provide specialist care for patients.

Occupational therapists, occupational therapy assistants and activity coordinators worked as a central team and deployed across wards. Activity coordinators worked seven days a week across the core service.

On the 4 to 5 January 2023 CQC visit staff on Willow, Cedar, Hadleigh, Peter Bruff wards staff were not aware of professional boundary training that had been introduced following the inspection in November 2022 CQC visit.

Managers gave each new member of staff a full induction to the service before they started work.

Managers did not support staff through regular, constructive appraisals of their work. The trust's target rate for appraisals was 90%. Data received from the trust November 2021 to 30 November 2022 had been manually calculated. Staff told us they received annual appraisals, but data showed across wards low appraisals compliance rates did not meet trust's appraisals target rate of 90%. For five wards Cedar, Kelvedon, Willow, Ardleigh, and Chelmer ward appraisals were low and ranged from 9% to 89% compliance rates. Ardleigh ward appraisals rates were lowest at 9% November 2021, increasing to 64% September. However, in October 2022 the figure had fallen to 46%. The trust manually calculated this ward at 94% compliance, however the trust manual calculations were not accurate. For Cedar ward November 2021 to April 2022 the appraisal rates ranged from 26% to 37%, however the trust had calculated the compliance across the 12 months as 100%. The trust's appraisals target rate for 90% were not met.

For seven wards Cherrydown, Peter Bruff, Grangewater, Galleywood, Christopher's psychiatric intensive care unit, Hadleigh psychiatric intensive care unit and Stort ward appraisals varied between 50% to 100% compliance rates with some months not meeting the trust's appraisal target rate of 90%.

Acute wards for adults of working age and psychiatric intensive care units

The trust clinical supervision and management supervision compliance target rate was 90%. The trust provided data for clinical supervision and management supervision between November 2021 to October 2022. Two wards Ardleigh ward 72% and Chelmer ward 78%, did not meet the compliance target rate of 90%. The remaining wards ranged from between 80-91% compliance rate.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw evidence of regular team meetings and daily huddles. Medical staff had their own specialist regular meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff across wards told us they were encouraged to attend training and development opportunities and staff forums.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers had support of human resources teams.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Meetings were held weekly across all wards.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and hub meetings.

Ward teams had effective working relationships with other teams in the organisation. We saw multidisciplinary teams worked closely with the social services GP practices and community nurses, including diabetic nurses.

Ward teams had effective working relationships with external teams and organisations. We observed a ward round on Willow ward and heard detailed discussion about patients care and treatment and discharge arrangements. Staff updated on patients' records during the meeting. The multidisciplinary teams worked closely with the crisis team and social services care coordinators.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Most wards were up to date with Mental Health Act mandatory training. However, two wards were not meeting the trust target of 85%. Peter Bruff and Stort were both at 80%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Managers said they would access the ward social workers or the Mental Health Act administrators for advice and guidance. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Acute wards for adults of working age and psychiatric intensive care units

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There was a standardised process in place for reviewing and updating Mental Health Act policies.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Posters were on display showing how to contact advocacy on the ward. Patients were also aware.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff and patients told us section 17 leave were rarely cancelled. Staff routinely completed risk assessments prior to patients leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw T3 certificates of second opinion in care records. Clinicians also completed reviews of treatment in line with Section 61 of the Mental Health Act.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Patients could request sight of these on the wards.

Not all informal patients knew that they could leave the ward freely. On Grangewater ward the assessment service, all 16 patients were informal. Patients told us staff asked them to stay on the ward until they completed their initial assessment. The assessment duration could be up-to 72 hours to complete. Staff provided patients with information about their informal status and procedure to follow on exiting. However not all patients knew they could ask to leave the ward.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The mental health administrator completed audits.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Not all staff were kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training compliance was under 85% on two wards. Peter Bruff ward was at 71% and Cherrydown ward 78%.

The trust- Lessons Identified October 2022 newsletter- included Mental Capacity Act awareness needed to be embedded in clinical teams in readiness for the introduction of Liberty Protection Safeguards.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards; and there was a mental health legislation team who provided advice and support.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Care records showed that staff revisited capacity regularly and documented the outcome.

Acute wards for adults of working age and psychiatric intensive care units

Staff mostly assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, patients being were observed, using a vision-based monitoring system and staff did not routinely record that they had assessed patients' capacity to consent to this. We raised this with staff who told us a standardised process was being developed to record this.

Is the service caring?

Requires Improvement 🟠 ⬇

Our rating of caring went down. We rated it as requires improvement.

At the previous 2019 inspection caring was rated as good. We currently rate caring as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Not all staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

At the November 2022 CQC visit, we saw across wards that most staff were discreet, respectful, and responsive when caring for patients. We spoke with 39 patients. Most patients told us that staff were responsive, kind and caring and promoted their recovery and independence.

However, two patients on Willow ward told us staff temporary had fallen asleep during their night observations. Three patients on Galleywood ward said staff at night were uncaring, talked loudly, had fallen asleep during their observations and talked in languages other than English.

Patients on Willow, Cedar and Hadleigh wards were searched in the corridor (which is part of the air lock), which did not protect the patients' privacy and dignity.

On Kelvedon ward, managers told us it was possible to see a patient unclothed following a shower in their bedroom, on the contact-free patient monitoring screen. However, access to contact-free patient monitoring and management systems were not routinely used, only when an alarm sounded staff would review the monitoring screen and check the patient.

On Cedar ward we saw some patients dressed in nightclothes early in the afternoon. Staff told us this was because the patients had not been changed back into their clothes after "toileting accidents." We did not see any soiled clothes in the laundry area. The practice did not ensure patients dignity and respect.

Four patients on Peter Bruff ward told us it was not dignified to queue up at the office hatch for their vapes. Patients said there were a lack of privacy at the office hatch. We observed when a patient attempted to speak to staff at the office hatch there were a lack of privacy.

Acute wards for adults of working age and psychiatric intensive care units

Staff gave patients help, emotional support and advice when they needed it. On Ardleigh ward we saw staff caring for a patient immediately following a seizure. Staff showed kindness, care and compassion. On Galleywood ward staff supported a patient with sensitivity, compassion and kindness during a de-escalation incident. Staff stayed with the patient and continued to monitor the patient whilst offering emotional support.

Staff supported patients to understand and manage their own care treatment or condition. We observed this during patient incidents where individual staff provided patients with emotional support and in patients mutual help meetings notes.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. We saw welcome packs on Ardleigh and Kelvedon wards for patients which included a range of information, including therapy on wards with the occupational health team.

Most staff involved patients in multidisciplinary reviews and gave them access to their care planning and risk assessments. Patients were not routinely offered a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Patients could give feedback on the service and their treatment and staff supported them to do this. Some staff involved patients in decisions about the service, through mutual help meetings. These were regular meetings where patients met together to discuss service improvements. Mutual help meetings were intended to be mutually beneficial and chaired by either a patient or a staff member. However, we saw how the quality of these meetings varied from ward to ward. For example, on Galleywood ward patients chaired the meetings three times weekly. While on Ardleigh ward the mutual help meeting was opened by a staff member asking patients "What they were thankful for." Patients were expected to think of something they were thankful for and provide a response. Staff then asked "How can you help us (staff). If you can help us, we can help you." The session showed a power imbalance that did not support patients.

Staff made sure patients could access advocacy services. We saw information about advocacy in ward welcome packs and displayed around wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, carer and family feedback regarding the service was mixed and didn't support staff's views.

Acute wards for adults of working age and psychiatric intensive care units

At the November 2022 CQC visit, we spoke with three families and carers. Two carers reported a lack communication between the staff and their relative. Two carers said some staff were very caring, engaging and built positive relationships with their relative. They had observed occupational therapy staff carry out therapeutic activities with their relative. A third carer was unhappy with the service their relative received and raised concerns directly with staff on the ward.

Staff supported, informed and involved most families or carers. We saw welcome packs on Ardleigh and Kelvedon wards which included carers information and contact details for carers support organisations.

The trust had a Carers Charter that highlighted the importance of involving carers. Ward welcome packs included information about access to friends and relatives support groups.

Is the service responsive?

Requires Improvement 🟠 ➡️ ⬅️

Our rating of responsive stayed the same. We rated it as requires improvement.

At the previous 2019 inspection responsive was rated as requires improvement. We currently rate responsive as requires improvement.

Access and discharge

Staff managed beds well. A bed was not always available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

At the November 2022 CQC visit managers made sure bed occupancy did not go above 85%. We saw trust data from November 2021 to October 2022. Four wards were below bed occupancy of 85%, Christopher's psychiatric intensive care unit 62%, Willow ward 65%, Hadleigh psychiatric intensive care unit 76% and Galleywood 84%. Eight other wards ranged in occupancy levels between 94% Cherrydown ward to 102% Cedar ward. Chelmer and Stort wards had swing beds between female and male to support demand. Other wards had patients that had been transferred to acute hospitals for physical health needs, were on leave; or supported by home treatment teams or the community teams as part of their discharge plans.

Staff from the home treatment team confirmed waiting lists were exceptionally high for beds. On the 4 to 5 January 2023 CQC visit staff reported access to beds had not improved. Staff caseloads had reduced over the Christmas break due seasonal variations. However, patients were still experiencing unacceptable waits for services and patients were frequently not able to access available beds in a timely manner.

Staff in the home treatment team reviewed patients' caseloads daily with bed meetings, patient risk management and safety planning. Where patients needed urgent help, staff referred patients to accident and emergency services. In the home treatment team incident report log for the past 6 months of 74 patients were being supported in the community

Acute wards for adults of working age and psychiatric intensive care units

because staff could not access a bed when required. Of the 74 patients waiting for admission 22 had been assessed under the Mental Health Act as requiring detention and were having to be managed in the community. This meant that staff were managing very high-risk patients in the community. Staff would support the patients in the community with visits sometimes twice a day, day and evening phone calls, Shout (text messages|) and other interventions. Staff tried to keep patients local as possible, and occasionally placed out of county. Staff told us senior managers had not taken action to improve bed availability, despite the trust providing examples such as safer staffing calls and 'huddles' where bed occupancy was discussed. Staff on wards did not provide these examples.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. We saw trust data from November 2021 to October 2022. The wards with the highest length of stay were Hadleigh psychiatric intensive care unit with 14 to 463 days. The ward with the lowest length of stay were Grangewater ward between nine and 17 days.

The service had out-of-area placements. We saw trust data from November 2021 to October 2022. The out-of-area placements were mainly low across the service from December 2021 (4) to August 2022 (21). The out-of-area placements became higher in October 2022 at 35 and in November 2022 were 44.

The psychiatric intensive care unit always had a bed available if a patient needed more intensive care and this was not far away from the patient's family and friends. Ward managers on the acute wards liaised closely with the intensive care beds team.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. We saw trust data from November 2021 to October 2022. Cedar ward had five patient delayed discharges in November 2021, four February 2022, five in March and April 2022 and four in October 2022. Kelvedon ward followed with three patient delayed discharges in October 2022 only. All other wards showed nil to low patient delayed discharges. The trust worked with local authority partners towards the implementation of an accommodation pathway which would support patients transferring from an inpatient pathway and help to prevent avoidable admission with appropriate support.

Patients did not have to stay in hospital when they were well enough to leave. We saw across ward patients would be discharged once well, in consultation with the multidisciplinary team and their family and carers.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. On Willow ward we observed a discharge meeting with the: patient, their family members, discharge care coordinator and ward staff. The patient's needs were central to the discharge planning process.

Staff supported patients when they were referred or transferred between services. The ward team provided after care support with wellbeing phone calls.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

On the November 2022 CQC visit on Cedar ward the indoor area was sparse and lacked comfort. The outside area was littered with rubbish and looked unkempt. On Hadleigh psychiatric intensive care unit the environment was sparse and awaiting refurbishment. On Peter Bruff ward the environment looked worn and did not promote patient's recovery.

Each patient had their own bedroom, which they could personalise. However not all patients could access their bedrooms and had to ask staff. Fob keys were being introduced across most wards so patients could access their bedrooms independently. However, on Willow ward the fob key system was fitted 22 November 2023 but not operational at the time of inspection. We did not see individual patients risk assessments or the ward plans for the fob keys.

Patients had a secure place to store personal possessions. We saw additional storage areas that included lockers on all wards for patients' personal belongings.

Staff used a full range of rooms and equipment to support treatment and care. Ardleigh ward had a patient search room. The manager on Cedar ward had identified a patient search room and awaiting final changes to the room.

The service had quiet areas and a room where patients could meet with visitors in private. Each ward had access to a family/visitor's room.

Patients could make phone calls in private. Each ward had a payphone. Calls could be made on the ward phone by arrangement. The trust discouraged the use of mobile phones in the ward communal areas. Patient were not allowed to hold a mobile phone on some wards.

Not all wards had an outside space that patients could access easily. On Peter Bruff ward patients said they would like to go to the garden when they wanted to. Currently the garden is only accessible at set two-hour slots throughout the day. Since the last November 2022 visit access to outside space had improved; patients had access to the garden at any time. We reviewed this during the visit on 4 and 5 January 2023. Staff told us they thought that as the ward was an assessment ward the restrictions were necessary and was not restrictive practice despite this being raised as part of the letter of intent sent to the trust.

Not all wards had provision so that patients could make their own hot drinks and snacks and were dependent on staff. We saw across wards in communal areas biscuits and fresh fruit bowls.

The service offered a variety of good quality food. The service provided a variety of food to meet the dietary and cultural needs of individual patients; and where appropriate patients were encouraged and supported to shop for themselves.

On the 4 to 5 January 2023 CQC visit we spoke with four patients on Peter Bruff ward. One patient told us the meal portion sizes were not big enough. They were in their twenties and had noticed they were given the same portion size as another patient with a smaller appetite. There was no toast available for breakfast.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

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Staff helped patients to stay in contact with families and carers. We saw information booklets for patients' families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community, for example attending church services.

Meeting the needs of all people who use the service.

Not all staff met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards were on the ground and first floor and supported disabled patients. However, on Peter Bruff ward the assisted bathroom was used as a storeroom. We saw, where appropriate patients had personal fire evacuation plans in place.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were notice boards across wards with a wide range of patient information displayed.

Managers made sure staff and patients could get help from interpreters or signers when needed. However, on Cedar ward we saw one patient did not have access to an interpreter.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us a range of meals were available. Not all wards had provision so that patients could make their own hot drinks and snacks and were dependent on staff. We saw fruit and biscuits available on all wards.

Patients had access to spiritual, religious and cultural support. Notice boards across wards showed access to spiritual support.

Therapeutic timetables varied across wards. Activities included psychology led groups, occupational therapy led groups, healthy living exercises, access to gym one to one with a trained instructor, art and music therapy and visiting therapy dogs.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives, and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patient complaint information was displayed around wards.

Managers investigated complaints and identified themes. The trust provided complaints data without dates about complaints received by patients with themes. Across wards there were 78 complaints. The highest theme identified in complaints from patients were 18 complaints regarding patients unhappy with treatment, followed by poor care 11 complaints. Cherrydown had the most complaints (13), Hadleigh psychiatric intensive care unit eight and Kelvedon and Christopher's psychiatric intensive care unit seven complaints.

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There were 13 formal patients' complaints received and upheld across this core service. Cherrydown Galleywood wards and Hadleigh psychiatric intensive care unit had the most concerns for: poor patient care. This was followed by three complaints for: patients belongings on Cherrydown, Ardleigh and Hadleigh psychiatric intensive care unit.

The trust provided data for the last 12 months for this core service with one complaint referred to the Ombudsman, however the decision not to investigate. We found there were delays in managing these types of complaints.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw outcomes from complaints in team meeting notes, in the trust monthly lessons identified newsletters and on the staff intranet under the culture of learning icon on staff desktops and laptops.

Is the service well-led?

Inadequate 🔴 ⬇

Our rating of well-led went down. We rated it as inadequate.

At the previous 2019 inspection well-led was rated as requires improvement. We currently rated well-led as inadequate.

Leadership

Not all leaders had the skills, knowledge and experience to perform their roles. Some leaders had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

On the November 2022 CQC visit we saw a lack of leadership on two wards. Two managers did not have the knowledge about the service they delivered or capability to lead effectively. For example, despite CQC raising serious concerns around restrictive practices impacting on patients in a previous inspection, one manager was unaware about restrictive practice on their ward. CQC were not provided with assurance in some cases when asked during our inspections, with one manager being resistant during our discussions. However, we saw on Kelvedon the ward manager was knowledgeable about patient centred care and quality issues.

There were opportunities for leadership development and staff said that there was a leadership training course available. We saw evidence of promotion within teams.

Vision and strategy

Not all staff know and understood the provider's vision and values and strategic goals.

Not all staff felt consulted and committed to the trust's vison and values. One manager told us there had been a consultation in the summer 2022 to refresh the trust Visions and Values. They were: Respect and dignity, Commitment to quality care, Compassion, Improving lives, Working together for patients, Everyone counts.

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These had changed to; 'What we do together, We Care, we learn, We empower'. The providers old vision and values were on display in reception and waiting areas across locations but had not been updated since the summer review.

Culture

Not all staff felt respected, supported and valued. Some staff said the trust did not always promote equality and diversity in daily work. Staff were provided opportunities for development and career progression. They could raise any concerns without fear.

At the November 2022 CQC visit not all staff felt respected, supported and valued by senior managers. There appeared to be a good culture developed within teams and most staff had a good understanding of the service they provided.

Some staff were unhappy that leaders had not communicated with all staff regarding the airing of Channel 4 despatches documentary. Staff told us that they had found out about the documentary from patients on Hadleigh ward.

At the November 2022 CQC visit on Christopher's psychiatric intensive care unit, we saw staff experience repeated racist abuse by a patient. In contrast staff on Ardleigh ward told us any racist comments from patients were not tolerated and managers would take immediate action. On 4 to 5 January 2023 CQC visit staff on Willow, Cedar, and Peter Bluff said any reports of racial incidents would be discussed at handovers and escalated with ward managers. However, not all staff said they would fill out an incident form for incidents of racial abuse despite the trust issuing guidance stating this should be done.

Staff were provided opportunities for development and career progression. On Ardleigh ward a health care assistant told they were selected for the associate practitioner scheme supported by the trust to study to be a nurse and attended university one day a week.

Governance

Leaders had shown little evidence of learning from previous inspections or taken sufficient action to improve safety. The delivery of high-quality care was not assured. The arrangements for governance processes did not operate effectively and performance and risk were not dealt with appropriately.

We rated safe and well led as inadequate, the other domains as requires improvement which means this service is still adequate overall**.** The trust failed to ensure that all the concerns highlighted in the warning notice issued in October 2022 had been achieved consistently across all wards. For example, on some wards staff still applied blanket restrictions. Examples included searching all patients returning to wards and preventing patients from taking fresh air. There remained ongoing challenges with staffing wards consistently; and we identified problems with staff completing patient observations safely in line with trust policies. The rating for safe had remained inadequate, the same rating applied during the inspection in October 2022. CQC recognised trust wide plans to address the issues such as staffing however several aspects of these plans were not fully implemented embedded to impact care on all wards yet.

We found one breach identified at the October 2022 CQC inspection had been met at this inspection. The trust must ensure ligature cutters are consistently accessible for staff. At the November 2022 visit across all wards visited we saw ligature cutters were accessible to staff. Ligature cutters were held in large plastic packs in clinic rooms and in nurses' stations.

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However, leaders had not ensured all aspects of breaches from the 2019 and 2022 inspection had been met. Five out of six breaches had not been fully met. The trust had passed the identified date for completion of 18 November 2022, despite senior managers taking steps to address issues, some of the risks continued to impact patients.

Leaders had not fully met the five breaches as follows: The trust did not ensure staff carried out observations in accordance with trust policy to protect patients from harm. At this inspection patients on Willows, Galleywood and Ardleigh wards told us temporary staff slept when they should be observing them. The service had close circuit television monitoring across inpatient wards. Managers were not always able to access this footage in a timely way to make the necessary improvements. Staff were still falling asleep while carrying out therapeutic observations. Improvement plans had started with staff training programme and videos and increased managers presence on some shifts. Risks remained and practice was not embedded. This breach had not been fully met.

The trust did not ensure that there were enough regular staff working on the wards who were familiar with individual patients. At this inspection shifts covered by bank or agency staff were high. The trust had international recruitment to address some of the staffing gaps during. On 4 to 5 January 2023 CQC visit, staff on Willow, Cedar and Peter Bluff said there were some improvements with staffing levels and managers present. This breach had not been fully met.

The trust did not ensure that all aspects of care and treatment of patients was provided with the consent of the relevant person in respect of the contact-free patient monitoring and management system. We were told this system helped clinicians to plan care and intervene proactively by providing them with location, activity-based alerts, warnings and reports on risk factors. The provider must ensure patients are aware of the nature of the contact-free patient monitoring and management system, are given an explanation of the reasons for its use and how the information obtained will be stored and used, along with who has access to it. It should seriously consider any individual patient's objection to the technology and respond appropriately. On Willow and Galleywood Peter Bruff ward wards we did not find consent for contact-free patient monitoring and management systems. On Christopher psychiatric intensive care unit, one patient had declined the contact-free patient monitoring and management systems. It was difficult for staff to locate consent given within the patient's electronic records. This breach had not been met.

The trust did not ensure patients could easily access the garden, bedrooms, bathrooms and toilets. At this inspection on Willow, Cedar, Ardleigh wards there were restrictions where patients must ask staff to access the garden, bathrooms, beverages areas. The door to the Willow ward and Peter Bruff ward garden was locked and the managers was unwilling to accept this was a restriction. Most wards had a fob key system. On Willow ward staff told us the fob door key system had been fitted 22 November 2022 during the inspection but wasn't operational at the time of inspection. This breach had not been fully met. On 4 to 5 January 2023 CQC visit, staff on Willow ward had ensured patients access to the garden area with hourly staff rostered on to cover. On Peter Bruff ward the manager still refused to accept this was restrictive practice and the restrictions remained in place. On Willow, Cedar wards we saw improvements where patients could freely access beverages and snacks. This breach had not been fully met.

The trust did not ensure that all incidents were accurately recorded or reported. We found multiple examples of incidents that had not been reported around patient safety. For example, one patient had a hand injury and went to A&E not recorded as an incident. On another day a patient had become stuck in an air conditioning unit and released by the fire services with no injuries. These had not been recorded as incidents. This breach had not been met.

Management of risk, issues, and performance

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Staff did not manage patient safety incidents well; recognise incidents and reported them appropriately. Safety concerns were not consistently identified or addressed quickly enough. Managers did not always make changes and improvements in safety specific to this service. Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

We found risks and issues were not addressed across all domains. Ward areas on Hadleigh, Christopher's psychiatric intensive care units, Cedar, Ardleigh, Peter Bruff were not always clean, well maintained, and well-furnished. In addition, the seclusion room at Ardleigh ward required maintenance. Managers had not taken the necessary steps in a timely manner.

Staff vacancies were high on Willow ward and Galleywood ward for nursing and health care staff. Other wards had high staff vacancies Cherrydown, Peter Bruff and Christopher's psychiatric intensive care unit. Willows and Cedar wards had no psychology staff and no plans to recruit. Staff turnover rates were high at four wards. The service target was 12%. The highest turnover rates were Ardleigh at 25% followed by Cedar, Willow, Christopher psychiatric intensive care unit and Stort ward. Levels of staff sickness were high. Staff sickness absence across urgent and inpatients care were 11% which were higher that the service target of 5%.

Mandatory training compliance rates were less than 75% on some wards. The trust staff training compliance target rate were 85%. For example, Stort ward fire compliant 73% and Cherrydown 71%. Three wards had low safeguarding training compliance rates ranged from 43% to 83%. Mental Capacity Act training compliance rates were low on Peter Bruff 71% and Cherrydown ward 78%. Mental Health Act training were low on Peter Bruff 80% and Mental Capacity / Deprivation of Liberty & PREVENT 71%.

Staff did not assess, monitor or manage risks well to patients who use the services. Patients risk assessments were not all complete or updated regularly including after an incident. On Willow, Cedar, Hadleigh, Peter Bruff wards, patient safety concerns were not consistently identified and addressed. Staff did not always know about risks to each patient and acted to prevent or reduce risks. For example, we saw incidents of a staff member holding a female patient's hand as they escorted them to a health appointment. This showed staff did not understand about risk and professional boundaries. On the 4 to 5 January 2023 CQC visit staff on Willow, Cedar, Hadleigh, Peter Bruff professional boundary training were not aware of training.

On Willow, Galleywood, Peter Bruff, Christopher's psychiatric intensive care units' consent to the contact-free patient monitoring and management system were not embedded or robust.

Ardleigh ward was the only ward out of twelve wards visited with a patient search room. Staff said patients on Willow, Cedar and Hadleigh ward were searched in the corridor which is part of the air lock. The current arrangements did not support patient's treatment and care or privacy and dignity. We reviewed this during the 4 and 5 January visit and found that action had been taken to identify appropriate areas for patient searches.

Levels of restrictive practices were high on some wards. On Willow, Cedar, Ardleigh wards there were restrictions where patients must ask staff to access the garden, bedroom, bathrooms and beverages areas. However, we saw improvements for Willow, Cedar during the 4 to 5 January 2023 CQC visit. Prohibited items lists varied from ward to ward. We saw prohibited items on wards for example plastic bags, bars of soap and pens.

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Staff did not manage patient safety incidents well; recognise incidents and reported them appropriately. It was unclear if lessons learnt were learnt, and lessons implemented. We found multiple examples of incidents that had not been reported around patient safety, staff sleeping on duty. Managers were not accessing the closed-circuit television footage of safety incidents and taking actions to make improvements.

Staff did not manage systems and processes well; to safely prescribe, administer, record and store medicines. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Patients care plans were not all complete or reviewed regularly and did not always consider the full range of patient's needs. Most staff assessed the physical and mental health of all patients on admission. We saw on Cedar ward one patient did not have access to an interpreter. The patient's communication needs were not considered.

There were gaps in management and support arrangements for staff. For five wards Cedar, Kelvedon, Willow, Ardleigh, and Chelmer ward appraisals were low and ranged from 9% to 89% compliance rates. Ardleigh ward appraisals rates were lowest at 9% November 2021, increasing to 64% September. The trust clinical supervision and management supervision compliance target rate were 95%. Two wards were not compliant Ardleigh ward 72% and Chelmer ward 78%.

Patients were not always respected and valued as individuals. Five patients on Willow and Galleywood ward told us temporary staff had fallen asleep during their night observations. Staff at night were uncaring, talked loudly and talked in community languages. On Kelvedon ward managers told us it was possible to see a patient briefly in their bedroom unclothed following a shower on the vision-based patient monitoring screen. On Cedar ward we saw two patients in pyjamas around 2.30 in the afternoon. The practice did not ensure patients dignity and respect. On Ardleigh ward the patients mutual help meetings showed a power imbalance that did not support patients. On Peter Bruff one patient did not feel their privacy and dignity were upheld when queuing on the ward and speaking with staff at the office hatch.

Information management

Information presented to the CQC team was not always accurate and reliable. Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff used electronic patient record systems. Information governance systems included policy on confidentiality of patient records.

Managers had access to dashboards with information that supported them. However, some trust staffing, staff supervision and appraisal data showed inconsistencies and anomalies. For example, staffing vacancy data provided was not reliable; and staff supervision and appraisal data was unreliable and did not correspond.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff actively and openly engaged with patients; planned, manage services at regular mutual help meetings.

Learning, continuous improvement and innovation

Acute wards for adults of working age and psychiatric intensive care units

Staff on Christopher's ward were working towards accreditation for inpatients mental health services (AIMS- PICU) for psychiatric intensive care units. Staff and managers were due to attend a conference to make plans early 2023. Front line staff currently told us this improvement work was on hold until they had attended refresher training.

Wards for people with a learning disability or autism

Requires Improvement 🟠 ⬇

Is the service safe?

Requires Improvement 🟠 ⬇

Requires improvement Down one rating

Our rating of this service went down. We rated it as requires improvement.

Safe and clean care environments

The ward was safe, clean well-equipped, well-furnished, well-maintained and fit for purpose.

People were cared for in wards that were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the ward was decorated and furnished to a good standard. Furniture was sturdy and suitable for people who had behaviours that challenged. All areas were well maintained. Staff completed monthly environmental checks and we saw examples of these.

Safety of the ward layout

Staff completed and regularly updated thorough environmental risk assessments of all wards areas and removed or reduced any risks they identified.

People were cared for in wards where staff had completed risk assessments of the environment and removed or reduced any identified risks. Staff completed environmental risk assessments of all wards areas and reduced any risks they identified. Managers made sure that staff on the wards had easy access to ligature packs with information on environmental risks. This included a map of hotspot areas. Staff we spoke with knew about any potential ligature anchor points and knew where ligature cutters were located and felt confident in their abilities should they need to use these. Staff could describe mitigations taken to reduce risks to people's safety. We saw from staff team meeting minutes that ligature audits and their findings were shared and discussed.

Staff could not observe people in all parts of the wards. This risk was identified and recorded within the ligature risk assessment and mitigated by the use of convex mirrors and staff observations. At the time of inspection, 100% of eligible staff had completed suicide by ligature prevention training.

People had access to three secure gardens, providing a space for people to access fresh air. Potential blind spots within the gardens had been identified. This risk was reduced by supervising people when accessing the garden and use of CCTV in outside spaces. All three gardens had adequate seating. Staff told us people could request to use the outdoor spaces at any time.

Wards for people with a learning disability or autism

CCTV was installed in the seclusion, de-escalation and long-term segregation areas and outside spaces. Staff were encouraged to put on body worn cameras in the event of an incident. A named security nurse was allocated daily who was always required to wear a body worn camera during the shift. However, on the second day of inspection the allocated security nurse was observed not to be wearing a body worn camera. Staff told us this was because incidents were rare. This was not in line with Trust policy.

People who had been placed in seclusion, were able to communicate easily with staff. Staff ensured that if people were in seclusion, that they were kept in a clean and safe environment, and their basic needs were met, including access to a toilet, food, water and outside space. The seclusion room and de-escalation room both met the Mental Health Act Code of Practice standards. There had been no episodes of seclusion in the past 6 months.

People had access to nurse call systems and staff had access to personal alarms in case of an emergency. All bedrooms were en-suite and each room had an alarm call bell. Communal areas with windows had privacy glass fitted throughout providing privacy for people.

The ward complied with guidance on mixed-sex accommodation. There was a female only lounge. There were male and female only bedroom corridors. A third corridor had two bedrooms, which staff used to accommodate either gender, enabling greater flexibility for admissions. Bedrooms were single occupancy with en-suite shower rooms. All bedrooms were fitted with viewing and privacy panels, which could be closed from the inside to provide people with privacy.

Maintenance, cleanliness and infection control

The ward and clinic rooms were clean and well-maintained.

The service made sure that infection outbreaks could be effectively prevented or managed. Staff

used personal protective equipment (PPE) effectively and safely. At the time of inspection there

was a COVID-19 outbreak on the ward. We observed staff followed infection control policy, including handwashing and the use of PPE. Staff followed local and government guidance for COVID-19. We observed staff regularly changing masks and using hand sanitiser throughout the day. Masks and hand sanitiser were available at the entrance of the ward and hand wash and sanitiser were available in bathrooms and toilets.

We observed a monthly cleaning walk-around audit. Staff also undertook regular cleaning audits, hand hygiene audits and infection and prevention control audits. We saw examples of these that were complete and up to date. We observed the environment to be visibly clean and well maintained.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We viewed the most recent monthly clinic room checklist summary record and Byron court were 100% compliant.

Staff carried out regular checks on equipment to ensure it was fit for purpose and recorded this. Staff used stickers to indicate when equipment had been cleaned.

Wards for people with a learning disability or autism

We saw the ward had an electronic blood glucose monitor, pulse oximeter and defibrillator machine present in the clinic room. Staff had not kept calibration records for the blood glucose machines. This meant there was the potential risk of inaccurate blood sugar readings for people. We raised this with managers during the inspection who completed an incident form and took action that day to calibrate the machine.

We found the first aid kit had two empty packets of triangular bandages and one bandage that was not in any packaging. Staff were unsure if the first aid kit had been checked on a regular basis. This meant we were not assured that staff regularly checked and replaced the contents of the first aid box.

The ward had visibly clean clinic rooms. Staff kept cleaning records for all clinic rooms and equipment.

Safe staffing

Nursing staff

The service did not have enough regular nursing and support staff, who knew the person well.

We reviewed staffing rotas for the previous 6 weeks. The service had high rates of bank and agency staff and relied on temporary staff to fill shifts. Managers attempted to book regular bank and agency staff to fill shifts up to 3 months in advance.

We reviewed the staff rosters and found during the period 10 October 2022 to 6 November 2022, 17 different registered staff worked on the ward, out of which 7 staff members worked regularly. For the same time period 27 different support worker staff worked on the ward, of which five worked regularly. A high number of different staff meant that not all staff working on the ward knew the people well which could impact on the consistency of care people received.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health care assistants for each shift. The ward manager could adjust staffing levels according to people's needs. Managers regularly reviewed rotas to ensure safe staffing levels were maintained. Managers attended twice daily trust wide meetings to review staffing levels and to raise any staffing concerns. Managers worked shifts if needed for example if staff were sick at short notice.

The service had a high number of vacancies for qualified nursing staff and support worker. At the time of inspection, the service had a 50% vacancy rate for registered nurses (5.7 vacant posts out of 11.3) and a vacancy rate of 18% for support workers (2.4 vacant posts out of 13.0).

Between May and October 2022, the sickness rate ranged from 0% (June) to 14% (October). The service target was for sickness rates to fall below 5%. During the previous 6 months the actual sickness rate was above the target for 4 months.

Between May and October 2022, the turnover rate ranged from between 9% (July and August) to 14% (June and October). The service target for turnovers rates to fall below 12%. During the previous 6 months the actual sickness rate was above the target for 3 months.

Managers ensured there was enough staff for people to have one-to one time. However, managers did not always ensure there was enough staff, for people to take part in outdoor activities and visits how and when they wanted. Families and carers told us that they were able to visit the ward as often as they chose to and were not aware of any activities being

Wards for people with a learning disability or autism

cancelled. However, one carer told us about an occasion when a person's walk had been cancelled and there had been one complaint about a lack of transport for an appointment. Staff confirmed that there were rare occasions when leave had been postponed as there was not enough staff. Staff told us that there was always enough staff for one-to-one time with people on the ward.

Managers made sure all bank and agency staff had a full induction and understood people's needs before starting their shift. Managers made sure that staff were made aware of essential information such as emergency procedures and were given a tour of the ward and an induction checklist. Staff confirmed they had completed the checklist when starting work and we saw examples of this. Each person had a clear one-page profile "about me" with essential information so that new or temporary staff could see quickly how best to support them.

Staff shared key information to keep people safe when handing over their care to others. Staff followed a set template and discussed each patient's needs in detail for example, their current Mental Health Act status, presenting risks, and changes in needs. We saw examples of these.

Medical staff

The service had enough daytime and night-time medical cover, and a doctor was available to go to the ward quickly in an emergency. The service had 3 consultants, 2 specialty doctors and 2 junior doctors. Managers ensured that staff knew how to contact medical staff providing 24-hour cover to the ward. We saw a flow chart so that all staff on the ward could easily see who was on duty, at what time, who and how to contact medical staff in an emergency.

Mandatory training

Staff had completed and kept up to date with their mandatory training.

Staff employed by the trust had completed and kept up to date with their mandatory training. Compliance rates for individual mandatory training course ranged from 83% to 100%. Examples of mandatory training courses included consent; infection prevention and control; engagement and observation; physical health screening and clinical risk for both registered and unregistered staff.

The mandatory training programme did not include specialist learning disability and autism training. There was a risk that staff did may not have sufficient skills or experience to meet the needs of the people they were caring for.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Managers told us that a central team in the trust had responsibility for ensuring that agency staff deployed on the ward had the appropriate training for the role. All agencies under the approved NHS agencies framework had full responsibility for ensuring agency workers received and were up to date with the NHS mandatory training standards.

Assessing and managing risk to patients and staff

Staff discussed and managed patient risks but did not always record how they assess and manage risks to people well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support peoples' recovery.

Wards for people with a learning disability or autism

The service helped keep people safe through formal and informal sharing of information about risks. Staff discussed specific risks to each person at handover meetings, daily safety huddles, weekly clinical meetings and monthly multidisciplinary meetings. We viewed minutes for these meetings and found risks were discussed and clearly recorded in these forums. Multidisciplinary staff held discussions that determined the level of risk for each person and the level of observation needed. Staff we spoke with knew about any risks to each person and acted to prevent or reduce risks.

Staff completed risk assessments for each person on admission. However, these were not always regularly updated. We viewed 5 risk assessments, we found there were gaps in 2 of these. For example, one record had identified staff had carried out a security check, however the outcome of that check and the level of risk was not recorded. This was not in line with Trust policy. We saw in another record that the multidisciplinary team had discussed a risk relating to a person's travel. This risk was not was added to the risk assessment and the person did not have a risk management plan.

Despite trust guidance available for staff on levels of harm, staff we spoke with gave differing views about the level of risk incidents could present. We saw 1 record that had 5 incidents of assault towards others in one month and that was rated low risk. Staff we spoke to told us this was low risk as the assault could have been a minor tap on the arm, as assault to others could be interpreted in different ways.

There were policies and procedures for observation and supportive engagement of people. We viewed observation charts for all 5 patients and found all were completed in line with Trust policy. At the time of inspection 100% of eligible staff had completed mandatory engagement and supportive observation training. We saw examples of daily checklists and completed induction competency checklists managers used to ensure staff undertook observation and supportive engagement in line with Trust policy.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff could recognise signs when people experienced emotional distress and knew how to support them to minimise the need to restrict their freedom to keep them safe. Staff gave an example of a person becoming distressed and attempting to self-harm by head banging. They described the action they took to calm the person and de-escalate the situation to prevent the need of use of restraint.

People were restrained only where evidence demonstrated it was necessary and for the minimum period of time. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained people only when these failed and when necessary to keep the person or others safe. Staff understood the Mental Capacity Act definition of restraint and worked within it.

In the previous 6 months there had been 6 episodes of restraint. During this time there had been no episodes of prone restraints and no use of rapid tranquilisation. At the time of inspection, 100% of eligible staff had received trauma and self-injury (TASI) training.

There had been no episodes of seclusion or long-term segregation in the past 6 months.

Safeguarding

Wards for people with a learning disability or autism

Staff understood how to protect people from abuse and the service worked well with other agencies to do so.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Staff knew how to make a safeguarding referral and who to inform if they had concerns. At the time of inspection, 100% of eligible staff were up to date with safeguarding levels adults and children levels 1 and 2; 100% of staff were up to date with safeguarding children level 3 and 83% of staff were up to date with safeguarding adults level 3 training.

We viewed the services' safeguarding log. In the past 6 months one safeguarding concern had been reported. This related to concerns regarding financial abuse. The concern had been properly reported and managed by the Trust safeguarding team.

The ward manager was the lead for safeguarding and worked with the Trust safeguarding team who had responsibility for overseeing the safeguarding process.

Managers took part in serious case reviews and learnt lessons. For example, during our inspection, staff had attended a review meeting (further to a serious case review) at an independent mental health provider, for adults with learning disabilities and/or autism.

Staff discussed and learnt from safeguarding concerns. We saw that safeguarding was a standard agenda item at staff team meetings.

Staff access to essential information.

Staff had access to essential information. However, it was not always easy for them to maintain high quality clinical and care records. Records were a mixture of paper-based or electronic. For example, positive behaviour support plans and 'ABC' charts were paper-based and kept in a folder. The electronic system was cumbersome, and the risk assessments were lengthy. This meant that it was not always easy for staff to find information quickly. Paper-based records were kept securely.

Not all agency staff had access to electronic systems. This meant that permanent qualified staff were required to complete some records. This added to their workloads and meant that records were not always updated in a timely manner.

Medicines management

The service used systems and processes to safely prescribe, administer and store medicines. Staff regularly reviewed the effects of medicines on each person's mental and physical health. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, medicine records were not always fully completed in line with Trust policy.

The ward safely stored and stocked emergency medicines. Review of stock medicines showed that medicines held on the premises were within the expiry date. The trust pharmacist supported staff to ensure that medicines were stored securely and audited.

Medicines requiring refrigeration were monitored and temperatures recorded were within range.

Wards for people with a learning disability or autism

We reviewed 5 medicine charts. Staff had not always recorded administration of medication. We found that one administration chart where one administration had not been signed off by staff. It was unclear from the records if this had been administered or omitted. We raised this with managers during the inspection who completed an incident form.

Of the 5 medicine charts we viewed 1 chart had a consent to treatment form. We raised this with staff during the inspection. Staff told us that there needed to be a change in the filing system, to ensure that consent to treatment forms were kept with medicine administration charts. All 5 medicine administration charts did not have the location of consent to treatment forms prompt completed.

Medicine administration charts had names and patient number on the front page however, they did not always have names and patient identifying number on all pages. This meant if the pages got separated it would be difficult to identify who they belonged to.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured that people's medicines were reviewed by prescribers in line with these principles. Staff knew about and worked towards achieving the aims of STOMP. We saw posters on display in staff areas.

Track record on safety

There were no serious incidents reported in the last 6 months for this service.

Reporting on incidents and learning from when things go wrong

Staff learned from safety alerts and incidents. Managers showed us examples of safety alerts both internal and external to the Trust. These could be accessed on the Trust intranet site. We saw paper copies of internal safety alerts were made available for staff to read in handover areas. For example, we saw a safety alert about staff sleeping on duty.

Staff raised concerns and recognised incidents. They reported them appropriately and managers investigated incidents and shared lessons learned. Staff knew what situations required reporting as an incident. The trust used electronic recording systems to record incidents and staff knew how to use the system. We reviewed the service incident report log. Since May 2022 there had been 85 reported incidents. There had been no reports of severe harm. The service had no never events.

Lessons were shared with staff. We reviewed staff team meeting minutes and saw evidence that learning from incidents, safety alerts and staff huddles were discussed and shared. A recent example included Mental Health Act section papers and a reminder to all staff to upload and send papers to Mental Health Act administrators. We saw example of a trust newsletter with five key messages. An example of recent learning was that all ligature cutters were to be stored in one bag. Staff told us there was an open forum with senior staff to talk about lessons from incidents.

When things went wrong, staff apologised and gave people honest information and suitable support. Managers understood the duty of candour.

Managers were aware of the Learning from Deaths Mortality Review (LeDeR) Programme.

Wards for people with a learning disability or autism

Is the service effective?

Requires Improvement 🟠 ⬇

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff undertook functional assessments when assessing people's needs. They worked with people and with families and families and carers to develop individual care and support plans. Care plans reflected the assessed needs, were personalised and comprehensive. However, it was not clear from records when positive behaviour plans were reviewed or if care plans had been shared with people and their families and carers.

Staff completed a comprehensive assessment of each person's physical and mental health either on admission or soon after. Care records showed that a physical examination had been undertaken at admission and there was ongoing monitoring of physical health problems. Staff ensured specific care plans were available for people with diabetes around diabetes management and weight and constipation for a person who had high levels of psychotic medication as well as uncontrolled diabetes. This was monitored on a water low chart which measured weight gain as well as constipation weekly. However, at the time of inspection there was no physical health nursing lead in post. Managers told us this post was in the process of being filled and there were staff checks underway for those offered this post.

People had care and support plans that were personalised, holistic, strengths-based and reflected

their needs and aspirations, including physical and mental health needs. People, those important

to them and staff reviewed plans regularly together. We viewed 4 care plans, these had

comprehensive plans for physical, mental and sensory information personalised to the individual.

Records showed that staff assessed people's communication skills and needs and provided information in a way that was tailored to these needs. For example, the speech and language therapist devised a holistic care plan to meet the needs of a non-verbal person. However, in three records staff had not completed the box to show that the care plan had been shared with people in easy read format. This meant we weren't assured people had been given a copy of their care plan. We saw one care record showed the care plan had been read to the person.

We saw 'about me' books provided comprehensive valuable person-centred information.

Staff assessed and managed challenging behaviour for people. We viewed three positive behavioural support plans, these were comprehensive. The positive behaviour plans included strategies around behaviour which was linked to therapies intervention as well as the care records around agitated behaviour and sensory strategies. Staff told us this was because the lead for positive behaviour support had recently left the service and the psychology team were taking the lead whilst a new nurse lead was identified. However, people, their families and the multidisciplinary team met on a monthly basis to review and discuss care plans and positive behaviour plans.

Best practice in treatment and care

Wards for people with a learning disability or autism

Staff supported people with their physical health and encouraged them to live healthier lives. This included access to psychological therapies, support for self-care and the development of everyday living skills.

Staff offered patients psychological therapies which they delivered in line with National Institute for Health and Care Excellence guidance. Patients received regular one to one sessions with members of the multidisciplinary team, such as psychologists, occupational therapists or speech and language therapists.

Staff prepared positive behaviour support plans to help plan their support of people with behaviour that was challenging or harmful. Staff told us that the lead for positive behaviour support had recently left the service and the psychologist team were taking the lead whilst a new nurse lead was identified. Staff also told us that there was a positive behaviour support lead in the learning disabilities community team that could be accessed. Staff prepared (antecedents, behaviour, consequences (ABC)charts for people however, we found one person did not have an ABC chart. Managers told us this had been missed.

Staff made sure people had access to physical health care, including specialists as required.

Staff provided access to physical healthcare when necessary and staff facilitated transfer of people to physical healthcare appointments. However, staff did not always record vital signs on the National Early Warning Scores (NEWS) charts. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients. Two of five charts did not always have a score on some dates. NEWS scores determine whether further action is needed. This meant that staff might not identify a deteriorating person and take prompt action to address their needs. The deputy ward manager told us NEWS training had been scheduled for all staff.

Staff developed easy read information for people such as, 'my choices for food and activities' and management of conditions such as diabetes. Staff used a document 'all about me', which detailed the best way staff, should communicate with people.

Staff met peoples' dietary needs and assessed those that may need specialist care for nutrition and hydration.

Skilled staff to deliver care

The ward team included or had access to the full range of specialist roles required to meet the needs of people on the ward. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff. However, managers did not ensure staff had access to specialist learning disabilities and autism training to provide high quality care.

The ward had access to the full range of disciplines to support people's care; including occupational therapists, psychologists, social worker, nurses and support staff and medical staff.

People were not always supported by staff who had received relevant and good quality training

including training in the wide range of strengths and impairments people with a learning disability and or autistic people may have or positive behaviour support. Not all nursing and support staff were trained to work with patients with a learning disability and/or autism. The service employed 6 permanent qualified nursing staff of which 4 were specifically trained in learning disabilities (RNLD). However, the Trust did not offer any specialist training including learning disabilities, autism and sensory awareness to other staff working in the service. Managers told us the psychology team had previously delivered training as part of the induction programme however, this was paused during

Wards for people with a learning disability or autism

the COVID-19 pandemic and had not re-started. Managers told us that training needs were identified through staff appraisal and supervision. However, we did not find any examples of staff accessing specialist training. Staff we spoke with told us they would welcome additional training. Psychologists told us they had offered training on positive behaviour support to the nursing team. However, managers were unable to release staff other than for one to one sessions due to staff shortages. Managers told us there used to be an 11-day learning disabilities course that most staff had previously undertaken, however this was no longer available. This meant we were concerned that not all staff had received the necessary up to date training or had the skills to fully meet people's needs.

At the time of inspection 22% of eligible permanent staff and 3 bank staff had received Makaton training. Mangers told us planned training was due to take place in February 2023.

Staff received support in the form of regular, constructive supervision of their work, appraisal and

induction training. At the time of inspection 86% of staff had received supervision and 82% had an annual appraisal. Managers ensured that new staff received the trust induction programme and a ward induction. We saw examples of induction training checklists that included essential information such as fire safety, emergency equipment and observation and supportive engagement protocols.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit people. They supported each other to make sure people had no gaps in their care. Multidisciplinary team professionals were involved in and made aware of support plans to improve care.

Staff held regular meetings to discuss people and improve their care. The multidisciplinary team included nursing staff, medical staff, physiotherapists, occupational therapists, speech and language therapists and social workers.

Staff shared clear information about people and any changes in their care, including during multidisciplinary team meetings and handover meetings. We reviewed weekly multidisciplinary team minutes (ward round), staff handover notes and monthly patient forum meetings and monthly commissioner's reports. We saw that staff regularly discussed people's care and support plans and shared clear, essential information about people.

The ward team had effective working relationships with staff from services that would provide aftercare following people's discharge and engaged with them early on in people's admission to plan discharge. The ward worked very closely with the community teams which were located opposite the ward. Staff told us there was good communication between the ward and community team when discharging people back into community placements and when accepting referrals.

We saw that people had health hospital passports that enabled health and social care services to support them in the way they needed.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain peoples' rights to them.

Staff understood their roles and responsibilities and were able to explain people's rights to them.

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Staff received and kept up to date with training on the Mental Health Act. At the time of inspection,

100% of eligible staff had undertaken training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support

Staff explained to each person their rights under the Mental Health Act in a way that they could understand. Staff told us how they adapted the information about rights to the needs of the individual to help them understand and we saw examples of easy read information.

People had easy access to information about independent mental health advocacy.

Staff made sure people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician, the Ministry of Justice or both.

Managers and staff made sure the service applied the Mental Health Act correctly by completing

audits and discussing the findings. Managers completed a monthly Mental Health Act audit. The

most recent audit showed the service was 94% compliant. However, the audit identified that consent to share information, people's capacity and T2/T3 forms had not always been completed.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005.

Staff received and kept up to date with training in the Mental Capacity Act. Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection 100% of eligible staff had received mental capacity act and Deprivation of Liberty Safeguards training.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave people all possible support to make specific decisions for themselves before deciding a person did not have the capacity to do so.

Is the service caring?

Good 🟢 ➡️ ⬅️

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Wards for people with a learning disability or autism

Staff treated people with compassion and kindness. They respected people's privacy and dignity. They understood people's individual needs of and supported them to understand and manage their care, treatment or condition.

People received kind and compassionate care from staff who used positive, respectful language at a level people understood and responded well to. There were easy read information leaflets that people were given on admission to the ward, and staff ensured that people were orientated to the ward environment. There were visual aids throughout the ward and Makaton signs throughout the ward that explained to people the purpose of the room or described various activities.

Staff were patient and used appropriate styles of interaction with people. They were calm, focused, and attentive to people's emotional and other support needs and sensory sensitivities.

Staff were discreet, respectful, and responsive when caring for people. Staff gave people help, emotional support and advice when they needed it. Staff supported people to understand and manage their own care treatment or condition. They did this in a way the person could understand and took time to prepare how best they could communicate with them. People and families and carers said staff treated them well and behaved kindly.

Staff showed warmth and respect when interacting with people. We observed staff treating people with kindness dignity and respect.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards people. One member of staff gave an example of a concern that they had raised, which had been quickly responded to by managers.

Involvement in care

Staff involved people in making decisions and planning their care and sought their feedback on the quality of care provided.

We viewed patient forum minutes and multidisciplinary team minutes which demonstrated that people had been involved in their care plans. Families and carers said they were invited to attend weekly and monthly multidisciplinary meetings. Families and carers also told us they felt involved in care planning.

People were listened to, given time and supported by staff to express their views using their preferred method of communication. Staff always took steps to make sure that people were supported to communicate their individual needs and preferences. People gave feedback on the service at monthly 'patient forum' meetings and daily morning meetings. We observed a morning meeting, where people were encouraged to give their views and make choices about daily activities, individual time with staff and menus. We viewed notes from the monthly patient forum meetings and saw examples of people voting for 'staff of the month', choosing food and activities. We also saw examples of feedback via, 'you said, we did'. One example was that people had complained about internal doors loudly banging shut. As a result, new internal doors were ordered and fitted.

Staff made sure people understood their care and treatment (and found ways to communicate with people who had communication needs). For example, each person received a meeting with family and medical staff and professionals

Wards for people with a learning disability or autism

once a month. Care and treatment and positive behaviour support plans were discussed verbally. We saw evidence that Speech and language therapists were involved in supporting the person with communication in advance of the meeting. This was beneficial as some subject areas might be difficult and the team recognised that people would need support to share their views.

Staff supported people to maintain links with those important to them. We spoke with families and carers who all told us that they could regularly visit with people and support them whilst they take community leave. Families and carers where able to visit the ward and attend weekly and monthly clinical and multidisciplinary meetings.

Staff informed and involved families and families and carers appropriately. Families and carers felt involved and informed about the care of the person using the service. Families and carers told us they were involved in reviews and discharge planning.

Staff helped families to give feedback on the service. Families and carers said they would feel comfortable to raise a concern but had no need to do so. We saw examples of written compliments received from families and carers.

Staff ensured that people had easy access to independent advocates. Staff ensured people had easy access to information about independent advocacy and posters were displayed in the ward.

Is the service responsive?

Good 🟢 ➡️ ⬅️

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed discharge well. They liaised well with services that would provide aftercare. Discharge was rarely delayed for other than a clinical reason.

Managers monitored average length of stay. Between June 2022 to October 2022 the average length of stay ranged from 69 days to 505 days. During this time the service reported there had been one delayed discharge. Managers told us this was because of a lack of appropriate provision of housing within the community. The service was working closely with the community team to address this issue.

There were no out of area placements in the service. The service only admitted people from the local area. Bed occupancy was at 100% across the service. Byron ward had capacity for 7 people, on the day of inspection there were 5 people on the ward.

When people went on leave there was always a bed available when they returned.

Staff carefully planned people's discharge and worked with other professionals to make sure this went well. The ward worked closely with the community learning disability team. Managers provided commissioners with weekly reports and updates on people including plans for discharge. Discharge plans were also discussed at weekly reviews. Families and carers told us they were involved in discharge planning.

Wards for people with a learning disability or autism

The service worked closely with the community team for learning disability and autism who provided community support as an alternative to hospital admission and supported people on leave from the ward.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported people's treatment, privacy and dignity.

Each person had their own bedroom, which they could personalise, with an en-suite bathroom. They were able to keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and was based on the person's likes and dislikes and dietary needs. People could make hot drinks and snacks at any time, with supervision. Managers told us that due to risks, staff assisted people with preparing refreshments. Light snacks such as fresh fruits and hot and cold drinks were available throughout the day and night. During our visit, we observed staff assisting people to access refreshments.

People's care and support was provided in a safe, clean, well equipped, well-furnished and well-maintained environment that met people's sensory and physical needs. The service had two sensory rooms. We viewed both the internal and external sensory rooms which were both well equipped. The external sensory room had a sensory swing.

The ward had a range of rooms to support treatment and care such as an activity room, female only lounge and an activities kitchen. The service had quiet areas and a room where people could meet visitors in private. Families and carers told us they were able to meet with people in quiet, clean, accessible rooms.

People had access to outside space and gardens that people could access easily, this included a ramp so that wheelchair users could easily access the garden. People could access the garden with supervision. Staff told us there were always staff available to support people to access the garden. We observed one person requesting to play football in the garden and staff playing with them.

Patients' engagement with the wider community

Staff supported people with family relationships, community and leisure activities outside the service.

Managers told us that the COVID-19 pandemic had been challenging and had adversely affected some links within the community. Staff were working on re-establishing these links.

Staff gave examples of community activities which included going to the nearby football ground, visiting shops and cafes, walks to the park and cycling. Relatives told us they regularly kept in touch and could visit with their person.

Meeting the needs of all people who use the service

The service met the needs of all people. Staff helped people with their communication needs and spent time with people to understand their individual needs.

People learned everyday living skills, understood the importance of personal care and developed new interests. People could access a range of activities. For example, life skills, mindfulness, self-esteem, cooking and relaxation groups. The activity room contained a variety of resources such as adult colouring books and a world map which was used to illustrate different countries and cultures. Each person had an individualised activity box which contained activities chosen by the person. These were available at any time.

Wards for people with a learning disability or autism

Staff ensured there was a range of choice in activities offered and personalised choice boxes were provided. Staff delivered planned sessions within the ward in a dedicated room with a range of activities as well as outdoor physical activities, sensory rooms. People could access community activities which were arranged as and when appropriate such as cycling and accessing shops and the community. People were supported to develop skills around laundry and preparing and cooking meals.

Psychology staff provided sessions on wards and speech and language therapy staff provided a journal session with an autistic focus around feelings and interaction.

We viewed the service's two sensory rooms which offered a quiet space for alternative therapies such as massage, aromatherapy and pamper sessions.

Staff identified people's preferences and staff were available to support people. Staff offered choices tailored to individual people using a communication method appropriate to that person. We spoke with one person who was using the service. They told us they enjoyed the food and showed us some visual meal choices they were making. They explained that their activity timetable was reviewed with the occupational therapist weekly and that they enjoyed mindfulness, walking, sports, cycling and colouring. We observed them playing football with a member of staff. We observed two people doing arts and crafts with staff.

The service met the needs of all people using the service, including those with needs related to their protected characteristics. There were suitable adjustments for people requiring disabled access including an assisted bathroom and bedroom and accessible ramps to outside spaces. We saw a compliment from a carer, they commented "it had been the best care they had ever had".

Staff ensured people had access to information in appropriate formats. People had individual communication plans/passports that detailed effective and preferred methods of communication, including the approach to use for different situations. For example, occupational therapists provided people with visual guidance for outdoor activities and to support transition into the community.

Staff had good awareness, skills and understanding of people's individual communication needs. They knew how to facilitate communication and when people were trying to tell them something. Staff were able to engage and support people with their communication needs by using Makaton and visuals.

Staff were trained and skilled in using personalised communication systems. At the time of inspection 22% of permanent staff and 3 bank staff were trained in the use of Makaton.

Managers made sure staff and people could get help from interpreters or signers when needed. Information was available in other languages for people for whom English was not their first language. Staff could access this and print leaflets from the Internet. Information was also available in easy read format and we saw examples of this such as information about treatments, people's rights and how to complain.

The service provided a variety of food to meet people's dietary and cultural needs. There was a designated chef on the ward. People had a choice of food to meet their dietary requirements and could make individual requests. People were supported to prepare their own meals if they chose. We observed people preparing pizzas for lunch with the occupational therapy assistant. Staff told us that people could request meal choices and we saw visual aids for people

Wards for people with a learning disability or autism

to choose their food. Staff told us people were encouraged to choose healthy-eating options, vegetables grown in the garden were used in menus. We saw the use of pictorial aids of different world foods as part of a weekly cultural menu. Each person had an individualised snack box with items chosen by them. People had access to drinks when they wanted. People accessed outside areas when they wanted.

People could access spiritual, religious and cultural support in the community if, and when they chose to.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

People and those important to them could raise concerns and complaints easily, and staff supported them to do so. Families and carers told us they knew how to raise a concern and make a complaint, should they need to.

Staff were committed to supporting people to provide feedback so they could ensure the service worked well for them. People were encouraged to give feedback on the service at daily morning meetings and monthly patient forum meetings.

Staff knew how to acknowledge complaints, and people received feedback from managers after the investigation into their complaint. We viewed the service complaints log. In the past 6 months there had been 1 formal complaint made by an advocate on behalf of a person. This complaint was undergoing investigation.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. Managers shared feedback from complaints with staff, and learning was used to improve the service. The service was open about investigating complaints and concerns. For example, one staff member gave an example of person's feedback regarding a staff member using their mobile phone whilst on escorted leave. The staff member described how the person had raised the concern, and how the concern was quickly dealt with by managers to the satisfaction of the person, and lessons were learnt.

Is the service well-led?

Requires Improvement 🟠 ⬇

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a clear understanding of people's needs. Management and staff put people's needs and wishes at the heart of everything they did.

Staff said leaders were good and supported them in their day to day work. We observed managers were visible in the service and knew the needs of the service and the people using the service in their care.

Vision and strategy

Wards for people with a learning disability or autism

Staff knew and understood the provider's vision and values and how to apply them in the work of their team.

Managers had a clear vision for the direction of the service that demonstrated ambition and a desire for people to achieve the best outcomes possible.

The vision for the service is that all people with a learning disability in Essex (with or without Autism) are able to:

Enjoy good health and wellbeing

Experience the best quality of life

Be fully included and feel valued members of the community

Lead independent lives and do as much as they are able to

Make their own choices.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

Staff felt able to raise concerns with managers without fear of what might happen as a result.

Staff were passionate about their work and committed to delivering a good service for people. They told us that the morale was generally good. However, staff said they had felt frustrated at times due to low staffing levels.

Staff said there was good team working and they felt supported by their manager. They said they knew how to use the whistle-blowing process and raise concerns without fear of victimisation. Managers said they have an 'open door' for staff to approach them with any concerns. Staff shared an example of a concern they had raised with managers following overhearing a member of staff using discriminatory language whilst watching television with a person using the services. Staff told us managers took immediate action and the staff member was required to undertake equality and diversity training.

Governance

Our findings from the other key questions demonstrated that whilst governance systems and processes where in place they were not fully embedded at team level.

The service had governance systems and processes in place. The manager had oversight of a wide range of monthly audit data that included for example, the environment, Mental Health Act, Mental Capacity Act, care plans, medicines management, infection prevention and control amongst other aspects of the care and treatment given to people. We saw findings from audits were shared in staff meetings and actions set to ensure outcomes were met and improvements made where needed. However, whilst audits and analysed data had identified the concerns addressed in this report, the required actions had not always been taken to fully address these concerns. For example, we found gaps in record keeping during the inspection in risk assessments, care plans, consent to treatment forms and administration of medicines.

Wards for people with a learning disability or autism

The ward manager ensured that systems were in place to gauge and monitor the performance of the team. The manager used key performance indicators to ensure that there were enough staff to support people safely and that staff received regular training, supervision and appraisals and feedback about their performance. Managers knew when staff required refresher training and knew the reasons for any delays.

The service had high vacancies, sickness and turnover rates. Managers told us recruitment of permanent qualified nursing staff was a challenge and recruitment processes were in place for a number of vacant posts. Due to the low number of permanent staff managers relied heavily on bank and agency staff.

Management of risk, issues and performance

Managers had oversight of performance and risk.

The service had a risk register. The register described the issue, rated the risk and detailed mitigations put in place. Staff were able to add items onto the risk register if needed. Managers were aware of what the risk to their service were and how they took action to reduce these.

Managers attended quarterly quality, performance and risk management group meetings for Essex Learning Disability Partnership. We reviewed minutes and found topics discussed included essential information such as, service user safety, workforce, clinical supervision, sickness rates, vacancies, incident reporting, restrictive practices, complaints, service engagement, risk assessments, audits and safeguarding.

Information management

Staff had access to the equipment and information technology needed to do their work.

Managers have access to a range of information to support them with their management role. This includes information on the performance of the service, staffing and people's care.

Engagement

The provider sought feedback from people and those important to them and used the feedback to develop the service.

The service used comments and compliments to improve the service. The service's principles had been co-produced with people who use services which have influenced the service. The principles expressed what good quality integrated care looks like from the person's perspective, in their words, and were a constant thread running through the service's model.

Managers engaged with other local health and social care providers and participated in the work of the local transforming care partnership.

Substance misuse services

Good ● ⬆

Is the service safe?

Good ● ⬆

Our rating of safe improved. We rated it as good.

Safe and clean environment

All premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. The premises used by the service were owned by a partner agency. The trust had completed risk assessments of the areas they used and ensured that any risks were mitigated.

All interview rooms had alarms and staff available to respond. All staff used an electronic safety device to call for assistance if required.

All clinic rooms had the necessary equipment for clients to have thorough physical examinations and staff regularly checked and calibrated equipment.

All areas were clean, well maintained, well-furnished and fit for purpose. Staff used clean stickers on equipment to evidence when it had been last cleaned.

Staff followed infection control guidelines, including handwashing and wearing personal protective equipment. Each team had an infection prevention and control lead.

Safe staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. The number of clients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each client the time they needed.

Nursing staff

The service had enough nursing and support staff to keep clients safe. Staff had manageable caseloads that allowed them enough time to spend with clients on a regular basis.

The service had low vacancy rates with four vacancies across the four services, with two of these covered by long term bank nurses and one covered by an agency nurse.

Substance misuse services

Managers made arrangements to cover staff sickness and absence. Managers could use bank or long-term agency nurses if required to cover absences and these were regular staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We spoke with an agency nurse who told us they had a thorough induction to the service including informal training.

Medical staff

The service had enough medical staff. The service had two consultant psychiatrists in post to cover the four teams. The service was nurse led and the consultants co-worked with nurses with complex case clients.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. The consultant psychiatrists covered two teams each and were available to provide advice and training to nurses when needed.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training and overall training compliance was 92%.

The mandatory training programme was comprehensive and met the needs of clients and staff. The programme comprised of nine mandatory sessions and 23 essential sessions, and these included infection prevention and control, immediate life support, medicines management, safeguarding adults and children, and anaphylaxis.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a weekly email update of training compliance.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

Assessment of client risk

Staff completed risk assessments for each client entering treatment, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 20 client records and saw they all had comprehensive risk assessments which included physical and mental health, medication home storage and forensic history. Staff liaised with client's GPs to ensure they had all the required information prior to starting treatment.

Management of client risk

Staff responded promptly to any sudden deterioration in a client's health. Staff completed prescribing reviews every 12 weeks to monitor client's health or more frequently if needed.

Substance misuse services

Teams held a meeting each morning with their partner agency and discussed any clients who had not attended their appointment or had not collected their prescription from the pharmacy to review their risk. The service liaised with pharmacies when clients did not collect their prescription medicines after 3 occasions and halted their prescription until they had been reviewed in person. .

Staff provided naloxone to clients with a history of opiate use, which is used to temporarily reverse the effects of an opiate overdose. Staff also provided harm reduction information including blood borne virus and safer sex advice as well as tolerance and overdose advice. Staff provided safe storage boxes for clients to store any medicine at home out of reach of children.

Staff followed clear personal safety protocols, including for lone working. All staff used an electronic safety alarm device to call for assistance if required. Staff attended home visits with a staff member from a partnership service so were not alone on home visits.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. All staff were up to date with level 1 safeguarding training, with 92% having completed level 3 safeguarding children and 96% having completed level 3 safeguarding adults training.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them**.** Staff we spoke with could all give examples of safeguarding referrals that they had made.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a safeguarding lead allocated to substance misuse and each team had a local safeguarding lead to advise on any concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Client notes were comprehensive, and all staff could access them easily. The service used a different electronic record system to the rest of the trust that was more suitable for the service type. Staff could also access the system used by GP surgeries to enable closer joint working.

When clients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff had individual log ins for client records to access the system.

Substance misuse services

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 40 medicine prescription charts and saw that staff had prescribed and administered medicines safely and within guidance.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Staff completed 12-week medicine reviews with clients in line with national guidance.

Staff completed medicines records accurately and kept them up to date. We reviewed 40 medicines records and saw that they were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely. We found a supply of rectal diazepam at the Harlow service which had been delivered in error by the trust pharmacy and had not been disposed of according to trust policy. However, this was a one-off error and all other medicines were stored and disposed of correctly.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff completed prescribing reviews every 12 weeks for clients to ensure that medicine levels were appropriate and safe.

Staff reviewed the effects of each client's medicines on their physical health according to National Institute for Health and Care Excellence guidance. Staff completed physical health checks including electrocardiogram tests for clients receiving high doses of methadone.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff knew what incidents to report and how to report them. The trust used an electronic incident reporting system and staff we spoke with knew what to report.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had reported 95 incidents in the six months before inspection with the highest number at 22 for medication errors. These incidents caused no or low harm to service users in all cases and represented a very small number in relation to the number of prescriptions issued. The trust had recorded 13 unexpected deaths in the six months prior to inspection. This is a low number of deaths in comparison to substance misuse services nationally.

Substance misuse services

Staff reported serious incidents clearly and in line with the service's policy. The service did not report any serious incidents in the six months before inspection. The service did not routinely report client deaths as serious incidents but did review all deaths in a monthly mortality review meeting. Learning from these meetings were distributed to all staff as a 'key learning' bulletin.

The service had no never events.

Staff met to discuss the feedback and look at improvements to client care. Staff discussed incidents and any lessons learned in the multi-agency clinical and team business meetings.

Is the service effective?

Good 🟢 ➡️⬅️

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each client at the initial clinical assessment.

Staff made sure that clients had a full physical health assessment and knew about any physical health problems. We reviewed 20 client records and saw that staff completed a full physical health assessment at the initial clinical assessment.

Staff developed a prescribing plan for each client that fed into the recovery care plan completed by staff from a partnership agency.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). We reviewed 40 medicines records and saw that staff followed clinical guidelines in prescribing and dose optimisation for opiate detoxification. Treatment was collaborative with clients and partner agencies to agree length of detoxification and maintenance.

Staff prescribed pabrinex to assist in alcohol detoxification and the Chelmsford service were able to prescribe buprenorphine injections as a long-lasting opiate substitution.

Substance misuse services

Staff made sure clients had support for their physical health needs, either from their GP or community services. We reviewed 20 client records and saw that staff updated GP's with outcomes of physical health reviews, including outcomes of electrocardiogram tests, blood pressure and blood tests. We saw examples of where electrocardiogram results were abnormal, and staff referred clients to their GP for further investigation. The electrocardiogram was then repeated regularly after.

Staff supported clients to live healthier lives by supporting them to take part in programmes or giving advice. The service offered testing for blood borne viruses and hepatitis B vaccinations, with 90% of opiate using clients having been fully vaccinated.

Staff did not regularly take part in clinical audits, benchmarking and quality improvement initiatives. The service had conducted an audit of Naloxone provision. Staff had completed two controlled drugs audits at Chelmsford in the six months before inspection but no other audits or quality improvement initiatives.

Managers used results from an audit when they took place to make improvements. We saw that outcomes of the controlled drugs audit at Chelmsford had been used to make improvements such as a signatory list of nurses authorised to order controlled drugs being kept in the drugs cabinet.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of each client. The service employed a range of nursing staff including non-medical prescribers to meet the needs of clients. The service also employed hospital liaison nurses who worked on hospital wards to support hospital doctors with safe detoxification prescribing.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Staff completed mandatory training, specialist training with the consultant psychiatrist and shadowed colleagues as part of their induction.

Managers supported staff through regular, constructive appraisals of their work with 98% of staff having an appraisal completed in the last year.

Managers supported staff through regular, constructive clinical supervision of their work and supervision compliance was at 85% across the service.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Teams held two meetings per month, one business meeting and one joint clinical meeting with partnership agencies to discuss client care.

Substance misuse services

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The consultant supported staff with any informal training required. The Colchester team had recently received training in National Early Warning scores for assessing physical health and the Basildon team had received training in dealing with aggressive behaviour.

Managers made sure staff received any specialist training for their role. Staff completed training in delivering pabrinex, in hepatitis testing and vaccination and nurses had the opportunity to qualify as non-medical prescribers.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation, however these were not always recorded effectively.

Staff held regular multidisciplinary meetings to discuss clients and improve their care. Staff held a meeting each morning with partner agency staff to discuss any complex or high risk clients, any clients who had not attended their appointment the previous day and any clients requiring additional support.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. Staff shared clear information with GPs when there was any change in clients' health or treatment.

Staff had effective working relationships with other teams in the organisation.

Staff had effective working relationships with external teams and organisations however they had not always clearly document joint working in client records.

Staff and patients told us appointments were regularly held with staff from the partner agency and we saw examples in client records of effective joint working. However, we reviewed 20 care records and saw clear documentation of joint working appointments in seven of these. This was a requirement from the previous inspection. Whilst a standard template to record joint appointments had been developed, this was not being used consistently across the different teams.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff we spoke with had a good understanding of capacity and 97% of staff had completed training.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew how to access the Mental Capacity lead for the trust.

Substance misuse services

Is the service caring?

Good 🟢 ➡️ ⬅️

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

Staff were discreet, respectful, and responsive when caring for clients. Staff worked with some clients who were unable to attend clinics and so visited these clients at home with partner agency staff to provide collaborative care.

Staff gave clients help, emotional support and advice when they needed it. We spoke with 7 clients who all told us they felt staff listened to them and were helpful and supportive.

Staff supported clients to understand and manage their own care treatment or condition. All clients we spoke with told us staff encouraged them to be involved in their treatment and took their wishes into account when setting treatment goals.

Staff directed clients to other services and supported them to access those services if they needed help. The partner agency worked with clients to access additional services such as housing and benefit support.

Clients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each client. Clients told us that staff were understanding and adapted treatment according to their needs.

Staff followed policy to keep client information confidential.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Care plans were completed by a partner agency, but staff contributed to the care plan and involved clients in agreeing goals.

Staff made sure clients understood their care and treatment. Staff involved clients in discussions about their prescribing plans and any changes in treatment.

Substance misuse services

Staff involved clients in decisions about the service, when appropriate including discussion about opening times and access.

Clients could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged clients to complete 'I want great care' feedback questionnaires and the results were collated centrally. The feedback from client satisfaction questionnaires was an average of 4.9 stars out of 5 across the service.

Involvement of families and carers

Staff informed and involved families and carers appropriately where required.

Is the service responsive?

Good 🟢 ➡️ ⬅️

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

The service had clear criteria to describe which clients they would offer services to. The service was commissioned to provide clinical interventions for opiate and alcohol use and worked alongside a provider agency that provided psychosocial interventions.

The service met the service's target times for seeing clients from referral to assessment and assessment to treatment. The target was for all clients to receive a prescribing appointment within 3 weeks of referral and 96% of clients were seen within this period, with 83% being seen within a week of referral.

Staff saw urgent referrals quickly and non-urgent referrals within the service's target time. Clients being released from prison were seen on the day of their release to ensure their safety. Pregnant clients were also prioritised for appointments.

Staff tried to contact people who did not attend appointments and offer support. The service liaised with pharmacies when clients did not collect their prescription medicines after 3 occasions. The partner agency would contact the client before the prescription could be restarted.

Clients had some flexibility and choice in the appointment times available. The teams all had one day of the week where they could offer evening clinic appointments. All of the teams also ran satellite clinics across the county in local community centres and could also offer to see clients at pharmacies or GP surgeries.

Staff worked hard to avoid cancelling appointments and when they had to, they gave clients clear explanations and offered new appointments as soon as possible. We saw examples of this in client records.

Substance misuse services

Appointments ran on time and staff informed clients when they did not.

The service did not have a waiting list.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. All teams had suitable clinic rooms to see clients and had separate bathroom areas to conduct urine drug screening.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication support needs.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The service locations were not accessible to clients who used a wheelchair or had limited mobility. However, staff held satellite clinics in accessible services and could visit clients at home if their mobility prevented them attending clinics.

The service worked closely with specialist midwives to support pregnant and post-natal clients.

The Colchester service had implemented a women only session which had been well received by clients.

Staff made sure clients could access information on treatment, local services, their rights and how to complain and had posters and leaflets displayed in the service.

The service had information leaflets available in languages spoken by the clients and local community.

Managers made sure staff and clients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Clients, relatives and carers knew how to complain or raise concerns.

The service had not received any complaints in the six months prior to inspection but the trust had a complaints policy in place. Clients we spoke with knew how to make a complaint if needed but were confident that any concerns they raised informally would be addressed.

Staff understood the policy on complaints and knew how to handle them.

Substance misuse services

Staff protected clients who raised concerns or complaints from discrimination and harassment.

The service used compliments to learn, celebrate success and improve the quality of care. Staff at each team collected compliments from clients and these were shared within the team.

Is the service well-led?

Requires Improvement 🟠 ➡️ ⬅️

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Team managers were based in their service and in some teams were also a prescriber and clinical lead for the team. Managers had good knowledge and skills and a good understanding of their services.

Managers and staff told us that local leaders visited and were visible within the service, that senior trust management had tried to be more visible and had more awareness of the service. However, frontline staff still did not feel that senior management were visible within the service or that they fully understood the service.

Vision and strategy

Staff knew and understood the trust vision and values and how they applied to the work of their team.

Most staff we spoke with were aware of the trust values of 'we care, we learn, we empower' and could evidence how they used these in their day to day work.

Culture

Staff felt respected, supported and valued. They reported that the service promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff we spoke with all felt supported and valued by their teams, they reported good morale and job satisfaction.

The trust offered opportunities for career progression including funding non-medical prescriber training for nurses.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, there was a lack of oversight of audit and quality improvement.

Substance misuse services

Governance processes generally operated well with teams with risks and performance managed well.

Whilst most of the requirements from the previous inspection had been implemented, client records still did not always clearly document collaborative working with partner agencies. The trust action plan from the last inspection stated that staff would use a standardised template for recording appointments that would capture joint working however only Harlow team were using a standardised template. Managers did not complete any audits of client records and so this had not been identified as an ongoing issue.

The service did not have an audit schedule or complete audits across the teams with only a naloxone audit completed for the service in the last six months. Chelmsford team had completed 2 controlled drugs audits but none of the other teams had completed any audits of controlled drugs or medicines management.

There was a clear framework for team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The service used an electronic client record system that suited the needs of the service and clients, and all staff had access to the system including bank and agency staff. The system was also used by partner agencies so that records were complete and stored on the same system.

Staff could also access the record system used by local GP surgeries which improved communication and ensured physical health issues were monitored effectively.

Information management

Staff collected analysed data about outcomes and performance.

Staff collated data for key performance indicators and input client data into the national drug treatment monitoring system.

Engagement

The service engaged with commissioners to ensure the needs of clients were being met. Staff worked closely with partner agencies, physical health providers and mental health teams.

Learning, continuous improvement and innovation

The service had an action plan in place following the last inspection to address the requirements.

SUMMARY OF THE RAPID REVIEW INTO DATA ON MENTAL HEALTH INPATIENT SETTINGS - FINAL REPORT AND RECOMMENDATIONS

● Information Item   👤 NL   🕐 10 minutes

REFERENCES

Only PDFs are attached

📄 Rapid Review Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	Summary of the rapid review into data on mental health inpatient settings – Final report and recommendations		
Executive Lead:	Nigel Leonard Executive Director of Major Projects & Programmes		
Report Author(s):	Nigel Leonard Executive Director of Major Projects & Programmes		
Report discussed previously at:	Executive Operational Sub Committee, 11 July 2023		
Level of Assurance:	Level 1	Level 2 ✓	Level 3

Risk Assessment of Report		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risks this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report summarises the recent rapid review, and highlights the key recommendations within the report for action by the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:
1 Consider and note the Rapid Review into Data on Mental Health Inpatient Settings.
2 Delegate authority to the Executive Directors to consider the Rapid Review and develop a schedule of actions and timings for consideration at the next Board meeting.

Summary of Key Issues

The rapid review was undertaken at the request of ministers and received contributions from over 300 subject experts. The review identified 5 key findings and makes 13 Recommendations.

The Board of Directors' attention is drawn to Recommendations 5 and 7, which are specific to provider organisations and Boards.

The Trust has made significant progress on a number of initiatives within the review, and the report seeks delegated responsibility for Executive Directors to devise an appropriate plan and timetable for action.

Further recommendations and guidance are expected from NHS England over the coming months.

The full report can be found via this link: https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications:			N/A
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Summary of the Rapid Review into Data on Mental Health Inpatient Settings: Final Report and Recommendations
Appendix 1:   Findings identified in the rapid review.
Appendix 2:   Principles for the collection, analysis, sharing and use of data and information about mental health inpatient pathways.

Lead

[signature]

Nigel Leonard
Executive Director of Major Projects & Programmes

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Board of Directors Part 1
26 July 2023

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EPUT

SUMMARY OF THE RAPID REVIEW INTO DATA ON MENTAL HEALTH INPATIENT SETTINGS FINAL REPORT AND RECOMMENDATIONS

| **1** | **PURPOSE OF REPORT** |

This report summarises the recent rapid review and highlights the key recommendations within the report for action by the Trust. This is a wide ranging review and it is anticipated that further guidance may be issued by NHS England in the next few weeks.

| **2** | **BACKGROUND** |

The rapid review was commissioned by ministers in response to concerns that the right data and information was not available to provide early alerts to identify risks to patient safety in mental health inpatient settings. The lack of appropriate safety information may fail to prevent safety incidents as well as undermine efforts to improve care and keep patients safe.

The rapid review led by Dr Geraldine Strathdee, who until recently Chaired the Essex Mental Health Independent Inquiry, consulted with over 300 experts in mental health inpatient pathways. This included experts by experience (including carers and families), healthcare assistants, nurses, psychiatrists, managers, clinical directors, chief executive officers (CEOs), chief clinical informatics officers, non-executive directors, integrated care systems (ICSs), safeguarding adults boards, regional and national leaders, academics, data experts, regulators, third sector organisations and others. The process also included roughly 50 submissions, reports and other documented evidence that had been sent to the review team.

The objectives of the rapid review were to:

- Review the data that is collected on mental health inpatient services by national bodies, regional teams, local systems, providers of NHS-funded care and others with a role in collecting information related to patient safety, and to understand how data streams are used and acted upon.

- Understand how the experiences and views of patients, families, staff and advocates relevant to mental health inpatient services are collected, analysed, collated and used.

- Understand whether data and intelligence are collected and used in such a way as to identify risk factors for inpatient safety and aid our understanding of patient and carer experience, if people are receiving high quality care, and cared for in a safe therapeutic environment. How data and intelligence are used by providers and local commissioners to reduce risk and drive a proactive culture of improvement.

- Identify ways in which the collection and use of data can better identify settings where patient safety might be at risk and to make sure that decision makers at all levels have the information they need to monitor and improve patient safety effectively - this should take into account the importance of minimising the burden of data collection, particularly for frontline staff.

| 1 |

3	SUMMARY

The review found 5 key themes for improvement:

1. Measuring what matters

2. Increasing opportunities to promote the voices of Patients, carers and staff

3. Freeing up time to care by reducing data collection requirements

4. Getting the most out of what information we have

5. Data on its own is not enough and Boards need to be engaged in visits.

The review also looked at the difficulty in obtaining information on patient deaths and the need to review this issue to aid learning.

These 5 key themes covered a wide range of issues and this detail is included in Appendix 1. EPUT is making progress on these 5 themes as part of our transformation and digital information initiatives.

Recommendations identified in the Rapid Review

There are 13 recommendations arising from the review. Although all recommendations are relevant to mental health services, recommendations 5-7 are specific to mental health providers and Trust Boards. The timetable for these recommendations creates urgency with the majority having an implementation date of the end of 2023.

In addition to data duplication and collection issues and recommendations the report also highlights the need for:

- reducing time on data collection and entry for frontline staff
- greater service user, carer and staff engagement so these voices are heard at all levels,
- a review of safety and quality reporting to the Board including 'soft' intelligence,
- the importance of board visits to wards, including unannounced and out of hours visits
- improving data skill sets on the Board and metrics in relation to clinical care and care pathways
- greater partnership working at national and system/ICB level

To aid the recommendations and mental health systems, a safety issues framework was also developed and is detailed in Appendix 2. This sets out the key safety issues relevant to mental health inpatients and the factors that create safety risks or foster protective, therapeutic environments.

The recommendations within the rapid review are as follows:

Recommendation 1

NHS England should establish a programme of work, co-produced with experts by experience and key national, regional and local leaders, including Care Quality Commission (CQC),ICSs, provider collaboratives, independent safeguarding bodies, professional bodies, provider representatives and third sector organisations, among others, to agree how to make sure that providers, commissioners and national bodies are 'measuring what matters' for mental health inpatient services, and can access the information they need to provide safe, therapeutic care.

This programme should:

a. Consider what metrics need to be collected, shared and used at different levels to drive improvements in care quality and safety in mental health inpatient settings by the end of 2023. This work should build on the themes identified in the safety issues framework and pay due regard to inequalities. The output of the 'measuring what matters' work should then inform ongoing improvements to quality and safety oversight and support arrangements.

b. Consider what enablers are needed to reduce burdens, improve data sharing and timeliness of reporting - based on co-produced principles to support a reduced data burden at all levels.

Recommendation 2

Every provider and commissioner of NHS-funded care should have access to digital platforms that allow the collection of patient information and associated data infrastructure to allow timely reporting of information to different decision makers.

These systems need to:

- Be compliant with the Digital Technology Assessment Criteria (DTAC).

- Meet the requirements of the Digital Capability Framework (DCF) for mental health electronic patient records (EPRs).

- Ensure usability with effective workflows and interfaces to reduce administrative burden.

The digital platforms and supporting data infrastructure must allow submissions into relevant national data sets, directly or through other interoperable platforms, and facilitate data flows between systems of different local provider organisations to support joined-up understanding of care pathways. These systems should allow the data collected to be made available to different decision makers, including CQC, at the appropriate level of aggregation and without requiring duplicative submissions, and allow benchmarking across trusts and independent sector providers.

NHS England's Transformation Directorate should scope out options for how this ambition could be delivered, including cost implications and a value for money assessment to help providers meet this aim specifically for mental health, including specific ways in which mental health electronic patient record improvement and data sharing can be prioritised and interdependencies with other systems and programmes of work. These options should be presented to DHSC by the end of December 2023. DHSC and the NHS should continue to implement the commitments set out in Data Saves Lives, the data strategy for health and care aimed at tackling the cultural, technological and legislative barriers to better sharing of data across the health and care system.

Recommendation 3

ICSs and provider collaboratives should bring together trusts and independent sector providers, along with other relevant stakeholders such as independent safeguarding bodies, across all healthcare sectors to facilitate the cross-sector sharing of good practice in data collection, reporting and use.

This forum should showcase examples of how data and information could be gathered and used to improve patient safety and quality of care and reduce the data burden on staff, including the ways that digital solutions can enable these improvements.

It should also facilitate the rolling out of examples of good practice and digital innovation between all data commissioners and both NHS and independent sector providers, including the use of administrative staff and coding specialists to gather and process data, the use of consistent codes to record clinical activity, the design of optimal service pathways, and the use of analytical resource to process data and draw out trends and insights to inform quality improvement.

Recommendation 4

More work is needed to map the full range of data on deaths, including what is collected by which organisation and what can be done to improve it. DHSC, in partnership with NHS England and CQC and supported by key experts from across governmental and non-governmental organisations, should convene all the relevant organisations who collect and analyse mortality data to determine what further action is needed to improve the timeliness, quality and availability of that data. This follow up should be completed no later than autumn 2023.

Recommendation 5

Provider boards have a vital role to play in ensuring safety and quality of care in mental health inpatient pathways. We recommend the following actions to improve boards' capacity to identify, prevent and respond to risks to patient safety:

- Provider boards should urgently review its membership and skillset and ensure that the board has an expert by experience and carer representative.

- Provider boards should ensure that its membership has the skills to understand and interpret data about mental health inpatient pathways and ensure that a responsive quality improvement methodology is embedded across their organisations. They should expect those skills to be at least to a level that matches that of financial literacy on the board. They should review and update their recruitment and annual review processes in line with the recommendations of the Kark review of the fit and proper persons test.

- This should ensure that people with the necessary competencies, including data literacy skills, are appointed to the board and these skills and competencies are updated. Boards should consider annual mandatory training for their members on data literacy, in partnership with their local ICS and other system partners.

- Every board should provide Mental Health Act training so that at least half their non-executive directors are trained as associate hospital managers under the Mental Health Act and participate in hearings to best understand the clinical care provided, the challenges, and the views of patients, families and clinical teams for the patients.

- CQC should assess and report on whether the membership of the boards of providers of mental health inpatient services includes experts by experience (including carer) representatives and whether boards are maintaining an appropriately high level of data literacy and quality improvement expertise on mental health inpatient pathways among their membership as part of their assessments.

- every provider board should urgently review its approach to board reports and board assessment frameworks to ensure that they highlight the key risks in all of their mental health inpatient wards, as set out in the safety issues framework, and that they support the board to take action to mitigate risks and improve care, including both quantitative data and qualitative 'soft intelligence' such as feedback from patients, staff and carers.

- Provider boards should also set out in writing how they will make sure the voice of carers and family members is heard both at board level and with clinical staff and make sure this information is publicly available.

- NHS England should review and update the guidance on board assessment frameworks.

Recommendation 6

Trust and provider leaders, including board members, should prioritise spending time on wards regularly, including regular unannounced and 'out-of-hours' visits, to be available to and gather informal intelligence from staff and patients. Priority should be given to those units where there is a known higher risk of 'closed cultures' including services for people with learning disabilities and autistic people, children and young people, those with cognitive impairment and neurodevelopmental conditions and patients held under powers of detention.

Recommendation 7

All providers of NHS-funded care should review the information they provide about their inpatient services to patients and carers annually and make sure that comprehensive information about staffing, ward environment, therapeutic activity and other relevant information about life on the wards is available. The CQC should assess the quality, availability and accessibility of this information as part of their assessment of services.

Recommendation 8

ICSs and provider collaboratives should map out the pathway for all their mental health service lines to establish which parties need access to relevant data at all points on the pathway and take steps to ensure that data is available to those who need it.

To facilitate this ICSs and provider collaboratives should make sure that their members have access to data literacy training relevant to mental health, including in relation to quality improvement and safety.

They should also bring together the mental health population leads from across their footprint to map out the mental health needs of their local populations and the potential for primary, secondary and tertiary prevention as well as equitable access to safe therapeutic services.

Recommendation 9

ICSs will develop system-wide infrastructure strategies by December 2023 and the mental health estate needs to be fully incorporated and represented in these strategies and in subsequent local action plans.

This recommendation is for local ICSs to review the mental health estate to inform these and future strategies, recognising there are evidence-based therapeutic design features that can contribute to reducing risk and improving safety.

The estate review should include:

- Identification of critical and significant safety issues and major derogations from National Health building notes, in particular where ligatures or unsafe observation areas are present. Including, where appropriate, updating the Estates Returns Information Collection (ERIC) to ensure that returns are thorough and underpinned by up-to date site surveys and identify safety risks relating to mixed sex accommodation.

- A parallel identification of current capital plans which will reduce or remove these estates risks - for example, the eradication of mental health dormitory provision by March 2025, and the plans for mental health safety work announced at recent fiscal events.

- A collaborative approach across the ICS and within individual providers to interrogate estates data to inform capital plans and investment priorities.

- Identification of any additional beneficial work that is vital to the inpatient estate's capacity to provide modern therapeutic interventions including self-management sensory rooms, rooms suitable for therapies and group psychological interventions, rehabilitation, occupational therapies rehabilitation treatments, and faith rooms

- Provision for safe family rooms for visiting with children and other dependents, and a room in which a family member can stay overnight, especially when a young person is admitted for a first episode of illness.

Recommendation 10

Ward visitors, whether unpaid carers, family members, friends or advocates, play an important role in providing feedback regarding the care provided and escalating any concerns. Providers should review their processes for allowing ward visitors access to mental health inpatient wards with a view to increasing the amount of time families, carers, friends and advocates can spend on wards. DHSC to consider what more can be done to strengthen the expectation for all health and care providers in England to allow visiting.

Recommendation 11

All providers of NHS-funded care should meet the relevant core carer standards set by the National Institute for Health and Care Excellence (NICE) and Triangle of Care, England. Regulators, including CQC and professional regulators, should consider how to monitor the implementation of these carer standards, especially where there is greater risk of unsafe closed cultures developing. ICSs should consider how to routinely seek carer feedback. Inpatient staff training programmes should identify how they can benefit from carer trainers. For patients detained under the Mental Health Act, families and carers should be part of all detention reviews.

Recommendation 12

Professional bodies, such as the Royal Colleges, should come together across healthcare sectors to form an alliance for compassionate professional care. This multi-professional alliance should:

- Work together and learn from each other to identify ways to drive improvement in the quality of compassionate care and safety across all sectors, including mental health services, and how they can support staff to provide it.

- Along with their specialist data units, where they exist, contribute to the work set out in recommendation 1 (measuring what matters).

Recommendation 13

Except where specified, these recommendations should be implemented by all parties within 12 months of the publication of this report. Government ministers, through the Department of Health and Social Care (DHSC), should review progress against these recommendations after 12 months.

What a better system would look like

The Rapid review identified the expected outcome following the implementation of the 13 recommendations. The review identifies that through these recommendations decision makers at all levels would have access to robust, consistent, real time data so that:

- They could identify the wards and services most at risk and intervene to raise standards and protect patients, including those settings where closed cultures are most likely to develop, before those risks materialise.

- They could learn from incidents in their own localities and nationwide quickly and comprehensively.

- They could have a better and more up-to-date understanding about what needs to be done to improve their services.

- More thorough and comprehensive benchmarking would be possible between providers and integrated care boards (ICBs) so that everyone could understand how they compare to their peers and identify trends and areas for improvement.

- ICSs could have clear, reliable indicators for decision making to understand and develop commissioning and collaboration plans to meet local population need.

- Innovations, interventions, and policies could be more easily assessed based on patient outcomes - this could also allow for greater equity of access and address unwarranted variation between services.

- There could be improved accountability for leaders and decision makers in mental health inpatient settings.

- Frontline staff would spend substantially less time entering data and have much more time to spend providing therapeutic care, improving outcomes for patient.

EPUT's Response to the Rapid Review

The Rapid review has already been discussed at the Executive Operational Sub Committee meeting. It was acknowledged that the trust has already put in place a number of initiatives detailed in the report e.g. MAST tool, increasing the patient and carer and staff voice.

However, there is further work and consideration required in relation to a number of the review recommendations and the Chief Executive has asked the Director of Major Projects & Programmes together with the Executive Nurse, Senior Director of Governance & Corporate Affairs, Director of Safety and Executive Director of Strategy, Transformation & Digital to discuss and develop proposals with a timetable for implementation for discussion with the Board.

4	ACTIONS REQUIRED

The Board of Directors is asked to:

- Consider and note the Rapid Review into Data on Mental Health Inpatient Settings.
- Delegate authority to the Executive Directors to consider the Rapid Review and develop a schedule of proposals, actions and timings for consideration at the next Board meeting.

Nigel Leonard
Executive Director of Major Projects & Programmes

13 July 2023

<u>Appendix 1</u>

Findings

The findings from the rapid review are listed under 5 key themes. The review also included a section that focuses on data on deaths in mental health inpatient pathways. This reflects the particular importance of this issue - every death in an inpatient mental health setting is a tragedy - but also the challenges that we identified over the course of the review around the collection and use of data on deaths that merit specific consideration.

1. **Measuring what matters**

    - To identify risk factors.

    - Whether people receive high quality care in a safe and therapeutic environment.

    - Our safety issues framework (see Appendix 1).

    - Some providers were doing impressive work using, for example, natural language processing tools and patient experience feedback app.

    - Innovation is flourishing, for example, in the development of digital first pathways, these are often inclusive of PROMs and CROMs. We heard from the national audit and GIRFT programmes about major variations in accessible information.

    - Key gaps in the availability of routine data sources to produce indicators to monitor certain safety issues. These include:

        o The voice of people in hospital and their carers about the safety and quality of care and their involvement in care.
        o Data on the culture on wards and staff attitudes towards people in hospital.
        o Data on key aspects of safe therapeutic care, such as PROMs and CROMs
        o Physical healthcare information.
        o Protected Characteristics.

    - One such example a good dashboard is from St Andrew's Healthcare's integrated safety and quality improvement platform.

    - Community mental health teams in Mersey Care NHS Foundation Trust are using a management and supervision tool (MaST) that uses predictive analytics to examine data and information from multiple sources to detect risk of crisis and inform decision making based on service user needs and the likely resource required to provide safe, high quality and effective care

2. **Patient, carer and staff voice**

    - To understand how the experiences and views of patients, families, staff and advocates relevant to mental health inpatient services are collected, analysed, collated and used.

    - Patients, carers and staff were also uniquely able to tell us what matters for patient safety and quality of care, and their input was invaluable to the development of the safety issues framework.

    - Patients and carers do not always feel that their voices are heard on wards. When carers or patients raised concerns with CQC, they often felt that action was not taken, or was not fed back clearly.

    - Digital solutions to gather feedback from patients in real time and use it to inform senior leaders. These are best used as a supplement to, rather than a replacement for, other means of gathering feedback from patients.

    - Experts by experience noted that advocates could be helpful when it came to making patients' voices heard.

- National Institute for Health and Care Excellence (NICE) and Carer UK Triangle of Care standards, standards were not always implemented.

- Carers value information about what life is like on the ward, including staffing, daily routines and therapeutic activity.

- Frontline staff do not always feel that their voice is heard, or that they are empowered to speak up when they see things going wrong.

- While providers have Freedom to Speak Up Guardians, staff felt intimidated by the process or worried about the impact of speaking up, especially where the Guardian was a senior manager.

- Staff evidence showed that when they raised concerns or issues they did not always feel that action was taken, or, where action was taken, that the outcome of the action was not well communicated.

- Ward culture can also have a significant impact on staff's confidence or ability to raise issues - for example, we heard in a closed or toxic culture staff may be discouraged from reporting issues.

- In Australia, the New South Wales (NSW) Ministry of Health runs a 'Your Experience of Service' (YES) survey. This is a consumer experience measure tool that aims to improve mental health services in community as well as hospital settings from the perspective of service users. It is offered on paper and electronically.

- Berkshire Healthcare NHS Foundation Trust have introduced iWantGreatCare on Berkshire foundation trust's website.

- People tended to feel more safe when staff were more qualified (for example, those who were qualified in trauma informed care), or when more senior qualified staff were leading and supporting less qualified staff.

- Safety is made up of both physical elements, including having positive ward environments, safe levels of staffing and robust safeguarding procedures to protect people, and emotional, relational and psychological elements, such as feeling supported, having well-run wards with positive environments, and positive relationships with staff.

3. **Freeing up time to care**

   a. Ministers emphasised that one of the fundamental issues we should be considering through this process was how to reduce the burden of data entry on staff.

   b. The amount of time staff can spend on data entry impacts on providing therapeutic care to patients is reduced, which in turn could itself contribute to risks to patient safety.

   c. Staff often have to enter the same data multiple times into multiple different systems and often those systems are outdated, difficult to use and do not communicate with each other.

   d. Information provided by frontline staff was critical to ensuring safety.

   e. Widespread agreement that data collection should be streamlined as far as possible, focused on the most important things, and tools should be made available to make entering data as easy as possible.

   f. Through their programme 'Shaping our Future', East London NHS Foundation Trust (ELFT) embarked on work to redesign the way they delivered services to meet the post-COVID 'new normal' and improve standards of care, co-designed with experts by experience and frontline staff. Within the first year of the work, the number of KPIs was reduced from 6,500 to 3,000 and they were able to improve the way they provided data to their commissioners, with greater use of statistical process control. Staff and patient

time was freed up to continue to engage with quality improvement in both hospital and community settings.

4. **Getting the most out of what we have**

   a. 'Mental health services are swimming in data'.

   b. While data is often entered in real time by frontline staff, the work involved in processing, analysing and sharing information, means that data presented to boards, commissioners and national data sets were often weeks or months out of date.

   c. Frontline staff feel they were 'feeding the beast' and that they did not receive useful outputs from the data they entered.

   d. Insufficient analytical resource in trusts to service the needs of all staff, from frontline clinical staff to leadership and board members.

   e. A lack of consistency across England in the way that key measures about patients were coded and recorded on systems, including information about their needs, diagnoses and therapeutic interventions. We were told by several clinical leaders that the varying use of ICD 10, ICD 11 and SNOMED coding meant that the same information could be recorded in different providers in different ways.

   f. Key information about patients does not always follow the patient through their therapeutic journey. This means that risk factors relating to the patient sometimes are not immediately identified or communicated to frontline staff on admission to the ward or to community services on discharge.

   g. On the ward patients and carers often have to give the same information multiple times to multiple members of staff, which increases the burden on staff and can be distressing or frustrating for patients and carers.

   h. Key information relating to the quality of care and patient safety in mental health inpatient pathways was not routinely shared. This means that benchmarking with peer trusts is often not possible, and opportunities to learn from others and improve services are often missed.

   i. Several trusts and independent sector providers have developed excellent dashboards that provide rich information about the quality and safety of care in their services.

   j. Due to existing protocols, published data that does not distinguish between missing data and low numbers or which rounds figures limits the ability to undertake accurate analysis.

   k. Data transparency is essential, and that providers needed to make more data more widely available. This will allow more benchmarking of different services and will help to increase cooperation across different services to drive improvement.

   l. Independent Safeguarding Adults Boards Chairs Network told us that there is wide variation on the quality of safeguarding concerns being reported from mental health inpatient services. We heard that the availability of information was often dependent on the quality of the professional relationships within local systems and willingness of organisations to be open and transparent.

   m. Transformation Partners in Health and Care (formerly Healthy London Partnership), in conjunction with stakeholders and the NHS Benchmarking Network, designed and commissioned the London mental health dashboard in 2016. Bringing together 276 metrics from 27 sources of data, it serves as a benchmarking tool allowing comparisons between different systems, organisations and providers across London to support service and quality improvements.

   n. 'Deep dive' reports are produced to summarise the trends and current status of health and wellbeing of the population in the London region. The dashboard also enables

bespoke reporting at provider level. The London mental health dashboard has been commended for its data transparency, use of multiple data sources in one accessible point and for its inclusion of wider determinants of health to give a holistic overview of the health system. It has been beneficial to identify trust and regional level issues and where improvement can be driven collaboratively.

o. People with psychosis form the highest proportion of those admitted to inpatient wards. The Psychosis Population Health Management Platform was developed by South London and Maudsley NHS Foundation Trust in collaboration with clinicians, academics, informaticians, computer scientists, biostatisticians and researchers. The programme demonstrates how inpatient and community data can be used by individual clinicians, teams and organisations. It demonstrates the potential for ICBs to use data in a way that enhances clinicians' ability to improve clinical outcomes in the local population through targeted prevention and by using an individualised risk calculator to support early intervention.

5. Data on its own is not enough/Data on Deaths

a. Several organisations that collect and report on deaths of people with mental health problems and on people with a learning disability but that these collections are fragmented, which presents significant challenges in providing an overview of how many people die while in contact with inpatient services.

b. There is no published national overview of the deaths of people in inpatient mental health settings nor of the total number of deaths of people in contact with mental health services at provider level.

c. There are opportunities through the linking of mental health, health and mortality data sets to provide this overview including the causes of people's deaths due to both physical health conditions and due to suicide.

d. Providers are not always made aware when someone has died, particularly if they have gone absent from the ward or died while on leave, after transfer to an acute hospital or following discharge home or elsewhere.

e. Providers have no ready access to information about the cause of a person's death to enable learning and have to follow up each person's death to find out the cause.

f. Definitions applied to produce suicide statistics and delays in death registration mean that figures are thought to be an underestimate and there is likely to be attrition at each stage of the process, particularly if deaths are not referred to a coroner in line with national guidance or if there are variations between coroners about reaching a conclusion in relation to suicide.

g. The Office for National Statistics (ONS) produces a range of mortality statistics, including the main causes of deaths using the International Classification of Diseases but there are variations in the way deaths are categorised by other organisations.

h. The use of natural and unnatural in relation to deaths can be unhelpful in that they relate to the way someone has died rather than the cause of death. We also found that there may be delays in determining cause of death, particularly if a person's death requires referral to a coroner, with implications for the timely production of statistics and learning.

i. National statistics are often reported annually and there can be a time lag in relation to the data they reflect, which means that it can be very difficult to get access to comprehensive data on deaths in a timely fashion. There are a number of initiatives that have tried to address this through the use of real time surveillance.

<u>**Appendix 2**</u>

Principles for the collection, analysis, sharing and use of data and information about mental health inpatient pathways

1. Data should be entered once and used multiple times.

2. All data entered should be analysed by informatics experts who can create high quality products to support decision making and promote safety and quality of care.

3. Anyone who enters data into a system should benefit from entering that data, for example, by having key information fed back to them in an accessible format in real time.

4. Patients, carers and staff should be able to provide feedback on care quickly, easily and anonymously, and should expect that feedback to be reviewed and to be used to improve services.

5. Those responsible for patient safety and quality of care in inpatient settings should agree 'what matters' for measuring safe and therapeutic care, and focus all data requests and infrastructure around collecting, using and sharing those measures. Inspired by UNESCO (The United Nations Educational, Scientific and Cultural Organisation) principles for the use of data in education, these data collections should:

   • get the right data: collect the data that is relevant to safe, therapeutic care

   • get the data right: collect data with precise definitions and appropriate measurements

   • get the data right away: collect data that is timely and current

   • get the data the right way: collect data through a rigorous process that can guarantee data quality and ensure consistency

   • get the right data management: collect reliable data that is guaranteed by good quality control conducted by relevant stakeholders

6. There should be a clear and explicit rationale for all data requests, including why they cannot be met through other collections.

7. All decision makers should have the skills they need to interpret data on safety and quality of care and should be able to use those skills to draw insights from the data they are given and to act on those insights.

8. The data collected on patient safety and quality of care in mental health pathways should have consistent, nationally agreed definitions.

9. Patient data should follow the patient between services, so that patients only have to provide their information once and to support joined-up care between different services.

10. The insight and experience of patients, carers and staff is vital to understanding the risks and quality of care in services and should be integral to decision making at every level.

11. As far as possible, mental health services and ICSs should be joined up with other health and non-health sectors, such as police and local authorities, to facilitate the sharing of data and information to promote patient safety and to better meet the needs of local populations.

Mapping of topics to key safety issues for mental health inpatient settings

A: poor safety outcomes

Abuse

Includes:
• harassment and intimidation
• discrimination

- verbal abuse
- threats of harm
- financial abuse
- bribery
- neglect

Assault and conflict

Includes:
- violence, aggression, conflict and physical assault leading to harm or injury to staff or patients
- behaviour that challenges staff

Self-harm

Includes:
- self-harm
- suicidal behaviour
- self-neglect
- self-starvation

Sexual safety

Includes:
- sexual harassment
- sexual exploitation
- sexual assault

Patient accident

Includes:
- falls
- injuries

Other incidents which may result in harm

Includes harm caused by:
- restraint
- illicit drug taking and/or alcohol use

Negative impact on physical health

Includes:
- worsening of health conditions or new health conditions which are not identified, monitored or treated
- unsafe medicines management
- illness due to outbreaks of infection (for example, COVID-19)

Negative impact on mental health outcomes

Includes emotional and psychological distress.

Death

Includes death due to:
- suicide
- self-harm
- preventable death due to physical health problems
- drugs and alcohol
- homicide
- self-neglect

- accident
- treatment, procedures or errors in care

B: Individual and practice factors which can contribute to poor safety outcomes

Profile of people using the service (context)

Including:
- protected characteristics
- inherent risk factors related to people being highly dependent on staff for their basic needs, being less able to speak up for themselves without support, being unable to leave the service of their own accord (for example, subject to the Mental Health Act or the Mental Capacity Act) or remaining in the service for months or years
- diverse people with diverse needs on wards

Service characteristics (context)

Including:
- isolated service with limited access to community services and facilities and less opportunities for friends and family to visit
- decline in safety and overall performance and lack of adherence to national guidance and standards

Lack of service user and carer involvement

Including:
- lack of individualised and personalised care, including culturally appropriate care plans which are not co-produced
- not involving people to manage risks
- not promoting independence, choice and control
- lack of access to independent advocacy
- lack of active involvement of carers, friends and families
- lack of involving service user and carers as patient safety partners

Lack of therapeutic clinical care and treatment

Including:
- lack of delivery of evidence-based care including holistic assessment of needs, care planning, diagnosis, consent to care and treatment, provision of appropriate therapies
- ineffective risk assessment and risk management
- poor observation practices
- ineffective relational security
- ineffective procedural security (for example, appropriate application of search procedures)
- ineffective application of Mental Health Act and Mental Capacity Act
- clinician reported outcome measures (CROMs), patient reported outcomes measures (PROMs) and patient reported experience measures (PREMs) not in use
- inappropriate use of electroconvulsive therapy (ECT)

Inappropriate use of coercive or restrictive interventions

Including:
- excessive, increasing use or repeated uses of restrictive interventions including restraint (physical, chemical, mechanical), seclusion, segregation; lack of following guidance if interventions are used including debriefing after incidents
- not taking action to prevent the escalation of situations that lead to the use of restrictive interventions. Not using restrictive interventions as a last resort
- being on a locked ward with high bed occupancy
- application of blanket restrictions

Unsafe ward environment and lack of safe, therapeutic estates

Including:
- unsuitable, untherapeutic estate with design of features that can increase risk (for example, hidden corners) and lack of access to facilities that can promote safety (for example, availability of sensory rooms)
- unclean and poorly maintained estate with ineffective infection prevention and control
- lack of provision of equipment, facilities and technology to promote safe care
- dormitory accommodation not eliminated
- lack of choice of single sex accommodation
- ligature risks not mitigated or eliminated
- services in an isolated location which limits access to community services and facilities and limits opportunities for friends and family to visit

Lack of safe physical health assessment and treatments

Including:
- lack of physical health assessment
- not monitoring adverse effects of medication
- not investigating causes of poor physical health
- not responding to deteriorating health and managing long-term conditions

Lack of safe, high quality and effective staffing

Including:
- poor therapeutic culture and ethos of staff team
- staffing levels, capacity and skill mix (including balance of registered and unregistered staff) unable to meet service user need
- lack of continuity of staffing, use of agency staff, sickness, vacancies and turnover
- lack of provision of regular support, training and supervision
- ineffective recruitment practices
- lack of promotion of staff well-being
- low staff morale and satisfaction
- staff feeling afraid to go onto the wards
- whistleblowing alerts

Lack of positive and therapeutic culture

Including:
- people not being treated with kindness, compassion, dignity and respect
- service users unsatisfied with care
- carers unsatisfied with care
- negative staff attitudes (for example, absence of caring values) and behaviour (for example, punishing regime) towards service users
- lack of provision of and engagement in activities, including on evenings and weekends
- lack of access to leave, or leave being badly managed, leading to unauthorised leave
- lack of access to one to one time with staff
- not embracing new ideas, external visitors and good community connections
- increasing number and ineffective follow up of safeguarding incidents
- lack of interprofessional collaboration

Unsafe medicines management pathways and practices

Including:
- ineffective administration and management of medicines
- dispensing medicines out of line with national guidelines
- ineffective monitoring

Unsafe inpatient care pathway

Including:
- admission to hospital that may have been avoidable or short lengths of stay where admission may have been inappropriate
- lack of timely access to an appropriate bed in the least restrictive setting and as close to home as possible
- inappropriate out of area placements
- inappropriate placement of young people on adult wards
- ineffective management of admission to hospital and transfers between services
- unsafe and delayed discharge, discharge planning not starting when someone is admitted to hospital, excessive lengths of stay
- ineffective communication, information sharing and services not working together to promote safe discharge
- ineffective follow up by community services after discharge

Poor learning culture

Including:
- inconsistent reporting and lack of learning from patient safety incidents and events
- people not informed and supported when things go wrong with care and treatment, lack of honesty and lack of an apology when things go wrong (duty of candour)
- lack of learning from complaints, concerns and compliments
- inconsistent approaches, delayed investigations and insufficient time to carry out thorough investigation of incidents and complaints

Lack of leadership for safety and governance

Including:
- lack of access to or lack of support from Freedom to Speak Up Guardians
- leaders failing to monitor and address issues raised by staff, people using the service, relatives and visitors to the service
- leaders failing to learn and improve from the feedback from those who speak up
- poor support for whistleblowers
- poor management and negative relationships between staff and senior colleagues
- absence of manager or leader
- lack of openness and transparency
- lack of internal oversight and poor governance for safety in inpatient mental health settings

High data burden but lack of real time information for rapid improvement

Including:
- inaccurate data that does not provide a comprehensive view about safety; delays in data submission
- lack of availability of digital technology to support live monitoring
- lack of training and support for staff to enable data literacy
- ineffective use of data to monitor services
- lack of information produced to inform improvement, governance and oversight

BOARD ASSURANCE FRAMEWORK 2022/23

● Discussion Item   👤 DG   🕐 10 Minutes

REFERENCES   Only PDFs are attached

📕 Board Assurance Framework 01 July 2023.pdf

NHS Essex Partnership University NHS Foundation Trust

Purpose of Report

The report provides a high level summary of the strategic risks and high level operational risks (corporate risk register). These risks have significant programmes of work underpinning them with longer term actions to both reduce the likelihood and consequence of risks and to have in place mitigations should these risks be realised.

➢ Section 2: Provides a high level summary of the Strategic Risks and the Corporate Risk Register (high level operational risks).

➢ Noting the following changes to current risk score:
  ➢ SR3 increase in risk exposure score as a consequence of national media coverage, parliamentary coverage and a total loss of public confidence.
  ➢ SR1 reduction in risk exposure score as a consequence of improvements through the Safety First Safety Always Strategy year 1-2 outputs.

➢ Section 3 / 4: Note that there are no new or closed risks in the reporting period and therefore these sections omitted from the report.

➢ Section 5: Provides a progress report for each strategic risk provided by the relevant senior responsible officer. Note the development of a new risk for Digital which will report to the Board along with the new Digital strategy (expected to Board September 2023).

➢ Section 6: Provides a progress report for each high level operational risks contained within the Corporate Risk Register provided by the relevant senior responsible officer.

➢ Section 7: Provides progress on risk movement across the BAF.

➢ Section 8: Additional Information

Recommendations/ action required :

The Executive Team is asked to :

The Board is asked to receive and note the report containing progress update.

Corporate Impact Assessment or Board Statements for the Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications:	Nil
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	

OUR STRATEGIC OBJECTIVES

We will deliver **safe,** high quality **integrated** care services.

We will **enable** each other to be the **best** that we can.

We will work together with our **partners** to make our services **better.**

We will help our communities **thrive.**

OUR VALUES

We **CARE**
We **LEARN**
We **EMPOWER**

02 - BAF Dashboard

July 2023

EPUT

Strategic Risks

Existing Risks	Recommended New Risks	Recommended for Change in rating	Recommended for Closure
8	1 (pending)	2	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
1	1	6	7	8

RISK RATING
Consequence

		1	2	3	4	5
Likelihood	1					
	2					
	3					SR1 / SR3 SR6
	4					SR2 / SR4 SR5 / SR7 SR8
	5					

% Risks with Controls Identified	% risks with assurance identified	Actions overdue
100%	100%	2

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR2	2	People	Safety, Experience, Compliance, Service Delivery, Reputation	SL	5x4=20	20 → 20 → 20	National challenge for recruitment and retention	• Successful application to Register of Apprenticeship Training Providers June 23 • Optimisation of electronic staff records now business as usual. Self-service on ESR live • People and Culture Strategy on track for November 23 • Trajectory in place for review of Dignity, Respect and Grievance Policy • Improving experiences of minority staff data collated and analysed and work on track to present to Board Seminar in Autumn 23
SR5	1	Statutory Public Enquiry	Compliance, Reputation	NL	5x4=20	15 → 15 → 20	Government led independent inquiry into Mental Health services in Essex	• Increased score to C5 x L4 = 20 as a result of the uncertainty in the change of status and Chair • Risk reworded to reflect the changes in the Inquiry • Consequence major 5 based on national media coverage, parliamentary coverage and a total loss of public confidence • Likelihood 4 likely (61% to 80% chance of occurring) • Target score will change accordingly to C4 x L2 = 8 • Two actions completed from the BDO audit around long-term responsibility for actions and sustainability, with follow up to Executive Team • See SR5 at a glance slide
SR7	All	Capital	Safety, Experience, Compliance, Service Delivery, Reputation	TS	5x4=20	20 → 20 → 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	• Progress published June 23 outlining programme structure and governance principles and timelines around Electronic Patient Record • EPR Oversight Committee Convergence and Delivery Board in place between EPUT and MSEFT • EPR programme may result in the need for a separate risk
SR8	All	Use of Resources	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x4=20	20 → 20 → 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	• Revenue plan submitted as revised to a break even plan • Dedicating time in transformation group around efficiencies. With MSE in turnaround process, part of this relates to higher level of efficiencies. • Residual efficiency (circa £1m) and recurrence of delivery.

Strategic Risks (continued)

NHS
Essex Partnership University

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Score 20+ (Existing risks)								
SR4	All	Demand and Capacity	Safety, Experience, Compliance, Service Delivery, Reputation	AG	5x4=20	20 20 20	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	• Making good progress with a week on week reduction in OoAPs – however due to ongoing industrial action and closure of capacity due to required refurbishment the risk score remains the same pending further review for next reporting period.
Score <20 (Existing risks)								
SR1	1	Safety	Safety, Experience, Compliance, Service Delivery, Reputation	NH	5x3=15	20 15 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	• As an impact of our safety culture programme there has been significant improvements over the first two years of the safety strategy leading to a reduction in the likelihood of avoidable harm occurring as reported to Board in March 2023 to a level 3, with a subsequent reduction in the risk being realised. A likelihood of 3, means it is possible that avoidable harm may occur (with a probability of 20-50%), based on the reported sustained reduction in serious incidents, 95% reduction in the use of prone restraint since January 2020, 80% reduction in seclusion incidents since November 2020, and 90% staff stated that Oxevision is enabling then to prevent potential incidents from occurring. The consequence of any avoidable harm remains unchanged at a 5 (for the following assessment 5 for patient safety as incidents when they occur may lead to death / irreversible health effects; 4 for regulatory breaches as the Trust has received an improvement notice and breaches within the safety domain in the latest CQC reports; and 5 for reputation as the Trust is likely to continue to attract both local and national media attention and MP questions).
SR3	All	Infrastructure	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	• Existing Estates and Facilities structure and proposed requirements discussed with CFO • New action added in relation to business case for revised Estates and Facilities structure • Apprentice and Waste Manager posts supported by CFO
SR6	All	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	ZT	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	• Server upgrade planned • Business continuity plans remains a gap whilst upgrades are in progress.
SR9	All	Digital		ZT				Risk assessment being carried out in alignment with the finalisation of the Digital Strategy (planned to be presented to Board in September '23) – the new risk will identify risk to delivery of that strategy and will be included within the BAF next reporting cycle.

Corporate Risks

Existing Risks	Recommended New Risks	Recommended Downgrading from SRR to CRR	Recommended Downgrading From CRR to DRR	Recommended for Closure
11	0	0	0	0

Risk Score Increases	Risk Score Decreases	No change in Risk Score	Risks Reviewed by owners	On RR more than 12 months
0	0	11	9	8

RISK RATING

Likelihood \ Consequence	1	2	3	4	5
1					
2					
3				11 92	34 81 93
4				45 77 96 99	94
5				98	

% Risks with Controls Identified	% risks with assurance identified	Actions overdue
100%	100%	0

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	20 20 20	CQC found observation learning not embedded	• Review of Observation and Engagement policy underway bringing a greater focus on engagement and providing staff with new engagement tools
CRR98	Pharmacy Resource	Safety	NH	4x5=20	20 20 20	Continuous state of business continuity plan	• There is a slight improvement in month to new staff in post (increase of 1.8WTE) • Continuation of recruitment campaign with 6.7 post under offer with start dates July, August and September 2023; and 5.4 WTE posts under offer to final year students which are exam dependent (3 WTE August 2023 and 2.4 WTE January 2024); shortlisting and interviews pending 1.0 WTE; and open advertisements 6.7 WTE • Impact of continued business continuity is being expressed in other functions e.g. ability of EPUT to sign up to some clinical trials (reported to the Quality Committee July 2023)
CRR11	Suicide Prevention	Safe	MK	4x3=12	12 12 12	Implementation of suicide prevention strategy	• Proposal for revised strategy going to steering group to consider working through the care groups
CRR34	Suicide Prevention - training	Safe	MK	5x3=15	15 15 15	Implementation of suicide prevention strategy	• Positive discussions with STORM licence provider and now beginning the process of completing the required information to update the agreement
CRR45	Mandatory training	Safe	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	• Actions on track

Corporate Risks (continued)

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Key Progress
Existing Risks cont'd							
CRR77	Medical Devices	Safe, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	• Regular updates with DDQS' and now part of controls • Shortlisting and interviews complete for Medical Device Safety Officer and Administration Support
CRR81	Ligature	Safe, Compliance, Reputation	AG/TS	5x3=15	15 15 15	Patient safety incidents	• Estates programme underway in line with risk stratification document and capital projects • Standards on outdoor garden furniture complete and ready for recommendations • Pilot on in-house training took place in June 23
CRR92	Addressing Inequalities	Experience	SL	4x3=12	12 12 12	Staff Experience	• Micro-incivilities pilot workshops completed and moved to controls • EDI framework developed and new action added to update following launch of NHS EDI Improvement Plan • £40k ring-fenced from WDT budget to source Inclusive Employers to create modules for Race Equality, EDI and Active Bystander training as well as Disability and Faith • Looking at compatibility of EDI learning offer with EPUT systems • Existing OLM courses and EPUT resources compiled into online staff resource
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	• Snap poll taken on live event 04/07 – 9 people had seen the ECOL desktop logo and 4 had not
CRR96	Loggists	Compliance	NL	4x4=16	15 15 15	Major incident management	• Training is now available provided the NHS East of England Region. The EPRR/Compliance manager has completed training which now provides the capacity to deliver in-house loggist training. • A proposal is in development to increase the number of staff who are defined as loggists and therefore require training. • Of the 8 EPRR events in 2022-23 all have been logged to date.
CRR99	Safeguarding Referrals	Safety	NH	4x4=16	16 16 16	Escalation from operations and high increase in referrals	• Southend Unitary Authority open referrals action now closed

05 – Strategic Risks

July 2023

SR1: Safety

At a Glance:

If EPUT does not invest in safety or effectively learn lessons from the past then we may not meet our safety ambitions resulting in a possibility of experiencing avoidable harm, loss of confidence and regulatory requirements

Likelihood based on: Incidence of incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions imposed historically

Consequence based on: Avoidable harm incident impact and extent of regulatory sanctions

Initial risk score C5 x 4L = 20	Current risk score C5 x L3= 15	Target score C5 x L2 = 8

Progress since last report:

As an impact of our safety culture programme there has been significant improvements over the first two years of the safety strategy leading to a reduction in the likelihood of avoidable harm occurring as reported to Board in March 2023 to a level 3, with a subsequent reduction in the risk being realised. A likelihood of 3, means it is possible that avoidable harm may occur (with a probability of 20-50%), based on the reported sustained reduction in serious incidents, 95% reduction in the use of prone restraint since January 2020, 80% reduction in seclusion incidents since November 2020, and 90% staff stated that Oxevision is enabling then to prevent potential incidents from occurring. The consequence of any avoidable harm remains unchanged at a 5 (for the following assessment 5 for patient safety as incidents when they occur may lead to death / irreversible health effects; 4 for regulatory breaches as the Trust has received an improvement notice and breaches within the safety domain in the latest CQC reports; and 5 for reputation as the Trust is likely to continue to attract both local and national media attention and MP questions).

Progress on actions to note:

➤ Action 1- PSIRP sent to stakeholders for comments and due for Executive Team approval by 31 August 2023
➤ Action 2- Year 3 priorities set at Trust Board in March 2023 with oversight through the Board Safety Oversight Group on the 15 June 2023, we held our first Patient Safety conference to celebrate the work of our first 2 years of the Safety Strategy (Safety First, Safety Always). The event was supported by Anglia Ruskin University.
➤ Action 3 – projected slippage to October 2023 (from July '23), due to Allocate (supplier) and is being escalated to them by the transformation team regularly (Action Amber RAG as delayed from original stated timeline)
➤ Action 4 –The QI framework is a key priority in development of the EPUT Quality Assurance Framework (QAF) and development will be taken forward as part of this work
➤ Action 6 – Development of SIP is on track,
➤ Action 7 – EPUT Safety and Lessons Management System. Sprint 1 of the software development is in progress and this is on track for Nov '23 delivery

Key Gaps/ delayed actions:

➤ Action 6 – Development of SIP, the potential for slippage has been identified due to resource and capacity

Executive Responsible Officer: Executive Nurse
Executive Committee: Executive Safety Oversight Group
Board Committee: Board Safety Oversight Group and the Quality Committee

Actions

Action	By When	*By Who*	*Gap: Control or Assurance*
1. Deliver the Patient Safety Incident Response Plan	May 24	Moriam Adekunle	Controls
2. Deliver the Patient Safety Strategy (Safety First Safety Always) for year 3	End March 2024	Natalie Hammond	Road Map / Control
3. Complete automation of two dashboard elements – IWGC and health roster	October 2023	Matt Sisto Adam Whiting	Control
4. Implement Quality Improvement Programme	March 24	Richard James	Control
6. Complete safety improvement plans from thematic analyses	November 23	Moriam Adekunle	Assurance
7. Implement Lessons Identified Management System (ESLMS)	November 23	Moriam Adekunle	Control
8. Ensure good governance controls set up for monitoring to progress towards action closures and addition of controls	July 23	Steve Yarnold	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Patient Safety Incident Management Team and EPUT Lessons Team	Team fully established	Report Safety First Safety Always – Leadership	PSIRF first year review of early adoption
Forums	Learning Collaborative Partnership /Quality and Safety Champions Network	Reporting to LOSC/ Quality	Pan Essex CQRG
PSIRP; Complaints; Claims; Safety First Safety Always Strategy; Reducing Restrictive Practice Framework 2022-25	Policy Register / Reducing Restrictive Practice Framework 2022-25	PSIRF reports/ risk management reports/ complaints reports/ ESOG reporting cycle / Clinical Audits	IA Reviews inc PSIRF May 22
Range of learning platforms in place – thematic analysis/ EPUT Lab/ Quality Academy/ Lunchtime Learning/ Key messages / Quality and Safety Champions Network	EPUT Lessons Team and Patient Safety Incident Management Team /Intensive Support Groups in place	EPUT Lessons Learned Programme; LOSC; Care Unit Quality & Safety meetings Learning from deaths oversight	Pan Essex CQRG
Information Sharing	Lessons Identified Newsletter Communications strategy Induction videos	Reports to ESOG and BSOG /Culture of Learning Steering Group /LOSC	
Capital investment in patient safety	Progress on delivery of essential safety improvements	Report on enhancing environments	CQC CAMHS inspection safety improvements
Patient Incident Response Plan	Refreshed	ET Approval Shared with Quality Committee	Shared with ICB
Culture of Learning Programme	Launched with ongoing programme to embed in EPUT	Quality & Safety Champion Network	Learning Collaborative Partnership Group
Patient Safety Assurance Dashboard	Dashboard in place		

SR2: People

At a Glance:

If EPUT does not effectively address and manage staff supply and demand, then we may not have the right staff, with the right competencies, in the right place at the right time to deliver services, resulting in potential failure to provide optimal patient care/treatment and the resultant impact on safety/quality of care.

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the sit rep return; staff morale; availability of key staff; attendance at key training.

Initial risk score C5 x 4L = 20	Current risk score C5 x L4 = 20	Target risk score C5 x L3 = 15

Progress since last report:
- 151 Student nurses offered roles within EPUT upon graduation (start dates to be confirmed)
- RISE Programme Graduation celebrated this month.
- Re-application to Register of Apprenticeship Training Providers successful June 2023 and reporting as a current control.
- Optimisation of electronic staff records (ESR) project now concluded. Delivery is back into business as usual and system development and reporting as a current control.
- Self-service on ESR now live – to be reviewed in September 2023
- Action 2- Time to Care Programme approved in principle by Board moved into implementation for year 1 subject to funding.
- Action 3 Development of the People and Culture Strategy is on track for November 23.
- Action 4 Note timeline for Education and Learning Strategy amended to align with the overarching People & Culture Committee (Amber RAG as delayed beyond original timeline stated).
- Action 5 timeline extended – hot desk pilot at The Lodge to inform future plans. (Amber RAG as delayed beyond original timeline stated).
- Action 8a in progress and informing the People and Culture strategy development workflow.
- Action9– collated and analysed all data with work ongoing on outcomes of the analysis. Plan to present to Board seminar in Autumn 23

Key Gaps in Assurance:
- Action 5 – transformation support around estate and desk space becomes available at the end August 2023.
- Action 6 – policy is beyond its review date. A planned review timeline has been agreed with the Policy Oversight and Ratification Group (noting co-dependency on any changes being agreed with Staff Side)

Executive Responsible Officer: Executive Chief People Officer
Executive Committee: Executive Team
Board Committee: People, Equality and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
2. Time to Care Programme	Dec 23	Paul Scott, Chief Executive	Control
3. Develop People and Culture Strategy	Nov 23	Paul Taylor	Road Map
4. Develop, seek approval and implement Education and Learning Development Strategy	Nov 23	Annette Thomas-Gregory	Road Map
5. Review long-term strategy for smart working	Dec 23	Alesia Waterman	Control
6. Review dignity, respect and grievance policy	Sept 23	Debbie Prentice	Control
8a. Complete diagnostic (Excel tool) to benchmark areas of good practice, and needing improvement	Sep 23	Lorraine Hammond	Assurance
9. Complete wider piece of work to improve the experiences of minority staff	Dec 23	Lorraine Hammond	Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
HR Team/ People & Culture Directors / HR Policies	Leadership team fully established 6 Employee Experience Managers Policy Register		
Care Unit Staffing Plans	Workforce plans in place (based on establishment reviews) / Safer Staffing Sit Rep Meetings /Safer Staffing Dashboard	Safer Staffing Report / KPIs within the Quality & Performance Scorecard	CQC Inspections – Requirement to improve regularity of temporary staffing on inpatient wards.
Use of Bank and Agency Staff			
Recruitment and Retention Programme (Including International Recruitment	Vacancy rate 12.5% (0.5% above target) / IR 19 AHPS arrived 31 March '23 / 45 RMNs June '23 / 260 Bank Staff converted to permanent employment since Nov '21 Turnover 10.4%	Safer Staffing Report / KPIs within the Quality & Performance Scorecard	Workforce Plan – MSE System Oversight Assurance Committee
Workforce Plans and strategies	Establishment Reviews Framework for Health and Wellbeing Offer Employee Experience Plan	Establishment Reviews/; Health and Wellbeing Toolkit	CQC inspections; NHSE & System Workforce Returns / benchmarks
Training and Development for staff / Apprenticeship Provider	Training Tracker in place RISE Programme (completed) Education specific policies in place	KPIs within the Quality & Performance Scorecard	Staff Survey / RoAPT successful June '23 /Ofsted inspection July '22 – Good / IA reviews
Staff wellbeing	Engagement Champions Employee Experience Managers	Workforce reports to PECC EDI Sub Committee	Staff Survey and Quarterly Pulse Survey /Here for You Steering Group with ICB membership
Just Learning Culture	Behaviour framework Review of HR modules in MDP F2SU Guardian substantive appointment	Employee Experience report to PECC	Pilot programme with external partner /MSE Civility & Respect Steering Group /H&WE Restorative Just Culture Steering
Equality and Inclusion Framework	Executive led sponsor for networks ED&I objectives in appraisal Racial abuse guidance for staff and debriefs	WDES reporting WRES action plan rated as outstanding By NHSE	

SR3: Finance and Resources Infrastructure

At a Glance:

If EPUT does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high quality care resulting in not attaining our safety, quality/ experience and compliance ambitions

Likelihood based on: the possibility of not having the right estate and facilities to deliver safe, high quality care
Consequence based on: the potential failure to meet our safety, quality/ experience and compliance ambitions

Initial risk score	Current risk score	Target risk score
C5 x 3L = 15	C5 x L3 = 15	C5 x L2 = 10

Progress since last report:
- Action 3- Existing estates structure and proposed requirements under review. Estates vacancies being recruited and appointed
- Apprentice and waste manager posts enabled
- Action 2 - Draft Commercial Strategy circulated to Executive for review.

Key Gaps
- Commercial strategy final version will be September 2023.
- Note new action on business planning for additional estates resource.

Executive SRO: Trevor Smith, Executive Chief Finance and Resources Director
Executive Committee: Executive Team, ESOG
Board Committee: BSOG, Finance and Performance Committee, Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
2. Develop Commercial Strategy	June 23 Draft released. Final September 2023	Liz Brogan Lauren Gable	Roadmap
3. Develop Estates Strategy & Development Plan	December 23 (align overlays)	Lauren Gable	Roadmap
4. Undertake procurement review	March 24	Liz Brogan/ Richard Whiteside	Control
5. Review tenancy responsibilities/ leased property risks, staff vs property owner accountability, PFI contract deficiencies	December 23	Lauren Gable Martin Whiteside	Control
6. Business case related to additional estates resource to be prepared prior to budget setting round for 2024/25	March 24	Linda Martin	Control – full establishment

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
EPUT Strategy		Board approval Jan 23 *Bi annual reporting to BOD Touch point Nov '23 Accountability framework*	
Operational Target Operating Model	Care Unit Leadership in place and Accountability Framework Established	AF Meetings established Transformation and Finance Teams restructured to align	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to ESOG Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register Performance Governance Framework in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO	In place	Audit Committee	
Premises Assurance		Premises Assurance Model in place with assessment	
Business Continuity Plans	Business Continuity Plan in place		

SR4: Demand and Capacity

At a Glance:

If we do not effectively address demands, then our resources may be over-stretched, resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions.

Consequence based on: Mismanagement of patient care and length of the effects.
Links to both inpatient and community.
Likelihood based on: Length of stay, occupancy, out of are placements etc.

Initial risk score C5 x 4L = 20	Current risk score C5 x L4 = 20	Target risk score 5 x 3 = 15

Progress since last report:
Making good progress with a week on week reduction in OoAPs – however due to ongoing industrial action and closure of capacity due to required refurbishment the risk score remains same pending further review for next reporting period).
- New Safety KPI dashboard in place
- Action 3: Signed off by MK. moving forward with system change and due to launch, with follow up training piece for junior doctors
- First Improving Flow Operational Group has taken place following repurposing of Purposeful Admissions Group. Completed Workbook in Terms of Reference and Governance Structure. Meeting schedule in place.
- Adult MH Clinically Ready for Discharge (formal and informal) below national benchmark at 1.6%
- Significant positive reduction in inappropriate out of area beds from 81 end of April to 35 end of June (excluding Danbury and Cygnet appropriate beds)
- MH discharge follow up within 72 hours above target May 23
- Bed modelling work is in progress supported by KPMG
- Time to Care signed off by Board June'23
- Readmission rates are below mental health target 3% as at May 23
- Adult occupancy rates decreased to 94.8% in May
- Flow team appointments with Clinical Flow Lead
- Recommended reduction in current and target scores

Key Gaps:
- Prolonged bed closure summary outlines gaps in bed stock control (not including short-term closure for minor estates work.
- Pending Time to Care implementation –staffing and digital
- 47% increase in referrals in June to North East single door – consistent increase in demand.

Executive Responsible Officer: Alex Green, Executive Chief Operating Officer
Executive Committee: SMT
Board Committee: BSOG, Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Time to Care Programme	December 2023	Alex Green	Control
3. Ensure recording of DTOCs on EPRs	July 23	Flow and Capacity Leads/ Bibi Hossenbux	Assurance
4. Analysis piece on demand vs capacity (Phase 1 May '23 – further phases to be advised)	Phase 1 May 23 with further phases to be advised	Jan Leonard/ Sue Graham	Control
5. Delivery of the overarching UEC/Inpatient MH Flow Action Plan 5.1 Implement Governance 5.2 Classification of OoAP contracted beds 5.3 Oversight on patient flow and OoAP 5.4 Improving Sit Reps 5.5 Discharge Co-ordinators 5.6 Reducing variations across wards 5.7 GIRFT Ambition 5.8 System Transformation supporting alternatives to admission	Dec 23	Detailed actions have individual leads	Control

See next slide for controls

SR4: Demand and Capacity (controls)

	Controls Assurance		
Key Control	**Level 1** *Department*	**Level 2** *Organisational Oversight*	**Level 3** *Independent*
Operational staff (including skilled flexible workforce via Trust Bank)	Establishment and fill rate; Discharge Co-ordinator Director of Operational Performance Activity Co-ordinators; Staffing Sit Rep/ fill rates Trust Bank Office – agency framework in place	Performance reporting to Accountability Framework meetings and F&PC Use of agency staff monitored via performance report Workforce Reports	
Recruitment and Development of the Care Unit leadership structures.	Establishment Integrated Director posts		
Target operating model/ care unit development, Accountability Framework, Safety First, Safety Always Strategy, Flow and Capacity Policy, MAST roll out	Dedicated discharge coordinator	Accountability meetings Safety First, Safety Always end of year 2 report to Board March 23	
MH UEC Project, MSE Connect Programme, Partnerships, Mutual Aid, Time to Care initiative, New ways of working and new digital solutions	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service dashboards Daily sit reps Range of performance reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets Datix and EPR	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Discharge Co-ordination Teams	Monthly reviews Clear treatment plans Multi-Disciplinary meets	Dashboard in place and reported	System escalation of DTOCs
Skilled temporary workforce via Trust Bank	Bank establishment		
Business Continuity Plans	Emergency Planning		
Therapeutic Acute Inpatient Operating Model for Adult and Older Adult Steering Group (formerly purposeful admissions group)	Therapeutic offer on wards Terms of Reference Governance in place Project/ Action plan in place	SMT and Accountability meetings Capacity and flow work stream Overarching patient flow action plan in place and discussed in Steering Group and utilised for risk register	
Care Unit Strategies	Developed including out of area plan	Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System escalation in place
Bed stock	157 North Adult beds 44 North Older Adult beds 89 South Adult beds 66 South Older Adult beds 24 Contracted appropriate OoAP beds		
Operational Plan 2023/24	Accountability outcomes	Performance reports Flow and capacity metric reporting	
MAST (Management and Supervision Tool)	CPA review performance	Performance reporting	
MSE Connect Programme	UEC in place		
Business Continuity Plans	In place		

SR5: Statutory Public Inquiry

At a Glance:

If EPUT is not open and transparent, with the correct governance arrangements in place then it will not serve the Inquiry effectively or embed learning from past failings resulting in undermining our Safety First, Safety Always Strategy

Consequence based on: National media coverage, parliamentary coverage and a total loss of public confidence
Likelihood based on: the possibility that the Trust cannot effectively meet the requests of the Inquiry nor embed earning, resulting in damage to its reputation and potentially poor CQC ratings

Initial risk score C5 x 4L = 20	Current risk score C5 x L4 = 20	Target risk score C5 x L2 = 10

Progress since last report:
- Long term responsibility for implementation of actions and progress sustainability will sit with the Care Units' Accountability Framework meetings. Working group closed.
- Action 1: is part of the Records Management Accreditation process
- New Action 2: Key Director and Executive director leads identified and recommended to BSOG for the meeting in July 2023
- On 28 June Secretary of State acknowledged the improvements and investments made by the Trust. However, the Secretary of State has converted the status of the Inquiry to a Statutory Public Inquiry under the Inquiries Act 2005

Key Gaps:
- The Secretary of State also announced the change to the Chair of the Inquiry and potential review of the Terms of Reference. At this stage it is unclear whether the Chair will be in place before the Summer recess.
- As a result of the uncertainty in the change of status and Chair this risk has a recommendation to increase the score to 20.

Executive Responsible Officer: Nigel Leonard, Executive Director, Major Projects
Executive Committee: Executive Team
Board Committee: BSOG, Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. EPUT should assure itself that its information processes and systems are fit for purpose, and controls around data input and records management to be reviewed across the Trust to minimise risks associated with information recording and management going forward.	March 24 for completion of actions	Gill Brice/ Working Group	Control/ Assurance
2. Key historical SI themes to be embedded within safety and quality initiatives across the Trust.	October 2023	Angela Wade/ Moriam Adekunle	Control/ Assurance

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Project Team Independent Director and Independent Medical Consultant Advisor	Establishment Expanded to meet increased ask	EOC and Audit Committee oversight	Independent Director and Independent Clinical Advisor in place
Internal methodology for working with inquiry	In place	In place and used for reporting Project Group overseeing	As above
Inquiry Terms of Reference MOU and Information Sharing Protocol	In draft		
Learning Log	Log in place	In place and used for reporting to ET Audit Committee and BOD	
Exchange portal in place to safely transfer information to the inquiry	Data protection impact assessment	Reporting in place	Independent Director and Clinical Advisor
Deep dive into sample of deaths in scope over 20 year period	Completed		
Deep dive in 13 prevention of future death notices	Completed		
Audit on Learning from Independent Inquiry	Completed	Assurance checks completed and presented to Executive Team – approved ongoing assurance through Care Unit Accountability Frameworks	IA – opinion Moderate for Design and Effectiveness

SR6: Cyber Security

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If we experience a cyber-attack, then we may encounter system failures and downtime, resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage.

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.
Consequence based on: assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

Progress since last report:
➤ Action 1: Appointed substantive permanent Cyber Assurance Manager with a start date of 12th June

Key Gaps:
➤ Action 3: one outstanding risk – Windows/SQL 2008 server – highlighted to Audit Committee. Upgrades are planned, currently in use acceptance testing phase. Planned for August 2023.
➤ Business continuity plans remain a gap whilst they are in progress. Date changed to December due to complexity of system configuration.

Executive Responsible Officer:
Zephan Trent, Executive Director Strategy Transformation and Digital
Executive Committee: IG Steering Group, Digital Strategy Group
Board Committee: Audit Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Appoint to substantive Cyber Governance Manager	Sept 23	BDO	Assurance
2. Develop business continuity plan and disaster recovery for each system (using third party)	Dec 23	Adam Whiting Deputy Director, ITT and Business Analysis and Reporting	Controls and Assurance
3. Complete actions from IT Security Health Check and Penetration Testing	Aug 23	Adam Whiting	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Permanent post recruited to – staff member in post from 12 June	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; BDO internal audit May 22 – overall Moderate Confidence level Medium	As above MSE ICS IG & Cyber Levelling Up Project (annual) BDO Audit actions completed
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT Areas identified for upcoming BDO Audit
Business Continuity Plans and National Cyber Team processes	BCP development plans in progress – due date Dec 23	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	Audit Committee	DPST BDO audit completed, recommendations accepted and in plan

SR7: Capital Resource

At a Glance:

If EPUT does not have sufficient capital resource, e.g. digital and EPR, then we will be unable to undertake essential works or capital dependent transformation programmes, resulting in non achievement of some of our strategic and safety ambitions.

Likelihood based on: percentage of capital programme unable to deliver / deferred
Consequence based on: what not delivered and the impact on the strategic plans.

Initial risk score C5 x 4L = 20	Current risk score C5 x L4 = 20	Target risk score 5 x 3 = 15

Progress since last report:
➢ EPR programme structure and governance – progress updated 07 June 23 around convergence between EPUT and MSEFT

Key Gaps:
➢ None to report

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
2. Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	Lauren Gable	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£New resource secured	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2023/24 in place		
EPR Programme			Progress published June 23 outlining programme structure and governance principles and timelines EPR Oversight Committee Convergence and

SR8: Use of Resources

Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources, then it may not meet its financial controls total, Resulting in potential failure to sustain and improve services.

Likelihood based on: EPUT financial risk and opportunities profile
Consequence based on: assessed impact on long financial model for EPUT and the System

Initial risk score	Current risk score	Target risk score
C5 x 4L = 20	C5 x L4 = 20	5 x 3 = 15

Progress since last report:

- Dedicated time in transformation group around efficiencies.

- Enhanced control measures agreed in principle.

Key Gaps:

- Action 1 - Residual efficiency (circa £1m) and recurrence of delivery.

Executive Responsible Officer: Trevor Smith, Executive Chief Finance and Resources Officer
Executive Committee: Executive Team
Board Committee: Finance & Performance Committee

Actions

Action	By When	By Who	Purpose
1. Identify remaining efficiency savings	July 2023	Simon Covill	Control
2. Deliver Financial Efficiency Target	31 March 2024	Trevor Smith	Control
3. In year forecast outturn (FOT) and associated risk and opportunities assessment	End of Sept '23 and Monthly thereafter	Simon Covill	Assurance
5. Deliver Operational Plan 2023/24	March 2024	Alex Green / Trevor Smith	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (Sep '22) Substantial opinion and Costing (March 2023).
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	
Finance reporting	Finance Reports AF Reports	EA of Accounts	SOF Rating
Budget setting	Completed mid year financial review and continues to forecast breakeven position. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2023/24			
Forecast Outturn and risk/ opportunities assessments 2023/24			

06 – Corporate Risks

July 2023

CRR94: Engagement and Supportive Observation

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not manage supportive observation and engagement; then patients may not receive the prescribed levels; resulting in undermining our Safety First, Safety Always Strategy.

Likelihood based on the probability of patients not receiving prescribed levels of observation and engagement

Consequence based on not meeting our Safety First Safety Always ambitions

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L4 = 20	C5 x L2 = 10

Progress since last report:
- All actions on track, action 5 timescale has been extended to October 2023 due to staff sickness (Amber RAG as action delayed beyond original stated timeline)
- Undertaking analysis following CQC report (12 July 2023) which identified further support needed for staff in undertaking engagement and observation in line with Trust Policy. This may lead to additional actions being added to this entry on the CRR.
- Observation policy has been reviewed, consulted on and receiving feedback, this is now with LEA for final draft with sign off in August 2023 Policy being focus on engagement including new resource tools and a socialisation plan has been developed.

Key Gaps:
- CQC (12 July 2023) reported that all observation and engagement activity was being undertaken by staff in line with EPUT policies.

Executive Responsible Officer: Executive Chief Operating Officer
Executive Committee: Executive Operational Committee
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Safe Wards to be implemented	Dec 23	KD and Ward Staff	Control
2.1. Commence delivery of training for regular and non-regular staff	Sept 23	KS and LEAS's	Control
3.1 Launch the grab therapy resources in tandem with training and updated policy	Sept 23	KS and LEAS's	Control
4. Increased garden access and garden gyms	Aug 23	Katy Stafford	Control
5. QI project Linden Centre	Oct 23	Rachael Poland/ KS	Control
7. Carers to support in production and delivery of training	Sept 23	Katy Stafford	Control
8. Patient personalised engagement boards (each patient to display a poster board of things they like to talk about/ do for staff prompts)	Completed Round 1 Pilot	All Ward Leaders	Control
10. Patients and Carers to co-produce engagement video at same time as releasing updated policy and training	August 23	Katy Stafford	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Engagement and Observation Project	Project Group	Plan Complete/ Group Closed	
Observation/ Engagement Policy and Training	Observation and Engagement Policy in place Observation and Engagement e-learning and training videos Rolling programme of staff supervision and other 1:1s to improve confidence	CG&QC / Accountability	
Ward Level Oversight	15 leadership steps Oversight of rosters Safety Huddle focus on Therapeutic Engagement and Observation priorities	Tendable Audits Patient led safety huddles (Basildon)	
Electronic observation recording tool	In trial stage		
Resources to improve therapeutic engagement / Ward improvements	Purchase of equipment e.g. games and newspapers for groups		

CRR11: Suicide Prevention

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services; then it may not track and monitor progress against the ten key parameters for safer mental health services; resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers

Likelihood based on possibility of not progressing against the ten key parameters for safety mental health services
Consequence based on not taking the correct action

Initial risk score	Current risk score	Target risk score
C4 x L4 = 16	C4 x L3 = 12	C4 x L2 = 8

Progress since last report:
- Action 1: Updated with proposal being engaged with Care Units one month delay to originally stated timeline as co-dependent on action 4 and 5 being finalised.

Key Gaps:
- One month slippage to actions.

Executive Responsible Officer: Executive Medical Director
Executive Committee:
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implementation of revised strategy, work plan and dashboard	July 2023	Nuruz Zaman	Roadmap
3. Review approach to Safer Wards and Ligature risk	July 2023	Glenn Westrop	Control
4. Work with care groups to develop new governance arrangements around suicide prevention into Suicide Prevention Group terms of reference	July 2023	NZ/SPG/GW	Control
5. Work with care groups to review and amend Suicide Prevention Group Terms of Reference	July 2023	NZ/SPG	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Identified Medical Lead	In place	Support via Human Engine and DDQS	
Annual report	Identification of four key priorities		
Suicide Prevention Strategy 2021-23 and revision of strategy	Suicide prevention group Roadmap in place	Overseen by Mortality Sub-Committee Alignment with Safety First Safety Always Governance in place Partnership with Human Engine	Feedback from ICS leads System transformation programmes and system wide suicide prevention group
Rolling communication plan and engagement with staff	Breaking the Silence Safety Plans 10 ways to improve safety	Monitoring in place National Patient Safety Day	
Local reflective sessions	In place		
Oxehealth digital monitoring	In place		
Suicide prevention training			
Suicide prevention outcome measures	Zero instances of preventable deaths 19.3% downward trend in instances of self-harm	95% patients have Personal Safety Plan 95% patients have 48 hours follow up post discharge from an in-patient ward Bio-psychosocial assessment Training trajectory Quality Committee	Monitoring delivery and annual assessment against NCISH toolkit
Self-harm reduction	Pilot project completed with success and evidence		
Focus groups with patients and families and research into family involvement in suicide	Complete and ongoing		

CRR34: Suicide Prevention - Training

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not train and support staff effectively in suicide prevention; then staff may not have the necessary skills or confidence to support suicidal patients; resulting in self-harm or death and a failure to achieve our safety first, safety always strategy

Likelihood based on the possibility of staff not having the necessary skills and confidence

Consequence based on a failure to prevent suicide and achieve our safety ambitions

Initial risk score C3 x L3 = 9	Current risk score C5 x L3 = 15	Target risk score C3 x L2 = 6 Sep 23

Progress since last report:
➤ Action 3: Conversation with STORM licence provider on 8 June to discuss the alternatives in light of the strict licence conditions in place. Beginning the process of completing the required information to update our agreement to complete the process but do not envisage any issues

Key Gaps:
• Action 2 – potential one month delay in completing the trajectory

Executive Responsible Officer: Executive Medical Director

Executive Committee: ESOG
Board Committee: .Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Expand the capacity of trainers to deliver STORM training	Sep 23	AT-G	Control
2. Develop improvement trajectory and report on suicide prevention training	July 23	Nuruz Zaman AT-G	Assurance
3. Conversation with STORM about use of licence with temporary staff	July 23	AT-G	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Trainers	Recruited 8 trainers and 8 more being trained in New Year on STORM. Licenses in place. Facilitators trained.		
Training	7 x 2 day courses held on line; schedule arranged for 2023 Interim refresher course Rolling programme on STORM training	Targeting inpatient units offering a blended approach MH/LD network discussion on suicide prevention training	
Suicide prevention strategy	Sets out training requirements overseen by Suicide Prevention Group	Reporting to Mortality Sub-Group, ESOG, QC Annual Report	
Quality improvement project	In place and addressing barriers on completing suicide prevention training		

CRR45: Mandatory Training

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements

Likelihood based on possibility of compromising patient and staff safety
Consequence based on scrutiny by regulators and not meeting statutory requirements

Initial risk score C4 x 3L = 12	Current risk score C4 x L4 = 16	Target Score 4 x 3 = 12 Dec2023

Progress since last report:
- Action 1 – recovery plan continuing – executive approval of incremental approach to reinstating annual training updates.
- Action 2 – remains on track for September '23
- Action 3 – training tracker in place and monitored by Care Units and Directorates.

Key Gaps:
- Annual updates creates challenge on training venues and resources.

Executive Responsible Officer: Director of People and Culture
Executive Committee: Executive Operational Team.
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Implement recovery plan	Nov 23	Training Team	Assurance
2. Review mandatory training policy	Sept 23	Annette Thomas-Gregory	Control
3. Ensure staff do not expire on their training all at the same time by spreading compliance across the year	Nov 23	Annette Thomas-Gregory	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Training Team	Established – current resource 8.5WTE TASI trainers increased		12 month TASI accreditation from BILD
Induction and Training Policy	Policy system Current policy reflects current practice		
Training Tracker	Managers check and provide oversight.	Reporting of training to PECC	
Training recovery plan	Team switching staff incrementally to an amber rating giving 3 months to complete training Recovery plan on TASI	Training venues Executive team approval to incremental approach to annual updates Task and Finish Group Communications strategy Executive team oversight on STORM training update and compliance	BILD
Flexible workers	Equal priority on mandatory training		
Monthly reporting to ET		Accountability. F&PC and PECC, SMT and TB	
Training Venues (ongoing programme)	Training room identified at The Lodge		

CRR77: Medical Devices

At a Glance:

If EPUT does not track missing/ unregistered medical devices or address the clinical rationale/ pathway; then unsafe, non-serviced, non-calibrated and inappropriate devices may be in use; resulting in a failure to achieve our safety ambition.

Likelihood based on probability of inappropriate devices being in use
Consequence based on failure to meet our safety ambitions

Initial risk score C4 x L4 = 16	Current risk score C4 x L4 = 16	Target risk score C4 x L2 = 8 July 23

Progress since last report:

- **Action 8** – agreed from closure this month as the Deputy Directors of Quality and Safety have been linked into medical devices via the Physical Health Group.
- **Action 5**: As reported within the May BAF discussions have now taken place and the action timeline has been extended from June '23 to September '23 to capture the output of the deep dive (action1) and recruitment of the Medical Devices Safety Officer. (Note: Marked with an Amber RAG due to the extension of original action).
- **Actions 9 and 10**: Shortlisting complete and interviews undertaken. Timeline extended to September '23 when candidates are planned to commence in post. (Note: Marked with an Amber RAG due to the extension of original action)

Key Gaps:
- CQC identified an un-calibrated blood glucose monitoring machine on their inspection

Executive Responsible Officer: Executive Chief Nursing Officer
Executive Committee: Medical Devices Group
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Procure a 'Deep Dive' in order to focus actions from recommendations in internal audit report	Sept 2023	Nick Archer	Assurance
1a. Implement the solutions from the outcomes of the deep dive	Mar 2024	Nick Archer	Control
2. Options appraisal for Capital replacement programme and Medical device replacement strategy	Sept 2023	Nick Archer	Control (Resource)
5. Review of Policy and Procedure to ensure clear process and monitoring set out	Sept 23	Nick Archer	Control (Policy)
6. Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Sept 2023	Nick Archer	Control (training)
7. Introduce point of care testing to avoid use of equipment that is not calibrated or serviced	Sept 2023	Nick Archer	Control
8. Link in with new Deputy Directors of Quality & Safety	Complete	Nick Archer	Control
9 . Appoint Medical Devices Safety Officer Band 6	Sept 2023	Nick Archer	Control (Resource)
10. Appoint Administration Support Band 3	Sept 2023	Nick Archer	Control (Resource)

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance.	Established Nominated Central Alert System person		
Medical Devices Group	Established	Overseen by Medical Devices Group and Physical Health Sub-Committee	
Ergea contract for device maintenance	Medical Devices Group oversight of Monthly KPI Report		
Procurement process in place Medical Devices Policy	eQUIP Asset Register	Tendable audits – medical device safety / management	Internal Audit Report 2021/22 (Moderate / Limited Assurance)
Incident Reporting	In place	Performance monitoring	
Business Continuity Plans	Ergea BCP		

CRR81: Ligature

At a Glance:

If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions

Likelihood based on possibility of serious incidents
Consequence based on failure to meet safety ambitions

Initial risk score C4 x L3 = 12	Current risk score C5 x L3 = 15	Target risk score C4 x L2 = 8 September 23

Progress since last report:

- Action 3 Moved to control with new estates programme agreed each year, supported by risk stratification document and Capital Projects Board
- Action 3: Garden standards moving towards finalisation
- Action 4 – programme of technical solutions underway, potential slippage highlighted below
- Action 5: full refresh of the environmental risk stratification document being undertaken, timescale to be reported to LRRG in August 2023.
- Action 6: Piloting on 1 ward

Key Gaps:

- Role that includes Ligature Co-ordinator is currently vacant
- Action 4: slippage co-dependant on PFI provider
- Number of ligature actions overdue following ligature inspections
- Incident on a Ward resulting in patient death via anchored ligature 2023

Executive Responsible Officer: Executive Chief Finance Officer / Executive Chief Operating Officer

Executive Committee: Executive Safety Oversight Group
Board Committee: BSOG Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Identify new system for recording ligature actions (overseen by Project Group)	September 23	Chris Rollinson Project Group Lead	Control
2. Ensure EPUT environments meet environmental standards	June 23	Linda Martin Director of Estates	Control
3. Review standards on outdoor garden furniture	August 23	Linda Martin Director of Estates	Control
4. Enhancing Environments	March 24	Linda Martin Director of Estates	Assurance
5. Review environmental risk stratification document	August 23	Linda Martin Director of Estates	Control
6. Pilot the in house training project for a year followed by evaluation	September 23	Project Team	Control

Controls Assurance

Key Controls	Level 1 Function/ Department Management	Level 2 Organisational Oversight	Level 3 Independent Assurance / Internal Audit
Estates Ligature/ Patient Safety Co-ordinator / H&S Team and Compliance Team / LRRG / Ligature Project Group / Local Area Ligature Network	Teams established and operational governance forums established. Ligature Risk Reduction Group chaired by Executive Director of Operations. Dashboard of top four Trust priorities.	Reporting to ESOG and BSOG (Including KPI and Dashboard oversight) SPC analysis ligature incidents Mar '21 – Mar '23: Adult inpatients a period of reduction Apr'22 – Feb '23 remaining on average slightly above the national benchmark of 42 per 10,000 bed days.	Most current IA (BDO) November 2022 (Patient Safety) provided an opinion of Design: Substantial; Effectiveness: Moderate Actions completed from BDO IA 2022. Actions completed from the CQC Brief Guide.
Ligature Policy and Procedure including environmental Standards	Annual ligature inspections for al MH wards- mitigation statements signed off by ward managers. Ligature wallet audits	Ligature Risk Management Annual Report	Most current IA (BDO) November 2022 (Patient Safety) provided an opinion of Design: Substantial; Effectiveness: Moderate
Ligature Training (target 85%) and Tidal training	138 staff trained (107 clinical) in TIDAL training (face to face ligature environmental training) with offer extended to all Band 4 staff and above to increase awareness. Support package developed & debriefing by senior team. Staff signposted to wellbeing support services and after action reviews carried out when an incident occurs.	Ligature Training 88% Compliance June 23 (above target)	

CRR92: Addressing Inequalities

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions

Likelihood based on possibility of not embedding equality and diversity
Consequence based on a failure to meet our people plan ambitions

Initial risk score C5 x 4L = 20	Current risk score C4 x L3 = 12	Target risk score C3 x L2 = 6 Nov 24

Progress since last report:

- Action 1: £40k ring-fenced from budget to source Inclusive Employers to create modules for Race Equality, EDI and Active Bystander training as well as Disability and Faith. This is in development and achieving full implementation in October '23. (Amber RAG as extension to original timeline)
- Action 1: Discussions taking place with Digital Training Team to ensure compatibility with EPUT systems.
- Action 1: Existing OLM courses and EPUT resources compiled into online staff resource
- Action 2: Staff Charter is a set of behaviours for staff to follow. Providers will undertake training for an on-line course on positive cultures and bite size courses will be on offer
- Action 2: The Behaviour Framework now threads through all relevant leadership and management programmes and courses
- Action 2: Policies and procedures updated
- Action 2: Ongoing socialisation and supporting positive cultures in place
- Micro-incivilities pilot workshops completed and moved to controls
- EDI framework developed and moved to controls– new action 3 added

Key Gaps:

- Feedback required from Micro-incivilities workshops to inform roll-out
- New action 3 added relating to updating the EDI framework
- Action 2: Update on kite mark from OD
- Action 3: Timescale required

Executive Responsible Officer: Executive Director of People and Culture
Executive Committee: Equality and Inclusion Sub-Committee
Board Committee: People and Culture Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Improve EDI learning offer for EPUT	Oct 2023	Lorraine Hammond	Control
2. Implement EPUT Staff Behaviour framework	Complete	Organisational Development	Control
3. Update the EDI framework following launch of NHS EDI Improvement Plan	Oct '23	Gary Brisco/ Lorraine Hammond	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Employee Team including Director	Established and 6 Employee Experience Managers in post. Project started with single front door.	Project resource Working with VAPR and safety teams	
Equality and Inclusion Policies	Policy System	Equality and Inclusion Sub-Committee with Exec lead PECC	
Range of equality networks and staff engagement methods	Established	Equality and Inclusion Sub-Committee	WRES and WDES (actions identified)
RISE Programme	In place	3 cohorts completed	Positive staff feedback
WRES and WDES	Strategy in place	Action plans approved Executive sponsorship of plans and networks Monitoring through ED&I Sub-Committee Assurance through PECC	
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying	Alignment with EPUT Strategy	
Training	Pilot workshops on micro-incivilities completed		
EDI Framework RAG system	Developed		

CRR93: Continuous Learning

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT does not continuously learn, improve and deliver service changes then patient safety incidents will occur and vital learning lost resulting in failure to achieve our safety strategy ambitions and maintain or improve CQC Good ratings

Likelihood based on the possibility of losing vital learning and patient safety incidents recurring

Consequence based on failure to meet safety ambitions and non-compliance with CQC fundamental standards

Initial risk score	Current risk score	Target risk score
C5 x L3 = 15	C5 x L3 = 15	C5 x L2 = 10 March 24

Progress since last report:

- Overdue action 3 - PSIRP documents have been socialised with stakeholders with comments returned and final process to executive team in August 2023 for a September Launch. (Note revised timeline marked as amber RAG as delay beyond original stated timeline).

- Action 4 – The Quality and Safety Champion role has been established, with 84 people on the register. There is an ongoing awareness campaign to continue to increase the numbers. (Note new action 7).

Executive Responsible Officer:
Executive Chief Nursing Officer

Executive Committee: Executive Safety Oversight Group.
Board Committee: Quality Committee

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Review Human Engine process maps to incorporate into patient safety incident team standard operating procedure	Aug 23	Moriam Adekunle	Control
2. Develop and implement EPUT Safety and Lessons Management System (ESLMS)	Nov 23	Moriam Adekunle	Control/ Assurance
3. Review PSIRP process	Sept 23	Moriam Adekunle	Control
4. Develop and embed Quality and Safety Champions Network to support embedding the culture of learning	Complete	Moriam Adekunle	Assurance
5. Link into UCL partnership who are implementing a range of collaboratives as part of MH Safety Programme	Sep 23	Angela Wade	Control
6. Develop QI methodology	Mar 24	Moriam Adekunle	Control
7. Ongoing awareness campaign to continue to increase the number of Quality and Safety Champions and embed the network	Mar 24	Moriam Adekunle	Control

Controls Assurance

Key Control	Level 1 Department	Level 2 Organisational Oversight	Level 3 Independent
Patient Safety Incident Management Team	Established Deputy Director appointed	Governance structure in place Training in place	
Quality and Safety Champion Network	In place 84 people registered (June '23)		
Learning Collaborative partnership meeting and Learning Oversight Committee	In place	Reporting to ESOG and Quality Committee	Pan Essex CQRG
Adverse incident policy inc PSIRF SOP and People and Culture Policies	Policy system	Staff engagement and co-production of framework principles aligned with Trust values	
Range of initiatives via culture of learning project	Range of evidence in place to support (on master doc) Communications plan	Monitoring of hits on various forums Reporting to ESOG/ BSOG ECOL Steering Group etc.	Internal audit completed – on Learning from Independent Inquiry March 23. Outcome: Design Moderate; Effectiveness Moderate
Themes allocation to clinical/ assurance/ transformation groups			
Learning information sharing	Range of evidence in place (on master doc)	Range of oversight, monitoring and reporting in place	
Patient Safety Dashboard	In place (Feb 23) Triage and early warning tool Power BI Workshops with key leads		

CRR96: Loggists

NHS
Essex Partnership University
NHS Foundation Trust

At a Glance:

If EPUT is unable to increase number of trained loggists and increase hours of availability for 24/7 then there may not be sufficient loggists available to log a major incident resulting in poor decision/ action audit trail in the event of a major incident occurring.

Likelihood based on the probability of insufficient loggists
Consequence based on poor audit trail of decisions and actions

Initial risk score C4 x L4 = 16	Current risk score C4 x L4 = 16	Target risk score C4 x L1 = 4 (September 2023)

Progress since last report:

Action 1: Loggist training now available from the region (our EPRR staff were prioritised). The Trust Emergency Preparedness, Resilience and Response / Compliance Manager has completed training which now provides the capacity to deliver in-house loggist training.

Action 2: Is at risk as drafted proposal to increase the number of staff who are defined as 'loggists' and therefore require training is being further reviewed prior to formal presentation to the Executive Team.

EPRR Annual Report 2022-23 notes that there were 8 EPRR events during the year whereby the command post was stood up to successfully manage each event; and all were logged in the period (assurance that mitigations are holding)

Key Gaps:
EPUT has four trained loggists available; with mitigation through the use if required of senior members of the Risk and Compliance Directorate (noting capability through experience gained through the COVID pandemic – not formally trained loggists).

Executive Responsible Officer:
Executive Director of Major Projects
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Establish in-house training capability	July 23	Nicola Jones Director of Risk & Compliance	Control
2. Develop proposal to increase number of loggists	July 23	Nicola Jones Director of Risk & Compliance	Control
3. Deliver Loggist training as per training needs analysis.	TBC	Amanda Webb EPRR/ Compliance Manager	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pool of trained loggists including EPRR team and Executive Director PA's	All EPRR incidents have been logged to date	Command structure	
Loggist Training	Available from NHS East of England Region		
Major incident policy	Board approved Major Incident Policy in place		

CRR98: Pharmacy Resource

NHS Essex Partnership University NHS Foundation Trust

At a Glance:

If EPUT is unable to fill new and pre-existing positions within Pharmacy Services then there will be a protracted period of operating within business continuity leading to a reduced pharmacy service to our care units and potential impact on the wellbeing of our staff.

Consequence of 4 is severe due to the possibility of significant service disruption and significant workforce shortages. Possible increase in Datix reports due to a range of issues (pharmacy as a contributing factor) Complaints increasing from clinicians.
Likelihood of 5 is almost certain as our ability to deliver a comprehensive pharmacy service to EPUT patients falls far short of business as usual

Initial risk score C4 x L4 = 16	Current risk score C4 x L5 = 20	Target risk score 4 x 2 = 8 (March 2024)

Progress since last report:
The Pharmacy Service continues to progress with the recruitment campaign with the pipeline of new starters coming into post commencing (1.8WTE in month).
➤ Currently recruited and in post is 23.8 WTE
➤ Number of posts under offer (normal notice) all with start dates July, August and September 2023.
➤ Number under offer (exam dependent) 5.4 WTE (3 WTE expected to start August 2023 and 2.4 WTE in January 2024)
➤ Shortlisting and interviews pending 1.0 WTE
➤ Open adverts 6.7 WTE

Analysis of Datix data on pharmacy related incidents (as an assurance) is now available using the Datix Dashboard .

CQC report (12 July 2023) highlighted the trouble in recruiting to Pharmacy roles, acknowledged the business continuity plan and noted '..however this did not have impact on patient care and staff were able to access pharmacy advise via telephone when required'.

Key Gaps/ delayed actions:
➤ Current number of vacancies 21.6 WTE
➤ Posts currently with no applicants 4.7 WTE (increase in month)
➤ Reported to the Quality Committee (July 2023) impact of protracted business continuity on pharmacy support for clinical trails

Executive Responsible Officer: Executive Nurse
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

Action	By When	By Who	Gap: Control or Assurance
1. Continue with recruitment campaign	Ongoing	Director of Pharmacy	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Pharmacy team	Part establishment Post established to support new registrants	Report to Executive Team secured additional funding for pharmacy resources	Collaboration with HEE and HEIs to develop a sustainable pipeline of staff
Use of bank and agency staff	Support from ICB secondment of pharmacists part-time		
Support from patient experience team			
Rolling recruitment programme	£300k substantive staffing agreed – implementation in progress to fill posts	Reporting to Executive Team Performance reporting	
Business Continuity Plan	Using Datix dashboard for pharmacy related incidents and monitored by pharmacy		

CRR99: Safeguarding Referrals

At a Glance:

If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patients' needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation

Initial risk score C4 x L4 = 16	Current risk score C4 x L4 = 16	Target risk score C4 x L2 = 8 March 24

Risk score is high based on just being managed at present but is not sustainable. Safeguarding discussing with operational senior managers how to address the risk and resources to mitigate it.

Progress since last report:

Action 1 – Complete. Datix categorisation and sign off reviewed. The sign off process is with team manager and second sign off with safeguarding team.

The number of open safeguarding enquiries remains high and is exacerbated by the complexity of cases taking a lot of time resource to complete.

The safeguarding team is sending out caseload reports to managers informing them of outstanding cases.

Key Gaps:

There is no additional funding for safeguarding resource available from operational teams to address increase in demand from referrals. North East and West Essex Community Services are considering funding options. There is an ongoing action plan for Southend Cases reporting to Southend Borough Council.

Executive Responsible Officer: Executive Chief Nurse
Executive Committee: Executive Operational Team
Board Committee: Quality Committee.

Actions

	By When	By Who	Gap: Control or Assurance
1. Review issue related to Datix sign-off risk around categories	Complete	Tendayi Musundire/ Datix Team	Control
2. Undertake internal consultation on management of complex cases – review resource implications for supervision	July 23	Tendayi Musundire	Control
3. Incorporate safeguarding forms into patient records	September 23	Tendayi Musundire	Control
4. Agree funding with Care Units for Associate Safeguarding Practitioners to assist Care Co-ordinator to facilitate safeguarding (adult patients)	October 23	Tendayi Musundire and Care Unit Directors	Control
6. Develop action plan to share with Southend UA to ensure all future open referrals are signed off	November 23 deadline	Tendayi Musundire/ Deborah Payne/ Ops Leads	Assurance
7. Review safeguarding establishment to resolve continuous additional hours on Bank by existing staff and business support for processing increase in activity	November 23	Tendayi Musundire	Control

Controls Assurance

Key Control	Level 1 *Department*	Level 2 *Organisational Oversight*	Level 3 *Independent*
Trust safeguarding team	Full establishment and additional caseloads Creation of Associate Safeguarding Practitioner roles	Local system to monitor child safeguarding case involvement	
Safeguarding policies and procedures	Review complete	PORG ratification expected May 23	
Prioritisation for oversight of S17, S47, MAPPA and MARAC attendance at appointments and involvement in reports as well as attendance at statutory meetings on behalf of doctors	In place	Reporting in place Monitoring in place	
Safeguarding training	In place and additional training to bring levels of compliance up to pre-Covid	Performance reporting	
Robust caseload management	Team managers monitor safeguarding caseloads Circulate monthly caseload reports to operational teams	Liaison with DDQS for reporting requirements of individual care units	
Monthly safeguarding reports	Reporting in place		
Datix reporting	Datix investigation		
Southend Unitary Authority open referrals closed	Completed 19 May 23		

07 – Risk Movement

July 2023

Risk Movement and Milestones

Strategic Risk Movement – two year period (August 2021 – June 2023)

Risk ID	Initial Score	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Risk ID
SR1 Safety	20			New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	SR1
SR2 People	20			New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR2
SR3 Infrastructure	15			New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR3
SR4 Demand	20			New	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR4
SR5 Inquiry	20	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20	SR5
SR6 Cyber	12	8↔	8↔	8↔	8↔	8↔	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR6
SR7 Capital	20												New	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	SR7
SR8 Resources	15												New	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	SR8

Strategic Risk Milestones – two year period (August 2021 – June 2023)

Risk ID	Initial Score	Time on SR/ old BAF	Aug21	Sep21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec2 2	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Risk ID
SR1 Safety	20	>1 year			New	20																		15		SR1
SR2 People	20	>1 year			New	20																				SR2
SR3 Infrastructure	15	>1 year			New	15																				SR3
SR4 Demand	20	>1 year			New	20																				SR4
SR5 Inquiry	20	>2 years					SR																		20	SR5
SR6 Cyber	12	>2 years					CRR	15																			SR6
SR7 Capital	20	>6 months												New												SR7
SR8 Resources	15	>6 months												New									20			SR8

Risk Movement and Milestones

NHS Essex Partnership University NHS Foundation Trust

Corporate Risk Movement and Milestones – two year period (August 2021 – July 2023)

Risk ID	Initial Score	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Risk ID
CRR11	16	12↑	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	15↑	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	9	9↔	9↔	9	CRR34
CRR45	12	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR77	16	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR81	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR92	20	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	16↓	16↓	16↓	CRR92
CRR93	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16	16	16↔	16↔	16↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	CRR94
CRR95	20												15	15↔	15↔	15↔	15↔	12↓	12↓	Close						CRR95
CRR96	16																New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR96
CRR98	20																	New	20	20	20	20	20↔	20↔	20↔	CRR98
CRR99	16																New	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR99

| Risk ID | Initial Score | Aug 21 | Sep 21 | Oct 21 | Nov 21 | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Feb 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Risk ID |

Risk ID	Initial Score	Time on CRR or old BAF	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Risk ID
CRR11	16	> 2 years	12																								CRR11
CRR34	9	> 2 years	15																								CRR34
CRR45	12	> 2 years																									CRR45
CRR77	16	>1 year																									CRR77
CRR81	12	> 2 years																									CRR81
CRR92	20	>2 years						12																			CRR92
CRR93	15	>2 years																									CRR93
CRR94	16	>1 year	16				20																				CRR94
CRR95	20	Closed												15					12		Close						CRR95
CRR96	16	>6 months																16									CRR96
CRR98	20	<6 months																	20								CRR98
CRR99	16	>6 months																16									CRR99

| Risk ID | Initial Score | Time on CRR or old BAF | Aug 21 | Sep 21 | Oct 21 | Nov 21 | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Risk ID |

08 – Useful Information

June 2023

Executive Lead Dashboard

Director of Governance and Corporate Affairs	Executive Director of People and Culture	Executive Medical Director	Executive Director of Major Projects and Programmes
	• SR2 People (Risk Score 20 no change) • CRR45 Mandatory training (Risk Score 16) • CRR92 Addressing inequalities (Risk Score 12)	• CRR11 Suicide Prevention (Risk Score 12) • CRR34 Suicide Prevention – training (Risk Score 15)	• SR5 Statutory Public Inquiry (Risk Score 20) • CRR96 Loggists (Risk Score 16)

Executive Director of Nursing	Executive Chief Finance Officer	Executive Director of Strategy and Transformation	Executive Chief Operating Officer
• SR1 Safety (Risk Score 16) • CRR93 Continuous Learning (Risk Score 15) • CRR77 Medical Devices (Risk Score 16) • CRR99 Safeguarding referrals • CRR98 Pharmacy Resources (Risk Score 20)	• SR3 Infrastructure (Risk Score 15) • CRR81 Ligature (Risk Score 15) • SR7 Capital (Risk Score 20) • SR8 Revenue (Risk Score 20)	• SR6 Cyber Attack (Risk Score 15) • SR9 Digital (20)	• SR4 Demand and Capacity (Risk Score 16) • CRR94 Engagement and supportive observation (Risk Score 20) • CRR81 Ligature (Risk Score 15)

Acronyms

BAF	Board Assurance Framework	**SR**	Strategic Risk
SO	Strategic Objective	**CRR**	Corporate Risk Register
RR	Risk Register	**DRR**	Directorate Risk Register
ICB	Integrated Care Board	**F&PC**	Finance & Performance Committee
QC	Quality Committee	**PECC**	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	**EOSC**	Executive Operational Sub Committee
BOD	Board of Directors	**ESOG**	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	**LRRG**	Ligature Reduction Group
MHA	Mental Health Act	**HSSC**	Health Safety Security Committee
ECC	Essex County Council	**CQC**	Care Quality Commission
CxL	Consequence x Likelihood	**CRS**	Current Risk Score
SMT	Senior Management Team	**HSE**	Health & Safety Executive
CAS	Central Alert System	**NHSE/I**	NHS England/ Improvement
PMO	Project Management Office	**ESR**	Electronic Staff Record
EFIN	Electronic Finance Record	**TBA**	To be advised or agreed
PFI	Private Finance Initiative	**NHSPS**	NHS property services
CMO	Chief Medical Officer	**EDS**	Equality and Diversity Standards
BAU	Business as Usual	**PCREF**	Patient and Carer Race Equality Framework
PLACE	Patient Led Assessments of the Care Environment	**EDI**	Equality Diversity and Inclusion
EDS	Equality Delivery System	**EPRR**	Emergency Preparedness, Resilience and Reporting
VPAR	Violence Prevention and Reduction	**BAU**	Business as usual
DDQS	Deputy Director of Quality and Safety	**BDO**	Internal Auditors (up until end March 23)
FFT	Friends and Family Test	**WRES**	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	**CAMHS**	Child and Adolescent Mental Health Service
BSOG	Board Safety Oversight Group		

EMERGENCY PREPAREDNESS AND RESILIENCE ANNUAL REPORT

● Discussion Item   👤 NL   🕐 10 minutes

REFERENCES   Only PDFs are attached

📄 EPRR Annual Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26th July 2023
Report Title:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report	
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Major Projects & Programs and EPRR AEO	
Report Author(s):	Amanda Webb, Senior Emergency Planning and Compliance Officer	
Report discussed previously at:	Health, Safety & Security Committee Quality Committee	
Level of Assurance:	**Level 1** **Level 2** ✓ **Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	EPRR training availability by NHSE	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report is provided to the Board of Directors to provide assurance to the committee that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue.

The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2022-23 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2022. | **Approval** | |
| | **Discussion** | ✓ |
| | **Information** | ✓ |

Recommendations/Action Required

The Board of Directors is asked to:
- Consider the detail within this report.
- Note the positive assurance provided.
- Request further action / information as required.

Summary of Key Issues

EPUT is compliant with all of its statutory duties under the Civil Contingencies Act 2004 and associated Cabinet Office Guidance. The Department of Health and Social Care (DHSC) requires all NHS Trusts to be prepared to a category 1 responder and EPUT has systems and processes in place to be prepared to this level and fulfils its civil protection duties.

The Trust has identified an Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board (Janet Wood). The Chief Executive Officer, Paul Scott holds overall responsibility. There is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions

EPUTs Major Incident Plan and relevant individual plans have been reviewed as required with the introduction of a Shelter & Evacuation Policy. These were approved at Health, Safety and Security Committee January 2022.

All Business Continuity Plans for inpatient services and non-critical sites are currently being reviewed and are stored both locally and centrally by the EPRR team.

EPUT has undertaken EPRR exercised in line with National Guidance.

NHS England EPRR Core Standards 2022-23. Following the "self- assessment" and "confirm and challenge" process; the position being reported by the LHRP is that EPUT are substantially compliant. 50 out of the 55 EPRR Core Standards have been assessed as compliant, with 5 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months) and the deep dive has been assessed as partially compliant.

Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. EPUT attend and contribute with NHSE/I, CCG's and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

Training has continued in 2021/22 utilising both internal and external courses available. The Diploma in Health Emergency Preparedness, Resilience and Response Programme has been available since 2005 (previously known as the Diploma in Health Emergency Planning) and is now recognised as the leading qualification for Health Emergency Preparedness, Resilience and Response professionals. There are extremely limited spaces available for the course and the Senior Emergency Planning and Compliance Officer has been successful in gaining one space starting April 2023.

The EPRR Workplace has continued to be progressed throughout 2022/23. Outstanding actions will be transferred into the 2023/24 workplan.

Relationship to Trust Strategic Objectives

SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓
Financial implications: Capital £ Revenue £ Non Recurrent £	
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	

Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report

EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
AEO	Accountable Emergency Officer	EPRR	Emergency Preparedness, Resilience and Response
CCA	Civil Contingencies Act	ERF	Essex Resilience Forum
BCP	Business Continuity Plan	LHRP	Local Health Resilience Partnerships
ICC	Incident Control Centre		

Supporting Documents and/or Recommended Further Reading

Emergency Preparedness, Resilience and Response Annual Report 2022-23

Lead

Nigel Leonard
Executive Director of Major Projects & Programs and EPRR AEO

ESSEX PARTNERSHIP UNIVERSITY NHS

FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2022-23

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

17 April 2023

CONTENTS

INTRODUCTION

PURPOSE

The purpose of this annual report is to provide assurance to the Trust Board of Directors, that EPUT has robust and effective organisational resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity event.

This report also presents evidence of the Trust's achievements and continued commitment to organisational resilience during 2022-2023.

ACCOUNTABILITY

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board (Janet Wood). However, the Chief Executive Officer, Paul Scott holds overall responsibility.

In addition, there is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning, supported by Amanda Webb, Senior Emergency Planning and Compliance Officer for day to day actions and duties.

RELEVANT GUIDANCE

This report confirms that the Trust is compliant with all its statutory duties under The Civil Contingencies Act 2004 and associated Cabinet Office Guidance and other relevant legislation and guidance such as:

1. The NHS Act 2006
2. The NHS Constitution
3. The requirements for EPRR as set out in the NHS Standard Contract(s)
4. NHS England EPRR guidance and supporting materials including:
5. NHS England Core Standards for Emergency Preparedness, Resilience and Response
6. NHS England Business Continuity Management Framework (service resilience)
7. Other guidance available at http://www.england.nhs.uk/our work/eprr/
8. National Occupational Standards for Civil Contingencies
9. BS ISO 22301 Societal security – Business continuity management systems

NHS ENGLAND EPRR CORE STANDARDS 2022-2023

NHS England carries out an annual EPRR assurance process in order to seek assurance that both NHS England and NHS organisations in England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care. The NHS EPRR process concludes with a submission to the NHS England Board and assurance is provided thereafter to the Department of Health and Secretary of State for Health.

NHS England carries out an annual EPRR assurance process in order to seek assurance that both NHS England and NHS organisations in England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care. The NHS EPRR process concludes with a submission to the NHS England Board and assurance is provided thereafter to the Department of Health and Secretary of State for Health.

NHS England Core Standards for EPRR set out the minimum requirements

expected of providers of NHS funded services in respect of EPRR and are split into ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

A self-assessment of compliance with the national EPRR core standards is required to be submitted on an annual basis providing assurance that the Trust is meeting all standards and supply relevant evidence on request.

Following the "self- assessment" and "confirm and challenge" process; the position being reported by the LHRP is that EPUT are substantially compliant. 50 out of the 55 EPRR Core Standards have been assessed as compliant, with 5 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months) and the deep dive has been assessed as partially compliant.

The table below illustrates the 5 standards assessed, as "partially compliant" and the action required which is being taken forward:

Ref.	Domain	Action to be taken
6	Governance - Continuous Improvement	Policy Statement required within the EPRR Policy summarizing the Trusts process' for continual learning.
16	Duty to maintain plans - Evacuation and Shelter	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.
24	Training and exercising - Responder Training	It was agreed by HSSC that this cannot be assessed as compliant due to the current lack of available training. The EPRR Team envisage that once Region identify what training is available, this will be undertaken as a priority.
39	Co-operation - Mutual Aid Arrangements	Military Aid to Civil Authorities (MACA) to be included within the Mutual Aid section of the Major Incident Policy.
50	Business Continuity - BCMS monitoring and evaluation	Trust to review and report on BCMS KPI's

CIVIL CONTINGENCIES ACT 2004

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level.

Under Section 1 of the CCA 2004, an "emergency" means:

(a) *An event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*

(b) *an event or situation which threatens serious damage to the environment of a place in the United Kingdom;*

(c) *War, or terrorism, which threatens serious damage to the security of the United Kingdom.*

For the NHS, incidents are classed as either:

- **Business Continuity Incident** - an event or occurrence that disrupts, or might disrupt, an organisations normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

- **Critical Incident** - any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions

- **Major Incident** - is an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. For the NHS this will include any event defined as an 'emergency' as detailed above.

An additional Incident specific to EPUT;

- **High Profile Incident** is a Trust definition for any incident that requires

executive level oversight but does not fall into BCP critical or major incident.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies).

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

1. Assess the risk of emergencies occurring and use this to inform contingency planning
2. Put in place emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance co-ordination
6. Cooperate with other local responders to enhance co-ordination and efficiency

The information contained throughout this report provides assurance in terms of how the Trust is meeting these duties as a Category 1 responder.

RISK ASSESSMENTS

The Civil Contingencies Act 2004 places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. EPUT is a member of both Bedfordshire Local Resilience Forum (BLRF) and Essex Resilience Forum (ERF) that undertakes this activity.

The purpose of the Community Risk Register is to reassure the communities of Bedfordshire and Essex that the risks of potential hazards have been assessed, and that preparation arrangements are undertaken and response plans exist.

The top five risks currently identified on both Risk Registers relate to

- Flooding
- Influenza-type disease (pandemic) / major outbreak
- Emerging infectious disease
- Energy/Fuel disruption
- Severe Weather - Hot or Cold

The Trust Major Incident Plan details the following as more specific risks for the Trust relating to the above:

- **Flooding:** Essex Coast Line, Thames Estuary and the Ouse
- **Energy / Fuel disruption:** Pipelines and Oil Storage facilities

The Trust's approach to emergency planning ensures that we would be in a position to respond appropriately in the event of an incident relating to those significant risks identified in the community risk registers. The Trust also uses its standard risk management framework and processes to identify any specific local risks relating to business continuity / resilience and these are managed in line with standard Trust risk management processes.

The Trust has developed a number of detailed plans to address the significant risks identified in the Local Resilience Forums' community risk registers. These align where appropriate with Local Resilience Forum plans for the same incident types and are as follows:

- Influenza Pandemic Plan
- Heatwave Plan
- Cold Weather Plan
- Flood Plan
- Fuel Shortage Plan

MAJOR INCIDENT PLAN

A Major Incident Plan has been developed by EPUT that details the role of EPUT in a major incident and how this role fits with those of other NHS organisations and the emergency services.

The Major Incident Plan is formally reviewed at least every three years, but is under continual review to
ensure any required amendments are made to reflect changes within the health sector, the Trust or Emergency Planning legislation.

The Major Incident Plan (RM14) and relevant individual plans were presented and approved at Health, Safety and Security Committee January 2023 following a full review which took into account learning from the Covid-19 pandemic in addition to requirements to meet the NHS England Core Standards.

BUSINESS CONTINUITY PLANS

The Business Continuity Plan is the tactical document that supports the Major Incident Plan and ensures that in the event of a business interruption the organisation will be able to maintain critical activities and restore normal business activities as soon as possible given the circumstances prevailing at the time.

As a provider service the Business Continuity plan is the key plan within our Organisational Resilience planning. This plan underpins all other plans as it prioritises our critical activities and allows us to effectively manage our business whatever the incident may be, including Pandemic Flu, Severe Weather and Industrial Action etc.

To underpin the organisational Business Continuity Management Procedure; which was approved by the Health, Safety and Security Committee in January 2023, all services across EPUT have developed Business Continuity plans which:

- prioritise their service activities into 5 levels of priority from critical activities which need to be restored within 1 hour, through to activities which can be progressively restored after 7 working days; and
- Detail the strategies for continued delivery of these activities.

All Business Continuity Plans for inpatient services and non-critical sites are currently being reviewed and are stored both locally and centrally by the EPRR team.

An internal audit has been undertaken to consider the design and effectiveness of the controls in place around the Business Continuity plans and to highlight any areas where the controls might be improved. The Final audit report; which has been submitted to the audit committee, has rated the 'Design Opinion' and 'Design Effectiveness' as Moderate. Throughout the audit a number of good practice points were identified in addition to some areas of concerns:

- Critical business services have been identified and prioritised, however the centre does not currently hold evidence of ownership and subsequent approval of BCPs from respective owners.
- There is Master List of BCPs, however it is not a clear and comprehensive source of information and solutions to be enacted in the event of an emergency.
- Whilst real incidents, for example, a heatwave, a roof collapse and a power outage, including loss of Wifi, have triggered the corresponding BCP plans to enacted, there was no schedule in place to ensure the BCPs are tested on a regular basis.
- 10/17 (59%) Gold Command/Director-on-Call and 6/7 (86%) loggists did not have an up to date training. However, we were advised that nationally the training is not available, and courses are in the process of being re-developed as part of learning from Covid-19.
- The EPPR directory does not include third parties and key suppliers.

COMMUNICATIONS PLAN

A well-informed public is better able to respond to an emergency and to minimize the impact of the emergency on the community, it is vital to ensure consistent messages appropriate to the needs of the audience.

The Trust has a Communications plan in place to ensure that this happens in a timely manner. There are various means available to be utilized i.e. Pando, WhatsApp, intranet, cascade text messages, resilience direct etc.

PARTNERSHIP WORKING

Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. It is thus important that, as well as coordination within individual NHS organisations, the planning for incidents is coordinated between health organisations and at a multi-agency level with partner organisations.

EPUT attend and contribute with NHSE/I, ICB's and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

LOCAL RESPONDERS

Local Resilience Forums

Local Resilience Forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others (i.e. Category 1 Responders, as defined by the Civil Contingencies Act).

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

An NHS England representative represents the Trust at the Bedfordshire Local Resilience Forum and Essex Resilience Forum, along with all other NHS providers. Two-way feedback into and from the LRFs is facilitated via Local Health Resilience Partnerships.

Local Health Resilience Partnerships (LHRP)

Local Health Resilience Partnerships (LHRPs) were established in August 2012 across the country as part of 'The Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013' published by the Department of Health in March 2012.

Their purpose is to deliver the national Emergency Preparedness, Resilience & Response (EPRR) strategy in the context of local risks. They bring together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level and provide a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. The LHRPs' footprints map to the LRFs. They therefore offer a coordinated point of contact with the LRF and reflect a national consistent approach to support effective planning of health emergency response.
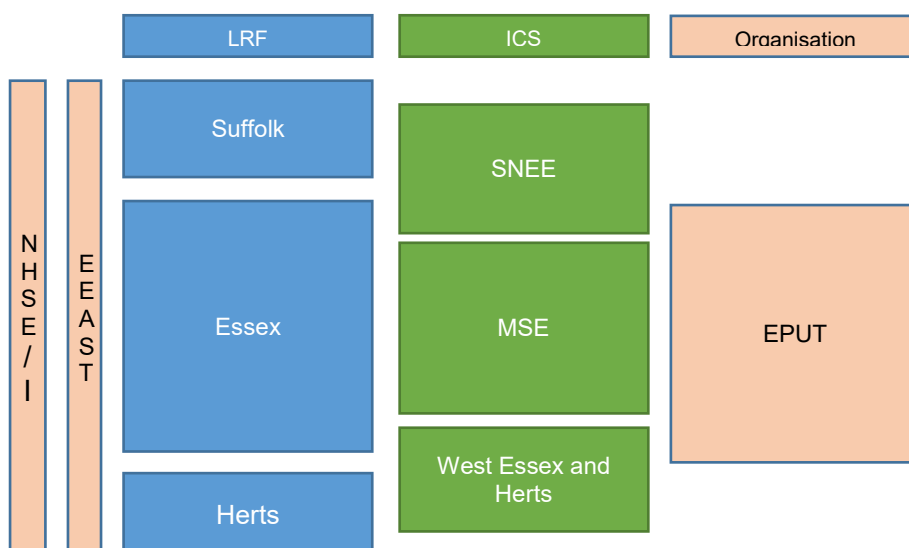
During 2022-2023 the Trust has kept abreast of the work of the LHRPs and attended regular meetings for the three LHRPs

- Essex LHRP is the main forum for EPUT attendance
- West Essex and Hertfordshire LHRP
- SNEE EPRR Forum is in place of the LHRP Working Group in Suffolk and covering health and social care EPRR within the SNEE ICS

EPRR EXERCISES

National Guidance states that as a minimum requirement, NHS organisations are required to undertake the following exercised:

- Communications - every six months
- Table top - every year
- Live Play - every three years
- Command Post   - every three years
- ICC Equipment test - every three months

COMMUNICATIONS EXERCISE

Exercise Eagle Prepare – July 2022

Exercise Eagle Prepare was held on 5th July in order to test the ability to hold an initial Health TCG for the SNEE system ahead of an SCG in response to an Offsite Nuclear Emergency (OSNE) with the following objectives:

- The exercise will evaluate the ability to send out a virtual meeting invite to health partners to an initial system call.
- The exercise will enable the ICB to review director on call numbers for our providers.

The EPRR team provided detailed systematic guidance and support to the Contact Centre and on-call Director who would be contacted in preparation for the exercise. It was confirmed that Exercise Eagle Prepare went off without a hitch and the ICB were put through to our Director on call within 6 minutes

Exercise Toucan – July 2022

Exercise Toucan was an in-hours, no-notice, communications exercise held on the 21st July 2022 to test the ability to cascade an incident alert through the agreed incident cascade channels from the national, through regions and Integrated Care Boards to provider level.

The exercise was designed with the following objectives

- To validate point of contact process for on call / nominated individuals
- To validate the functionality of the notification systems and equipment as appropriate.

The exercise consisted of 2 parts,

- Email sent to EPRR asking for immediate response
- Contact made with Director on call via the Contact Centre

EPUT identified 2 areas of concern within the debrief document that was

returned as part of the exercise

1. Exercise was received via the C19 inbox rather than the EPRR inbox. As the Covid ICC is still be monitored, the exercise was picked up however once the ICC is stood down, the email address will either be closed or intermittently monitored. This could mean either a delay in responding or no response made.
2. EPUT is part of three ICBs, therefore all were attempting to make contact with the Director on call at the same time meaning there was a delay in EPUT's response to 1 or more of the ICBs.

The success for disseminating the alert from the national to provider was found to be 95% overall (nationally), based on the returns received from regions and ICBs. A successful outcome was considered as contact being made, the message transmitted, and receipt of the alert being confirmed.

Utilising the data collated from the debriefs, the following recommendations for organisational improvements were suggested:

Recommendation	
1: Review contact routes	Organisations should review their contact routes to ensure alerts are sent to the most appropriate contact in the event of an incident or emergency.
2: Minimising multiple contacts of organisations	ICBs and NHS England regions should work together to ensure that organisations are contacted once by the most appropriate region, particularly ambulance Trusts.
3: Validating contact information	Organisations should ensure that the contact details that are held on file, including on-call rota information, is accurate and up to date.
4: In hours point of contact arrangements	Organisations should review arrangements in place to ensure that a suitable individual can be identified and contacted in the event of a live incident or emergency in hours in line with NHS EPRR Core Standards.
5: Switchboard training	Organisations utilising switchboards should consider further training and review where support could be provided to ensure that switchboard operators are able to facilitate incident notifications in an efficient and timely manner.
6: Awareness of exercise play as part of on-call	On-call training should include an awareness of participating in exercises whilst on-call (communications, command post, live), including exercise nomenclature (i.e. no duff).
7: Exercise scheduling	Future communication exercises should wherever possible be deconflicted with events that impact the validity of the exercise.
8: Trusted email addresses	Organisations must be able to recognise valid email addresses of the NHSE ROC as well as ICB and provider operations centres.

Exercise Toucan2 – October 2022

Exercise Toucan2 was an out of hours, no-notice, communications exercise held on the 27th October 2022 to test the ability to cascade an incident alert through the agreed incident cascade channels from the national, through regions and Integrated Care Boards to provider level.

The exercise was designed with the following objectives

- To validate point of contact process for on call / nominated individuals
- To validate the functionality of the notification systems and equipment as appropriate.

EPUT fulfilled our responsibilities; however, it was identified that although we responded appropriately and in a timely manner, the ICB had to make 2 calls to the contact centre in order to contact the Director on Call.

This was escalated and investigated by the Director of ITT, Business Analysis & Reporting who identified the first agent did not follow the process in place in regards to contacting the Director on Call. This has been addressed.

No debrief has been provided following the exercise by NHSE.

TABLETOP EXERCISES

Essex Resilience Forum (ERF) Cyber attack – June 2022

Essex Resilience Forum (ERF) Cyber attack exercise was held on 14th June; EPUT EPRR was on standby however was not required to participate.

Artic Willow (November – December 2022)

Exercise Artic Willow was a workbook exercise whereby the ICB and relevant providers worked through each scenario and inject as a group and submitted a collective response back to NHSE.

The aim of the exercise was:
- To explore the health response to multiple, concurrent operational and winter pressures in England, and the interdependencies with Local Resilience Forum (LRF) partners in responding to these pressures.

The objectives of the exercise was:
- To assess the EPRR arrangements in place at Integrated Care Boards (ICBs) as Category One responder facing concurrent operational issues and winter pressures.
- To identify the likely type and range of decisions that would need to be made by senior leaders across health and partner organisations when responding to multiple, concurrent operational issues and winter pressures.
- To explore the practicalities of mutual aid support from resilience partners, in order to identify potential areas for further development, and

explore the response to simultaneous operational issues and winter pressures that reduce the facility for mutual aid.

- To identify options for maintaining patient flow during multiple, concurrent operational issues and winter pressures.
- To explore business continuity arrangements, at Trust and ICB level, in relation to potential medical supply disruption, energy supply disruption, prolonged and significant industrial relations action, including strikes, and reduced staffing numbers resulting from multiple concurrent operational issues and winter pressures.

EPUT actively contributed to Herts & West Essex ICB's response to NHS England.

No debrief has been provided following the exercise by NHSE.

LIVE PLAY

Exercise Walker

East of England region arranged a Reinforced Autoclaved Aerated Concrete (RAAC) face-to-face exercise with an Emergo element, which was held on the 11th May 2022 (originally planned for November 2021). The aim of the exercise was to explore and manage the impacts of a catastrophic RAAC Plank failure within an Eastern Region Hospital focussing on the Regional response looking at the following objectives:

- To simulate patient tracking across the region in an evacuation from an acute Trust
- To explore realistic management of media and communications across the region
- To ensure all health organisations and multi-agency partners understand their responsibilities in relation to an escalating RAAC plank catastrophic failure
- To consider patient co-ordination and distribution using the revised East of England planning assumptions and latest pre-evacuation modelling

The scenario for the day had injects at different stages of the exercise with a requirement to update with our initial actions and priorities for each organisation including how we would react at each inject of the scenario. For EPUT the main actions were around warning and informing, ensuring information flow from regional team to CIMT and system and getting an overview of system capacity being mindful that the Trust has buildings in a few other commissioned areas. The learning from the exercise identified the need for a common way of calculating capacity including how we count shared capacity across our ICB boundaries.

We are awaiting the regional formal feedback and debriefing from the exercise for any wider learning.

Exercise Fox – November 2022

On the 9th November 2022, Exercise FOX was undertaken as a follow on from Exercise Walker that was held earlier in the year. It was designed to test East of England's' region response to a RAAC plank Incident, requiring the evacuation of

patients from Queen Elizabeth Hospital King's Lynn. The scenario is based upon the heightened risk of a RAAC Plank failure at any of the RAAC Plank hospitals within the region.

The aim of the exercise was:
- To walk through in real time the operational expectations of PDCC exploring the regional response to patient distribution following a catastrophic RAAC Plank failure within an Eastern Region Hospital

The objectives of the exercise was:
- To stress test the NHS E/ regional PDCC response utilising a sample of patients to be distributed
- To test the SMART evacuation and sharing patient records
- Ensuring that the PDCC has a whole system approach to distribution and discharge

EPUT was available throughout the day as a participant to respond to the exercise however was not called upon to assist.

No debrief has been provided following the exercise by the organising ICB.

FloodEx – November 2022

FloodEx was run over a four day period starting Tuesday 15th November and continued until Thursday 17th November in order to test our system of preparedness; that being our planning content, awareness and use of those plans, training and exercising effectiveness, and coordination/collaboration effectiveness.

The objectives of the exercise was:
1. To test and evaluate specific plans, including:
    a. ERF Combined Operating Procedures for Essex (COPE)
    b. ERF Strategic Multi-Agency Flood Plan
    c. District Tactical Flood Plans
    d. High Risk Area Information Sheets
    e. ERF MAIC Plan
2. To practice specific procedures, including:
    a. MACA requests
    b. National Flood Asset requests
    c. Multi-Agency Strategic Holding Areas (MASHA)
    d. Mutual Aid
    e. Coordination of voluntary and community resources
    f. Use of ResilienceDirect Collaborate and ResilienceDirect Mapping
    g. Vulnerable Intelligent Persons Emergency Response system (VIPER)
3. To provide Tactical and Strategic Officers an opportunity to practice participation within TCG and SCG environments. These will all be virtually hosted.
4. To raise awareness of planning arrangements.
5. To identify lessons, notable practice and future training needs.
6. Test procedures for identification of and distribution of Turnkey funding.

7. Practice the decision process with LRFs for issuing emergency alerts to selected population groups.

EPUT was available throughout the four day period as a participant to respond to the exercise however was not called upon to assist.

No debrief has been provided following the exercise by the organisers.

Mighty Oak – March 2023

The National Tier 1 Power Outage exercise, Mighty Oak, took place over Tuesday 28th, Wednesday 29th and Thursday 30th March 2023 with the exercise starting early and ending late each day with EPUT participating on Day 2 (Wednesday 28th) and Day 3 (Thursday 29th)

The aim of the exercise was to support the development of the national response and recovery to a National Power Outage.

The national objectives of Exercise Mighty Oak were:
- Provide confidence and assurance to ministers and permanent secretaries that priorities are shared, challenges are accounted for, impacts have been assessed and interdependencies are understood by the key partners in a national power outage response.
- Validate across all levels of government the critical elements of the notification process, the activation of response functions, communications and information flow, the use of response plans and powers, and the early stages of recovery from a national power outage.
- To rehearse the co-ordination of a national response to a national power outage across relevant government, public sector and industry partners.

The initial debrief within the Essex Resilience Forum is due to take place end of April 2023.

COMMAND POST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident.

Due to Pandemic, we have a virtual Incident Control Centre which remains operational as per request from National. Command is currently held via Microsoft Teams due to the Social Distancing. An electronic log is being maintained as required by a team of trained Loggists with the support of the EPRR team.

There were 8 EPRR events/incidents during 2022-23 whereby the command post was stood up to successfully manage the event/incident.

ICC EQUIPMENT TEST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident. The equipment and rooms are checked quarterly to ensure they are ready to be used at any time. The checks include room suitability, telephone lines, major incident paperwork, stationary box and loggist folders. The checks are documented for auditing purposes.

EPRR EVENTS (incl Lessons Learned)

COVID-19

The Covid-19 pandemic first emerged at the end of 2019 leading to a national wide lockdown in March 2020. The pandemic has a significant impact on all NHS organisations as well as the wider country

On 31 August 2022, the national Covid-19 level was reclassified from a Level 3 (Regional) Incident to that of a Level 2 incident that indicates Covid-19 is in general circulation in the UK but direct Covid-19 healthcare pressures are low and transmission is declining or stable. The NHS incident level has not as yet been altered and therefore remains at Level 3.

Once notification of a reclassification of the NHS incident level is officially received the Trust will be in a positon to consider closure of both the Silver and Gold Command structures and will carry out an internal structured debrief as an opportunity to learn and improve our incident management responses.

Gold and Silver command meeting are only to be scheduled if a decision is required regarding Covid-19. In practical terms this means that a Silver command time is provisionally held in diaries on a Tuesday morning to ensure that if it is necessary to be 'stood up' the appropriate command members are available and a Gold command time is incorporated into the existing Executive Team Tuesday afternoon meeting. This ensures Gold are able to review, discuss and approve any decisions on the same day. A weekly command update is provided through the command structures distribution list to ensure members still receive the relevant information on weeks where command is not required (stepped down).

The (virtual) Incident Control Centre (ICC) has been running since March 2020 and has remained operational 7 days a week with varied hours in line with the East of England Operational Centre. However, as of August 2022 we have been able to revert the ICC to core business hours supported by the EPRR team with any urgent escalations out of hours managed by the Director on call via the

contact centre. The EPRR Team have changed business as usual (BAU) hours in the team to run from 8am - 6pm weekdays.

The regular sit rep submissions required by the Centre continue, namely the National Covid daily sitrep (including weekends), Community discharge weekly sit rep, the regular patient Lateral Flow Testing numbers and Long Covid activity. These are now being submitted by the Performance Team as part of BAU.

Covid-19 Outbreaks have also been reported through the IPC in line with national guidance. Any services where 2 or more staff and/or patients are tested as Covid positive are reported as an outbreak to NHS England. Daily submissions are made provided changes to NHS England until the service has seen 28 days without any new cases.

The incident control inbox continues to receive the national and regional information/guidance alongside a wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through we are able to remain responsive. Any national/ regional guidance, information and/or requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response. The number of notifications via the virtual ICC has reduced since 2021 – 22 from over 4000 notifications to approximately 400.

Heatwave Level 4 (Q2 2022-23)

Heatwave Level 4 warning was received on the 15th July confirming a heatwave between 00.00 18/07/22 – 00.00 20/07/22. The Trust initiated the Heatwave Plan. A critical incident was not declared by EPUT however a briefing command structure was set up to identify and mitigate any potential risks.

Linden Centre / Derwent Centre Bomb Threat (Q2 2022-23)

On the 6th September at approximately 17:35, the Receptionist at the Linden Centre received a call whereby the caller identified 'they had explosives and is going to bomb the Linden Centre and other mental health hospitals and units'.

The site enacted their Lockdown Procedures successfully whilst obtaining further clarification from the Police. Following guidance from the police, Lockdown was lifted at 18:45.

Whilst the Service Manager was investigating the incident the following day, it was identified that a threat was also made to the Derwent Centre earlier in the day on the 6th September.

An investigation is being undertaken in regards to version of events and action taken in regards to the Derwent Centre so ensure learning is identified.

Following the investigation the following issues have been identified:

- Security Policy Appendix 6 not referred to therefore correct documentation not completed to capture the caller information.
- Incidents were not recorded on Datix.
- Communication email sent from the Linden Centre receptionist and then they finished for the day.
- Lockdown was not enacted at the Derwent Centre
- Service Manager and Associate Director were not made aware of the threat made to the Derwent Centre
- The director on call was involved however there is no log kept to strengthen the understanding of what action was undertaken in response to the incident.

Actions to consider:

- Review Security Policy Appendix 6 to enhance and develop the process ensuring clear communication in addition to considering Lockdown.
- Review Director on call process - Consider a Log for all calls received. This could be used as learning and development as part of a wider scope.
- Receptionist information packs with relevant guidance / information / action cards

Operation London Bridge (Q2 2022-23)

On the 8th September, Buckingham Palace's announced the death of Her Majesty Queen
Elizabeth II.

The Trust command structure was immediately stood up to review some key requirements for the Trust as information developed during the period of mourning. Key areas for consideration were:

- Communications during the period of mourning
- Flags flying at Half Mast
- Book of Condolences
- Additional Bank Holiday arrangements

The Trust followed the communication and specific NHS national guidance as advised however this was not forthcoming and required interpretation at a Trust level in regards to bank holiday planning. Minimal communication was also received from the Local Resilience Forums and / or Strategic Command Groups in order to assist EPUT with ensuring all measures we covered and communicated.

There was no forward planning as would be for usual bank holidays and with the need to understand what could be safely stood down and how services planned to do this needed urgent discussion and early input from medics

External Incident – Interruption of IT Systems (Finance) (Q2 2022-23)

On the 5th August at approximately 0800, an external incident (Cyber Attack) occurred which caused interruptions of EPUT key finance systems including EProc. By 17:30 confirmation was received that the system was back up and running.

A National Meeting on the 9th confirmed that Advanced had re-opened HSCN connection before NHSD signed off and cannot give assurance as they had already undertaken a backup, Recommendation from National was to disconnect until they had the opportunity to investigate to determine if there were any risks which would take approximately 11 days.

Incident was declared as a Business Continuity Incident and the Finance BCP was enacted as the following risks for EPUT were identified:

- Unable to pay suppliers
- Unable to raise orders
- Unable to access List of suppliers

A briefing command was established while BCPs were being enacted and to ensure risks were identified and mitigated.

Opel Escalation Level 4 Bed Pressures (Q2 2022-23)

Unprecedented pressure on inpatient admission lead to a lack of mental health bed availability and impacted on system partners . Action was taken to declare a black alert / Opel 4 escalation and implement Business Continuity Plans and the Black Alert Action Plan. The Incident was managed by Operations and a briefing command was established to ensure risks were identified and mitigated. Key black alert actions included;

- Establishing a clear command structure, including daily system calls so that we can work collaboratively with partners to manage supported discharge and better plan admissions and community support
- Supporting staff to work differently so that they are enabled to make decisions in the context of the current situation (while maintaining professional judgment and patient safety)
- Focusing teams across EPUT to better support colleagues in our inpatient mental health services.

Key learning was identified in the 'after action review':

- Annual Leave planning and communication. - OPEL 4 / Black Alert response was compromised by multiple people having leave agreed at same time.
- Roster management of consultant leave and cover arrangements - Specific demand placed on key individuals working long hours to support recovery from OPEL 4.

MH Urgent Care and Inpatient Staffing (Q3 2022-23)

A series of watching briefs were facilitated by the EPRR Team in order to assist operations, using EPRR principles, to help to plan, mitigate, prepare and implement precautionary measures to reduce potential increase to a critical incident in relation to staffing risks which were raised in the Urgent Care and Inpatient Services Accountability meeting held on 7th November 2022.

The group met on an adhoc basis for 2 weeks to identify and implement area's to pause, adapt and continue to manage the escalating demands.

Hadleigh Unit – Heating Failure (Q3 2022-23)

On the 12th December, it was identified that there were 8 patients on Hadleigh Unit, Basildon Mental Health Unit (MHU) with no heating during the severe cold weather. The heating system on the ward is a 2 part system which both were identified as faulty following a flood at Basildon MHU. The parts for system 1 were expected on the 17th December with the 2nd not being available until approx. 23rd January 2023. Due to the delay, the Ward and Estates enacted their BCP's and EPRR facilitated daily meetings to monitor the situation.

Due to Hadleigh Unit being a PICU unit and the acuity of the patients, decanting to the vacant Assessment Unit was deemed unsafe therefore security blankets and temporary oil filled heaters were provided. Extra staff was made available to the unit due to the risks posed with the temporary oil filled heaters in addition to updating and sharing the General Workplace Risk Assessment to ensure all staff were aware of the risks and the mitigations in place. During a H&S and EPRR site visit on the 14th December, back up emergency heaters were rebooted with success in the male corridor until system 1 was repaired on the 17th & 18th December. Unfortunately heating was still not available in the communal areas or the female corridor.

Parts of the backup emergency heaters in the female corridor were received and fitted on 23rd December providing the female corridor with temporary heating until the parts to the main system are due to arrive in January 2023. The heat from the corridors warmed the communal areas so that all the temporary oil filled heaters could be removed from the unit.

All individuals involved in the Business Continuity Incident were asked for feedback for learning; however no response has been received. Estates are reviewing their BCP following the incident in order review and document the measures Estates undertake in the event of 'Loss of Heating'.

Oxygen Cylinder Shortage (Q4 2022-23)

On the 3rd January 2023, the NHS faced high demand for Oxygen due to the twin demands of Influenza and Covid admissions. NHS Trusts were asked to increase the monitoring of Oxygen and escalate any concerns to the ICB's

A Daily Return regarding oxygen cylinders was requested by EoE Region from 2nd – 8th Jan 23. EPUT is a small user of Oxygen and has no current concerns therefore it was agreed with East of England that EPUT would complete a one off

return and only complete further if there are concerns identified.

No further concerns were identified by EPUT.

Junior Doctor Industrial Action (Q4 2022-23)

A critical incident was not declared by EPUT however a briefing command structure was set up to identify and mitigate any potential risks.

Key learning was identified in the 'after action review' prior to the preparation for the 2nd round of industrial action:

- Consider language in terms of command structure – not a critical incident criteria.
- Issue with access to rooms (West)
- Teaching – we had to adjust the plans from cancelling to reinstating teaching at last minute which meant the teaching provided was not of the usual quality.
- The need to identify budget costs and financial implications for shadow rota.
- Industrial Action – dedicated space on InPUT?
- Training and resource pack for 'on call'
- Consultants 'stepping down' – additional clarity on expectation and potential remuneration – EPUT were not contacted by BMA with concerns.
- Understanding the resource implications and effect
- Management of system calls across all three ICB's multiple times per day – recognise impact on acute Trust's in particular within A&E Depts.
- Flow and capacity – reduced EDD's during the industrial action with the majority of EDD's taking place towards the end of the week.
- Earlier engagement with JLNC – socialising scenarios
- Additional support for urgent care pathway and phlebotomy – need to identify earlier and look more widely for support in these areas – to be included in BCP.
- Ensure Gold Command are informed prior to decisions being confirmed (e.g. cancellation of outpatient appointments).

Incident / Event Management

During 2022-23; there have been a number of potential incidents that EPRR have proactively managed to ensure an internal incident did not occur.

- Ride London
- Womens Tour
- Rail Strikes
- Ambulance Strikes
- Monkeypox
- Jubilee Weekend

Prior to the events; details were circulated asking Services to review the potential Impact and what mitigations they were to put in place.

TRAINING 22-23

During the year a number of Organisational Resilience training courses have been completed by EPUT staff:

Internal Training

General Awareness Training

E-learning resources in relation to organisational resilience & response and Business Continuity Plans are available on the Trust's intranet. Introduction training is provided as part of the Risk Management section on the mandatory staff induction course whereby compliance is monitored via the Workforce Development Team.

External Training

Diploma in Health Emergency Preparedness, Resilience and Response

The Diploma in Health Emergency Preparedness, Resilience and Response Programme has been available since 2005 (previously known as the Diploma in Health Emergency Planning) and is now recognised as the leading qualification for Health Emergency Preparedness, Resilience and Response professionals.

There are extremely limited spaces available for the course and the Senior Emergency Planning and Compliance Officer has been successful in gaining one space starting April 2023.

Principles of Health Command Training (Previously Strategic Commanders Training) (Gold)

This programme is run by NHS England (East) and provides those who may become involved in managing a major incident response with appropriate knowledge and skills to undertake the role. A number of directors and staff are trained and up to date with their training. Trust is waiting for further dates from NHSE/I to increase the number of staff trained.

Loggist Training

This programme is run by NHS England and the Joint Commissioning Team (based on Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist in a Major Incident Response Team. A number of directors and staff are trained and up to date with their training. The Trust is waiting for further dates from NHSE/I to increase the number of staff trained. EPUT currently only have 4 loggists in EPUT which is insufficient to continue managing and responding to incidents especially in the event of a physical ICC being required or if an incident occurs out of hours. This has been escalated to the Trust Corporate Risk Register.

Emergo Senior Instructor Course
The Senior Emergency Planning and Compliance Officer was nominated, by Mid & South Essex ICB and successfully gained a place, on the EMERGO Senior Instructors Course.

The aim of the course is to provide participants with the knowledge and skills to plan and conduct Emergo training & simulation exercises within their own organisations and to support UKHSA led local and regional exercises.

Emergency Planning College Debriefing Course
The Senior Emergency Planning and Compliance Officer was nominated, by Mid & South Essex ICB and successfully gained a place, on the Emergency Planning College Debriefing Course.

The aim of the course is to equip participants with the knowledge and skills they need to conduct a debrief following an emergency, major or significant incident or an exercise.

EPRR WORKPLAN

EPRR Work plan for 2022-23 was developed to incorporate the actions required to fully comply with the Core Standards in addition to development actions identified by the EPPR Lead. This is attached in appendix one.

It should also be noted that during 2022-23 there were the following significant achievements by the EPRR team:

- The Senior Emergency Planning and Compliance Officer successfully gained a place on the Diploma in Health Emergency Preparedness, Resilience and Response Programme; starting April 2023.
- Regulation attendance and participation within the three Local Health Resilience Partnerships (LHRPs)
- Developed networking and sharing of EPRR planning/resources with NELFT
- Improved connections with the three ICB EPRR Leads
- Re-write of Major Incident and EPRR policies following learning of incident management.
- Introduction of new Shelter & Evacuation Policy
- Introduction of new 'After Action Review Template' to capture good practice, lessons learned in addition to review of BCP following the incident / exercise / event.
- Successful Core Standards Self-Assessment
- Involvement in a number of National / Regional exercises
- Successfully managed a number of EPRR events to prevent escalation to Critical Incidents
- Ongoing cover of the ICC, Covid19 outbreak and sitrep submissions and the preparation and organisation of Gold and Silver Commands.

ASSURANCE

The Health, Safety & Security Committee holds responsibility for and oversees delivery of the Trusts annual Emergency Planning, Resilience and Response work plan.

The committee is chaired by the Director of Risk & Compliance and includes representatives from all services areas. The Committee meets monthly and considers progress against the work plan as a standing agenda item on a quarterly basis.

A quarterly EPRR report is provided to the Trust Quality Committee, a standing committee of the Trust.

EPRR risks have been highlighted in 2022/23 and have been escalated to appropriate risk registers and included on the Board Assurance Framework presented to the Trust Board of Directors.

The Executive Director and Non-Executive Director who lead on EPRR have been actively involved in the EPRR work required in 2022/23 and have provided support to the EPRR Team.

Essex Partnership University NHS Foundation Trust

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Tel: 0300 123 0808

EPRR Workplan 2022 / 2023
(Last updated 31st March 2023)

Key Leads				Status	
Nigel Leonard	NL	EPRR AEO		Green	Closed Action
Amanda Webb	AW	EPRR Lead		Amber	Ongoing Action
Comfort Sithole	CS	Head of EPRR		Red	Outstanding Action
Sarah Pemberton	SP	VAPR Manager		Grey	Future Action

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
Part 1 – Actions to fully achieve Core Standards						
6	Governance	**Continuous Improvement** The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Policy Statement required within the EPRR Policy summarising the Trusts process' for continual learning	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	
16	Duty to maintain plans	**Evacuation and Shelter** In line with current guidance and legislation, the organisation has arrangements in place to	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		evacuate and shelter patients, staff and visitors.				🟩
24	Training and exercising	**Responder Training** The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Work with region to identify appropriate training	AW ~~Jan 2023~~ Dec 2023	It was agreed by HSSC that this cannot be assessed as compliant due to the current lack of available training. The EPRR Team envisage that once Region identify what training is available, this will be undertaken as a priority. **Update 09.01.2023** Principles of Health Command Training becoming available via ICB's. • 20% Gold Command • 21% Director on Call • 100% EPRR Leadership scheduled • 50% Loggists up to date Loggist development – courses will mirror NELFT and be undertaking in house by EPRR Lead Action to be carried over into 2023/24 Plan	🟧
39	Co-operation	**Mutual Aid Arrangements** The organisation has agreed mutual aid arrangements in place outlining the process for	Military Aid to Civil Authorities (MACA) to be included within the Mutual Aid section of the Major Incident Policy.	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	🟩

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.				■
50	Business Continuity	**BCMS monitoring and evaluation** The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Trust to review and report on BCMS KPI's	AW Aug 2023	Already undertaking. Tightening up process' to ensure evidence available for ICB After Action Reviews key link for evidence Action to be carried over into 2023/24 Plan	■
D1 – D13	Evacuation and Shelter	Activation Incremental Planning Evacuation patient triage Patient movement Patient transportation Patient dispersal and tracking Patient receiving	Trust wide Shelter & Evacuation Plan to be added as an additional appendix to new Major Incident Policy.	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	■

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		Community Evacuation Partnership Working Communications – Warning and Informing Equalities and Health inequalities Exercising				

<p style="background-color:purple;color:white">Part 2 – Actions increase robustness of EPRR processes</p>

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
2	Governance	**EPRR Policy Statement** The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: Business objectives and processes Key suppliers and contractual arrangements Risk assessment(s) Functions and / or organisation, structural and staff changes.	Routine review of EPRR policy	AW <s>Jan 2023</s> March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	
3	Governance	**EPRR board reports** The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.	Development of annual report for 2022/23	AW July 2023	Report submitted to HSSC April 2023, Quality Committee May 2023 and Trust Board May 2023	

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
15	Duty to maintain plans	**Mass Casualty** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Update EPRR and Major Incident Policy to strengthen detail relating to the Core Standard	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	
17	Duty to Maintain Plans	**Lockdown** In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Develop and implement lockdown testing plan	AW / SP March 2023	Lockdown process now with VAPR	
21	Command and Control	**Trained On-Call Staff** Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Develop information pack for Directors on Call	AW March 2023	PA for COO developed information pack. EPRR had input in regards to Major Incident management within Pack and Training. 1st training held	
23	Training and Exercising	**EPRR Exercising and testing programme** In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response	Develop and implement proposal for table top EPRR exercise plan 2023	CS / AW ~~Jan 2023~~ Q1 23/24	Briefing packs to be designed for: • Communication (in hours, OOH incl middle of night) • ICC response Action to be carried over into 2023/24 Plan	

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		arrangements, (*no undue risk to exercise players or participants, or those patients in your care)				
26	Response	**Incident Co-Ordination Centre (ICC)** The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance.	Development of ICC SOP	AW ~~Jan 2023~~ March 2023	Approved by HSSC January 2023 and PORG. Approved by Trust Board March 2023	
26	Response	**Incident Co-Ordination Centre (ICC)** The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance.	Quarterly check of ICC physical components including site, memory stick, major incident box etc	AW Jan 2023	Quarterly checks continue to be made	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Take forward actions required following IA outcome	TBC	Actions to be added to workplan once final report received Following 11 actions came from the Independent audit	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in	Review of all business critical BCPs to be undertaken with owners and agree strengthened process for	TBC	Operational BCP's being reviewed April 2023 Action to be carried over into 2023/24 Plan	

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		place to respond to a business continuity incident	review and submission to central EPRR Team			
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Review of review frequency for MIP, CBCPs and SBCPs based on business impact and risk assessment. Revise EPRR policy as required	TBC	Action to be carried over into 2023/24 Plan	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Review process for Director sign off and update policy	TBC	Action to be carried over into 2023/24 Plan	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Review options for a strengthened BCP tracker system	TBC	PowerBi system reviewed. EPRR Lead to liaise with Trust PowerBi to explore options. Action to be carried over into 2023/24 Plan	🟧
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Testing schedule will be developed taking into account live incidents	TBC	Action to be carried over into 2023/24 Plan	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in	BCP review following testing		BCP review added on After Action Review Template which is to be utilised for any Incident / Exercise or Event	🟩

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		place to respond to a business continuity incident				🟩
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Escalate training concerns to Region		Training concerns have by escalated by the EPRR Team to Region and NHSE	🟩
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Develop an annual EPRR e'learning training video for Gold, Silver, Loggist and director on call including lessons learnt.	TBC	Action to be carried over into 2023/24 Plan	
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Participate in the new EPRR training, the regional strategic course has been replaced with a new National course for Gold, Silver and Director on Call which EPUT will access going forward	TBC	Action to be carried over into 2023/24 Plan	🟧
28	Response	**BCPs** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	Third party details to be added to EPRR directory	TBC	Action to be carried over into 2023/24 Plan	
29	Response	**Decision Logging** To ensure decisions are recorded during business	Pull together all C19 logs and email log to show decision making through Covid 19	AW ~~March 2023~~	Part of Inquiry preparation	🟧

NHSE Ref	Domain	Core Standard	Action Required	Lead / Timescale	Comments	Status
		continuity, critical and major incidents		Q1 23/24	Action to be carried over into 2023/24 Plan	
29	Response	**Decision Logging** To ensure decisions are recorded during business continuity, critical and major incidents	Pull together Covid 19 recovery plans and outcomes	AW ~~March 2023~~ Q1 23/24	Part of inquiry preparation Action to be carried over into 2023/24 Plan	
51	Business continuity	**BC audit** The organisation has a process for internal audit, and outcomes are included in the report to the board.	Commission and undertaken internal audit for BCPs	AW June 2023	Action to be carried over into 2023/24 Plan	

INFECTION CONTROL ANNUAL REPORT

● Information Item   ● NH   ● 5 minutes

REFERENCES

📄 Infection and Prevention Annual Report 2022-23.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	**Infection Prevention and Control Annual Report 22/23**
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse
Report Author(s):	Katheryn Hobbs, Head of Infection Prevention and Control
Report discussed previously at:	Infection Prevention & Control Group (IPCG) and Quality Committee
Level of Assurance:	**Level 1** ✓ **Level 2** **Level 3**

Risk Assessment of Report		
Summary of risks highlighted in this report	Annual programme of work contains elements where improvement is ongoing	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides: • Assurance and evidence of IPC service delivery for the reporting period; including the planned programme of work for the year 23/24 • The report details assurance linked to key documents and legislation as included in the report.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the report - this is the first report using the new format - the final 2 tabs demonstrate the Trust overall compliance and with each criterion of the code of practice at a glance 2 Confirm acceptance of assurance given in respect of risks and actions identified

Summary of Key Issues- Executive Summary

It is important to acknowledge the contributions made by key stakeholder colleagues within the organisation to this report.

The report outlines the achievements and activities of the Infection Prevention and Control (IPC) team during the year and includes the work and audit programme for 2023/24.

The aim of the IPC service is to ensure that all Trust staff members recognise how they can contribute to achieving and maintaining a safe, clean environment and adopt best practice to do this. Infection prevention and control depends on everyone in the organisation knowing their role and fulfilling it. The IPC team also supports the Physical Health Care agenda across Mental Health services.

The Director of Infection Prevention and Control (DIPC) and Infection Prevention and Control (IPC) team have continued to work through unprecedented demand during 2022/23 as the COVID 19 pandemic continued. Specialist advice has been provided to all levels of the organisation both from a clinical and non-clinical perspective in order to support staff and patients not only in relation to COVID 19 safety and as the international outbreak of MPox was identified.

During the reporting period, the Trust command structure meetings have representation from the DIPC and IPC teams to ensure decision-making, information dissemination and monitoring and assurance of IPC principles in accordance with national guidance is robust. Initially meetings were held on a weekly basis, as the year progressed and we learned to "live with covid" as a nation, meetings were held on a decision making basis only.

Assurance of policy has been provided through regular updating of the Board Assurance Framework, which has been reviewed bi-monthly and reported through Quality committee. This links closely into the updated IPC Code of Practice, which was updated late in 2022

The IPC Team are committed to ensuring learning from cases of health care associated infection (including outbreaks) is shared across the organisation. Work is ongoing with the clinical teams to identify learning points, which are then communicated via the culture of learning platform and IPC newsletter.

In order to give assurance of compliance with the Hygiene Code an audit programme is undertaken each year, in part by the IPC Team members and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, cleaning, and mattresses are audited. The ongoing COVID 19 pandemic has meant this has been a challenge during 2022/23 due to peaks in COVID 19 cases and outbreaks over the year, however, the team have been able to audit all required departments during the reporting period, and support has been provided for the clinical teams in the completion of their self-auditing.

The IPC team play an active role in essential safety committees including Water quality, ventilation safety. Medical Devices and Physical Health. A quarterly Infection Prevention and Control Group meeting is held as a part of the wider clinical governance structures within the organisation, which includes engagement of key stakeholders.

Our commitment to closer working with our care partners has seen us have regular discussion and moves towards policy alignment with our partners taking into consideration differing needs; with the desired outcome of promoting a smooth patient journey. EPUT is the lead provider for IPC within our Mid & South Essex (MSE) community collaborative, which contributes to the collaboration and joint approaches pertaining to key IPC principles.

The team have continued to provide training for staff as part of the induction programme and ongoing mandatory training is provided via E-learning. In August 2022 the Trust transitioned to take on the National IPC training E-Learning programme to align with key care partners across Essex. Ad hoc training sessions have been provided for clinical teams as the IPC team has increased in number.

The Organisation has acknowledged the impact that the IPC team have had during the pandemic period and as a result agreed to commit to a programme of recruitment into the IPC team. All posts advertised have been successfully recruited into. As of March 2023, the Trust now has an IPC Nurse supporting each of the

care units providing colleagues and patients with a broad spectrum of knowledge and skills within the specialism.

Key Infection Prevention and Control Achievements in the organisation:
- The IPC team have continued with the robust response to requests from the National Government, UKHSA, NHS England in relation to the management in relation to the management of the COVID 19 pandemic
- Provision of a robust response to requests from the National Government, UKHSA and NHS England in relation to the management of MPox during the international outbreak
- Over 8000 staff have received individual support by the IPC team nurses when testing positive for COVID-19 or been in contact with a case via the robust track and trace system set up and delivered by the IPC team
- Preparation of documents and attendance at the Trust Command and control structure during the pandemic by ensuring national guidelines are put into practice at local level with user friendly policies to support staff clinical decision making
- Provision of expert advice and leadership on the management of nosocomial outbreaks of infection within the organization
- Bi- monthly review and submission of the national board assurance framework
- Maintained levels of support in relation to non COVID 19 related IPC issues/ queries
- Carried out supportive site visits for clinical and non-clinical staff and provided bespoke responses to team IPC needs
- Carried out yearly IPC audits as per the annual audit programme in order to assist teams in identifying and actioning areas of good practice and improvement in accordance with evidence based best practice and national technical memorandum standards
- Supported the Trust estates teams in refurbishment projects providing advice to align with the national health technical memorandums to ensure health care standards are met when changes of use or refurbishment projects are in the planning stages
- Attendance at and provision of expert IPC advice at the Trust water and ventilation safety committees
- Support of the Trust facilities team on the development of the Trust response to the National Cleaning Standards
- Led on the provision of the staff influenza vaccination campaign with the support of the mass vaccination and occupational health teams
- Led the fit testing project for colleagues within EPUT and provided fit testing for colleagues within the integrated care system, in particular during the MPox outbreak
- Lead provider of the MSE community IPC collaborative work stream working to unify aspects of IPC standards and policy across Essex
- Delivery of the Trust induction programme for staff including face to face sessions for international colleagues joining the organisation
- Provision of adhoc training sessions in the workplace for staff
- Creation of a monthly IPC newsletter providing updates, education and lessons learned whilst out in the clinical departments
- Support the Trust Estates team in assessing compliance of clinical hand wash basins in the organization and subsequent replacement in order to align with national technical memorandum standards
- The mass vaccination teams have offered Covid 19 vaccinations both to staff and patients in mass vaccination centres, inpatient and care home settings and patient's own homes
- Provided expert IPC advice to EPUT teams working with migrant populations across the geography of the trust
- Support of clinical community teams in the tender process relating to pressure relieving equipment
- Support of the facilities team in the tender process relating to securing an appropriate waste contract
- Secured a service level agreement with a Consultant Microbiologist to provide expert clinical advice when required.
- Facilitated the development of an antimicrobial stewardship group by supporting the antimicrobial stewardship Pharmacist
- The Covid mass vaccination team reached over 1.57 million people including patients, staff and members of the public by early March 2023

Relationship to Trust Strategic Objectives

SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	✓
Communication and consultation with stakeholders required	✓
Service impact/health improvement gains	✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	
Governance implications	✓
Impact on patient safety/quality	✓
Impact on equality and diversity	✓

Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report

UKHSA	UK Health Security Agency	AGP	Aerosol generating procedures
IPC	Infection Prevention and Control	NERVTAG	New and Emerging Respiratory Virus Threats Advisory Group
MSE	Mid and South Essex Hospitals Trust	PPE	Personal Protective Equipment
FFP3	Filtering Face Piece	OH	Occupational health

Supporting Reports/ Appendices /or further reading

Infection Prevention & Control Annual Report

Lead

Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control ANNUAL REPORT 2022-2023

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST Infection Prevention and Control

ANNUAL REPORT

2022/2023

CONTENTS

EXECUTIVE SUMMARY

The purpose of this report is to provide assurance that the Trust provides a robust, proactive and effective Infection Prevention and Control (IPC) service. Additionally, the report provides assurance that the Trust is compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This assurance also extends to the Care Quality Commission's Fundamental Standards and other related standards.

It is important to acknowledge the contributions made by key stakeholder colleagues within the organisation to this report.

The report outlines the achievements and activities of the Infection Prevention and Control team during the year and includes the work and audit programme for 2023/24.

The programme is founded on key documents and legislation including:

- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Care Quality Commission (Registration) Regulations 2009
- Care Quality Commission Fundamental Standards 2015
- Code of Practice for health and adult social care on the prevention and control of infections and related guidance (July 2015)
- All relevant NHS / DH / NPSA Guidance
- All relevant expert guidance / evidence-based practice / NICE Guidelines

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Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

The Trust has acknowledged the key role that IPC teams play in the provision of safe care for patients and reduction of risk to staff. As a result of this recognition, the IPC team have successfully recruited into the team. The new structure of the team aligns with the organization strategy of a care unit/ specialty approach

Director of Nursing and Infection Prevention and Control

Head of Infection Prevention and Control
Band 8B 1 wte

| Care Unit-Specialist Services Band 7 1wte | Care Unit-Inpatients and Urgent Care x2 Band 7 1 wte job share | Care Unit-West community Services Band 7 0.8 wte | Care Unit-North East Community Services Band 6 0.8 wte | Mid and South Essex Community Services Band 6 1 wte |

IPC team Administrator Band 4 1 wte

IPC team Associate Practitioners x2 Band 4 wte

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Role of the IPC team members within the Care Units:

- Establish positive working relationships with the Deputy Directors of Quality and Safety for the Care Unit
- Establish a good understanding of the services provided in the care unit and build positive working relationships with the staff in order to increase staff engagement and therefore, quality of safe care
- Spend approximately 50% of the working week in clinical departments, supporting practice, ad-hoc education, case review.
- Visit sites within the care unit to complete annual environmental audit and action planning which will inform training/ teaching requirements
- Support clinical teams with their auditing and reporting into KPI including provision of narrative when required
- Delivery of appropriate IPC training sessions as required by the care unit, driven by local and national direction
- Support the DDQS in providing robust reporting into the IPCC and other relevant committees including HCAIS reporting
- Support fit testing of the staff in the care unit alongside Health and Safety team members, in line with the organisational PPE risk assessment
- Support the delivery of the annual influenza vaccination programme and delivery of vaccination for staff within the care unit
- Assist in IPC winter planning for the care unit
- Attend Care unit quality and safety meetings ensuring IPC is on the agenda and reported on at each meeting with the aim the DDQS will deliver IPC report by exception in the longer term
- Support team colleagues who may have competing work demands as required
- Monitoring of relevant incident reporting and action planning where appropriate
- Be open and available to take direction from other members of the senior nursing team in the absence of the Head of IPC
- Band 4 Administrator and Associate Practitioners will support all team members as required

A service level agreement is in place with a Consultant Microbiologist who continues to work within the local acute Trust, and provides expert clinical advice to the organisation and on an individual basis when required

A quarterly Infection Prevention and Control Group meeting is chaired by the DIPC with key stakeholder attendance and engagement (including clinical and estates and facilities representation). Over this reporting period, membership has been reviewed in order to ensure it is current and relevant and supports the care unit approach to working that is being developed by the organisation. The meeting is also attended by all three commissioning board colleagues
This meeting provides oversight and assessment of IPC assurance across the Trust

IPC information training and supervision:

The IPC team deliver induction training as part of the trust corporate induction programme. This has

been delivered using a virtual platform during the last year due to the covid 19 pandemic.
Mandatory training is provided for all staff using the Oracle Learning Management platform. The trust
has procured IPC training via the national skills for health programme to ensure training is updated in
a timely way as changes in national guidelines are made, as well as to align with our partner
community Trust organisations.

As of March 2023, the trust traininfg department have reported compliance with IPC mandatory
training as follows:

1 Yearly mandatory training compliance	3 Yearly mandatory training compliance
93%	96%

Ad hoc training is delivered in the workplace by the IPC team as required, following audit, site visits or
as part of lessons learned following incidents of health care associated infection
A monthly IPC newsletter is in production, which is shared via the trust Wednesday weekly forum and
is used as a means of providing training relating to specific organisms and feeding back information
found whilst out and about on site visits. An example of this can be seen below;

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NHS Foundation Trust

Infection Prevention & Control NEWSLETTER

March 2023

Welcome to the latest edition of our newsletter. This month's edition includes a focus on Diptheria, reminders about the latest IPC guidance and hand hygiene.

Focus on: Diotheria

Diptheria is a very rare infection in England due to the success of the routine immunisation programme in 1942, a time when the average annual number of cases was about 60,000 per year with 4,00 deaths.

Over the past decade, the number of diphtheria cases has increased to an average of 2 -11 cases per year. In 2021 there were 10 cases in the UK, 3 of which were toxigenic Corynebacterim diptheriae.

There has been an increase in the number of cases of C. diptheriae amongst asylum seekers arriving in the UK from January –November 2022 where 50 cases were isolated. Whilst many cases originate from diphtheria endemic countries it is likely that they have acquired their infection whether in their country of origin or those they have travelled through.

Symptoms of diphtheria

Symptoms usually start 2 to 5 days after becoming infected.

Diptheria infection can present with a range of symptoms.

Classical respiratory diphtheria which obstructs the airways. Respiratory diphtheria is characterised by a swollen 'bull neck' and strongly adherent pseudomembrane which obstruct airways.

A milder respiratory form of the disease where patients present with sore throat or pharyngitis can occur in immunised or partially immunised individuals.

- A thick grey-white coating that may cover the back of your throat, nose and tongue
- a high temperature (fever)
- sore throat
- swollen glands in your neck 'bull neck'
- difficulty breathing and swallowing

In tropical regions cutaneous presentation of the infection are higher and cutaneous lesions or wounds have been the most prominent presentation reported amongst migrant cases to date.

If it's cutaneous diphtheria, it can cause:

- Pus-filled blisters on legs, feet and hands
- Large ulcers surrounded by red, sore-looking skin

Transmission

Diphtheria is a highly contagious bacterial infection. It's spread by coughs and sneezes, or through close contact with someone who is infected.

You can also get it by sharing items, such as cups, cutlery, clothing or bedding, with an infected person. Contact with lesions of those infected.

Prevention of spread

- Good standards of hand hygiene
- High standards of cleanliness of the environment
- Appropriate use and disposal of PPE in clinical practice
- Apply standard precautions at all times

Patient placement if considering diphtheria as a possible diagnosis nurse in isolation and inform IP&C Team

The main treatments are:

- Antibiotics to kill the diphtheria bacteria
- Medicines that stop the effects of the harmful substances (toxins) produced by the bacteria
- Thoroughly cleaning any infected wounds if you have diphtheria affecting your skin
- Treatment usually lasts 2 to 3 weeks. Any skin ulcers usually heal within 2 to 3 months, but may leave a scar.

People who have been in close contact with someone who has diphtheria may also need to take antibiotics, or may be given a dose of the diphtheria vaccination.

Whenever taking samples for microbiology – please add as much information as possible about recent antibiotic use, overseas travel including hospitalisation or contacts with infectious diseases

Further reading: https://www.nhs.uk/conditions/diphtheria/

Out and About

Take a look in the inner aspects of radiators in your area - they should be cleaned inside 6 monthly & when there have been outbreaks of infection

Please remember to check expiry dates on all products

CLEAN HANDS COUNT

National standards of healthcare cleanliness colour coded cleaning equipment – check your area are the correctly coded mop buckets mop handles/clothes in use

Further reading:
https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/

Red	Blue
Bathrooms, washrooms, showers, toilets, basins and bathroom floors	General areas including wards, departments, offices and basins in public areas
Green	**Yellow**
Catering departments, ward kitchen areas and patient food service at ward level	Isolation areas

Water and Ventilation Safety:

The Trust has systems in place to assess and monitor water quality, safety, and ventilation safety across all sites.
Water quality and ventilation safety meetings are held bi- monthly and are led by the Estates compliance team supported by an Authrosied Engineer, the IPC team and Consultant Microbiologist.

1.1 – Water Risk Assessments

Under the policy and procedure with guidance via the Water Quality Group (WQG), the trust continues to work on a two yearly frequency for water risk assessments across the property portfolio.

Over this period we have completed the below risk assessments across the Trust.

- The Gables
- Northgate
- Edward House
- Landermere
- Kings Wood Centre
- The Lakes
- C&E Centre
- All Saints House
- Bradd Close
- 19 Fairview
- 230/231 Mountnessing Rd
- Edward House

Going forwards the below sites will be completed as part of the programme this year.

- Basildon MHU
- Brentwood Resource Centre
- Chelford Court
- Cherry Trees
- Clough Road
- Coach House Halstead
- Crystal Centre
- Doolittle Mill
- Derwent Centre
- 17 Gordon Road
- Grays Hall
- Harland Centre
- 1,2,3,4,4A,5 Heath Close
- Herrick House
- Holmer Court

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- 1/2 Hospital Road
- ILC
- 439 Ipswich Rd & Coach House
- Knightswick Clinic
- Long Lane Grays
- Maldon Clinic
- St Aubyn Centre
- Mountnessing Court
- Pride House
- Reunion House
- Rivendell Flats
- Robin Pinto
- Rochford Hospital
- Sankey House
- Severalls House & Training Centre
- The Lakes Bungalow
- Linden Centre
- The Lodge
- Thurrock Hospital
- Warrior House Kingsley Ward
- Woodlea Clinic

1.2 - Water Risk Assessment Remedial Works:

WRA remedial works are a rolling programme monitored by the Task and Finish who monitor and track completion and progression.

The tables below detail last WRA programme remedial actions completed and outstanding for EPUT's last Priority 1, 2 and 3 estate. The new WRA programme has already commenced as outlined in 1.1 of this report.

Priority 1 Sites

The majority of outstanding actions relate to PPM management outstanding from our current contractor, these will be resolved when our new incumbent is commissioned in April.

Data Table	High	Medium	Low	Total
Total Actions Completed	130	200	80	410
Breakdown of Outstanding WRA Remedial Actions				
Total Actions Outstanding	14	9	1	24

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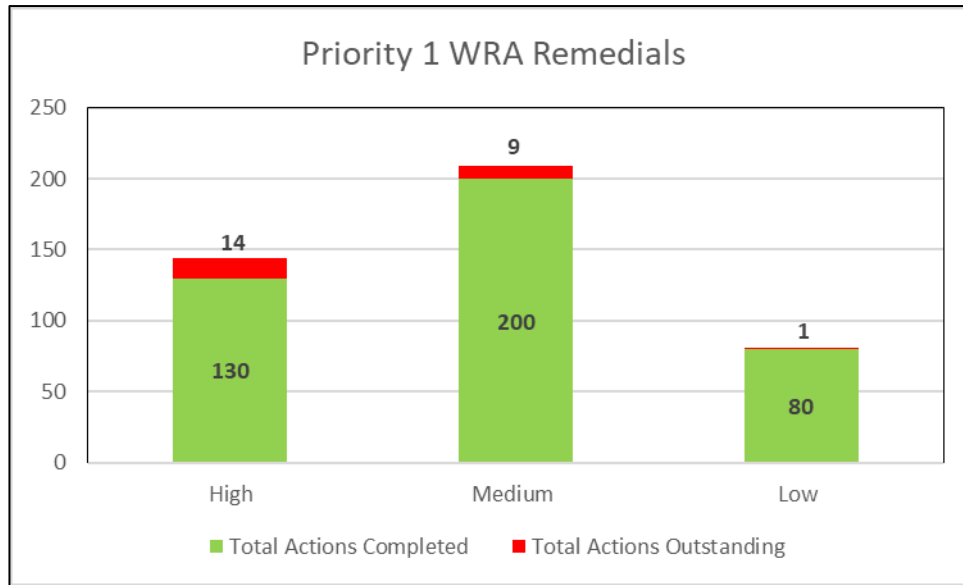
Priority 2 & 3 Sites

The below outstanding remedial relate to PPM management which is in the process of resolution.

Data Table	High	Medium	Low	Total
Total Actions Completed	101	185	65	351
Breakdown of Outstanding WRA Remedial Actions				
Total Actions Outstanding	1	5	1	7

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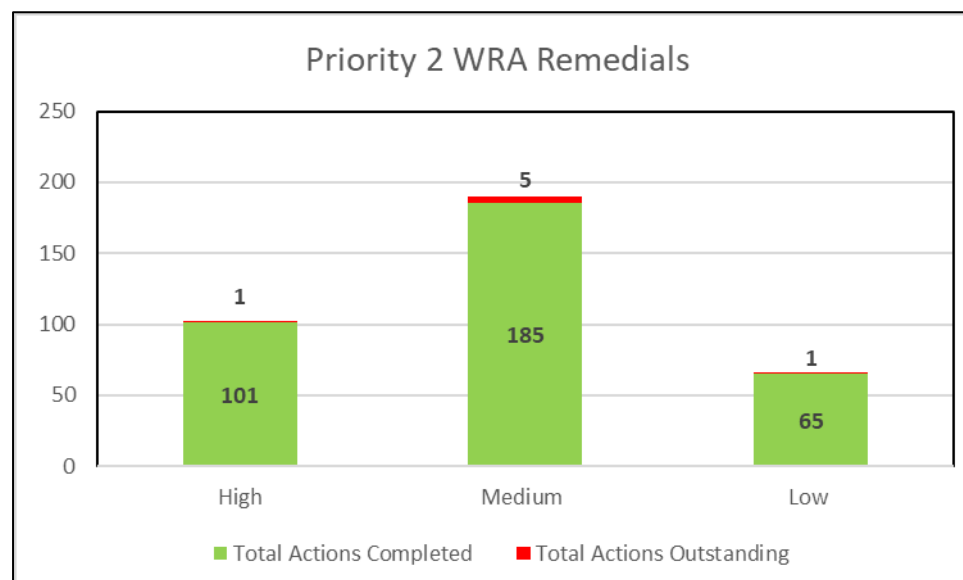
2.0 – Pre Planned Maintenance

This year has been challenging for the water PPM programme, the Trust has been working with its current contractor on poor performance relating to completion of the planned programme and poor standards of service reporting on the Zetasafe system.

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Open Defects as at 23 March 2023

[Pie chart showing Open Defects as at 23 March 2023: North 163 (green), South 110 (blue), West 109 (yellow)]

- North ■ South ■ West
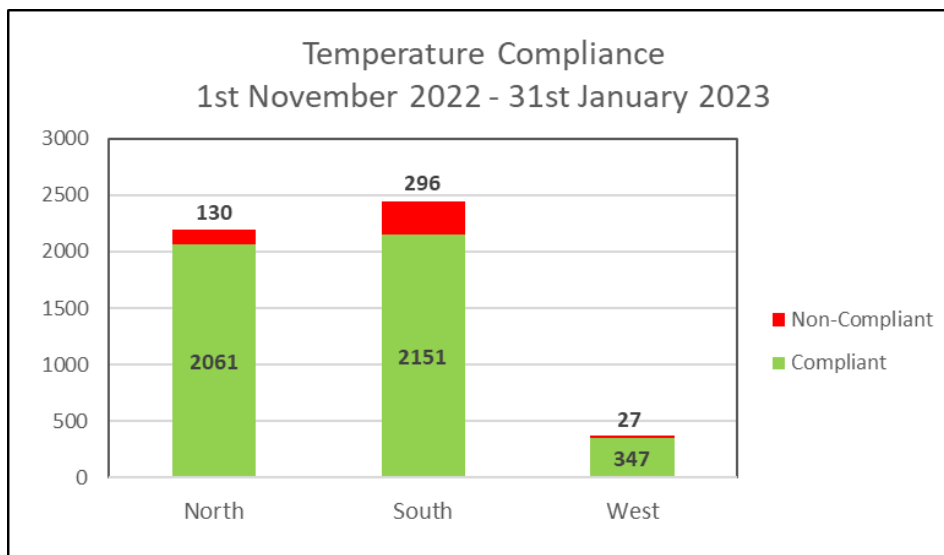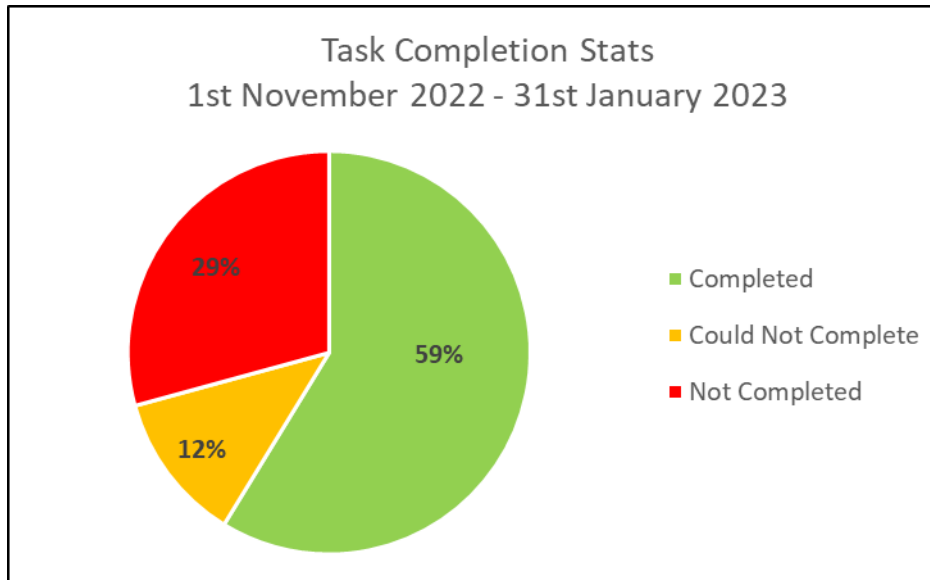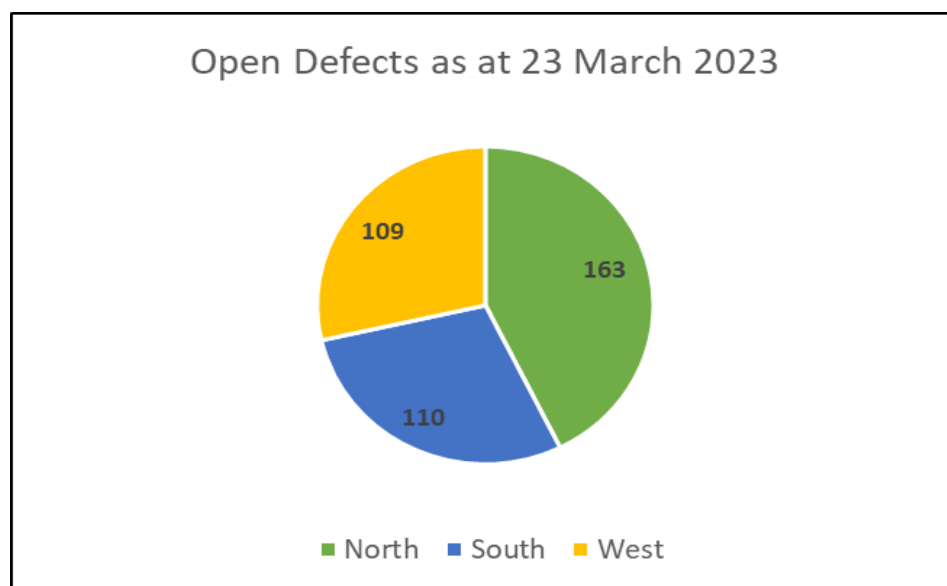
The Trust took the decision to commission an alternative contractor for formulation of a recovery programme from February through to April.

Service reports for those PPM's missed in February have now been provided and are ongoing which have been uploaded to Zetasafe.

March and April also form part of programme with the programme including the following.

- TMV servicing.
- Sentinel and representative temperature testing.
- Cold water storage tank inspections.
- Showerhead de-scales.

The contract has been market tested with evaluations ongoing as part of the procurement process with award and mobilisation by the end of April.

3.0 – NHS Property Services

The Trust has been working with NHS Property Services on two water related issues at the below sites the Trust occupies.

Saffron Walden Community Hospital

NHS PS have worked on a water recovery programme over the last 2 years following a number of counts in Avocet ward included below.

- Installation of two new cold water storage tanks.

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- Installation of a chlorine dioxide dosing unit.
- Increased flushing programme.
- Installation of filters on all outlets on the wards.
- Ongoing sampling programme.
- Re-piping of majority of ward including new shower installation

Over the last 6 months, in conjunction with the Trust water quality group, Authorised Engineer, Microbiologist, IPC and Estates team a significant improvement has led to the decision to remove all remaining filters and decrease the sampling programme although ongoing monitoring will continue.

St Margaret's Hospital Mental Health Unit Epping

There has been a long term water management programme across the whole site with NHS PS alerting us to positive sample results in the MHU.

Filters were installed on all positive outlets with ongoing sampling.

An EPUT capital project is in the process of completion with the Capital Team working in conjunction with NHS PS to ensure ongoing management of the water systems pre/post project.

4.0 – Water Training

The Estates & Facilities team this undertook a comprehensive legionella awareness training programme in line with the Trust water policy frequency of 3 years.

Over 60 Managers (over 86%), Supervisors and members of IPC have been trained with the programme nearing conclusion.

A further basic training programme has been designed, aimed at domestic staff, which will be rolled out for cascade training throughout 2023.

Training programmes on Duty to Manage (Responsible Person) will be scheduled for this year for the Trust R/P as well as existing and new Authorised Persons (A/P's) going forwards.

Once management training has been completed, a review and amendment of the Trust water structure will take place as well as an overall review of the Water Policy and Procedure via the Water Quality Group and Trust Governance process.

5.0 – Edward House

In December 2022 the site experienced issues relating to plant heating and hot water issues. As a contingency the Trust has taken forwards the below water management programme

with a safety group including Estates Water R/P, Chief Engineer, IPC, Authorised Engineer, microbiologist and clinical leads.

- A legionella sampling programme has been undertaken and is ongoing.
- As a contingency, all showers were fitted with filters at the start of the programme as a precaution. The filters have a 3-month lifespan, which expires in April.
- Thermostatic mixing valves have had their yearly strip down and disinfection.
- A water risk assessment had already taken place as part of the programme.
- Increased temperature monitoring.
- The flushing has been increased.
- Pasteurisation of the system.
- A Remedial works programme to the plant is ongoing.
- The PPM programme continues to monitor temperatures and maintain the system ensuring compliance.

A shower has been identified with a small positive count for legionella however a filter is in place. The programme will continue until all issues have been resolved.

6.0 Water Legislation

The trust works in line with Health Technical Memorandum (HTM) 04-01 safe water in healthcare premises and L8 ACOP, The control of legionella bacteria in water systems (Approved Code of Practice and Guidance).

The Trust, along with our contractors also follows the below guidance documents.

HSG 274 Part 2 – The control of legionella bacteria in hot and cold water systems.
HSG 274 Part 3 – The control of legionella bacteria in other risk systems.
BS 8580:2019 Water quality. Risk assessment for legionella control. Code of practice.

In conjunction with our water Authorised Engineer, Responsible Person and Water Quality Group, the Trust continues to closely monitor any changes in legislation or guidance and will make any necessary changes to its policy and procedure and well as water management programmes accordingly.

7.0 - Ventilation

Over the last year the Trust have taken forwards the below developments on ventilation management.

- The appointment of an assigned Authorised Engineer.
- The formation of a Ventilation Safety Group.
- Ventilation Awareness Training to Estates and IPC management.
- Audits at key sites completed and provided by the Authorised Engineer.
- Identification of future capital schemes to improve ventilation systems in the future including feasibility studies.

The Trust will continue to expand ventilation with the formulation of a policy and procedure document, continued training for identified authorised persons and identification of risks and schemes going forwards

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Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

  EPUT currently operate their cleaning regime through an in house service managed by the Facilities team. This includes the majority of inpatient wards, offices, Health Centres and Clinics across the whole geographical span of EPUT. There are the odd areas such as 439 Ipswich Road that currently provide their own in house cleaning. EPUT have staff in buildings that are currently cleaned by NHS PS most of these are in the southeast. In house cleaning has been part of EPUT for several years and has gone through various tendering exercises to ensure value for money and the appropriate cleaning frequencies in all areas. Following the launch of the new National Cleaning Standards in 2022, it has been necessary to review along with our colleagues in IPC and Estates, all items within a building that need to have regular cleaning and maintenance.

Element	After Patient Use or if visibly soiled	Daily Clean Responsibility	Periodic Clean Responsibility
Bed pan (reusable), bed pan holder, patient wash bowls.	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Bed pan washer / macerator.	Ward/Dept Clinical team	~~Ward/Dept Clinical team~~ External Cleaning Team	Ward/Dept Clinical team
Other sluice equipment including sluice sink and equipment holders.	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Commodes.	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Patients hoists.	Ward/Dept Clinical team	N/A	~~Cleaning Team~~ - Ward Dept Clinical Team
Weighing scales including neonatal, seated and standing scales.	Ward/Dept Clinical team	N/A	Ward/Dept Clinical team
Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, medical gas bottles and stands, walking aids. Refer to local protocol for medical equipment connected to and not connected to a patient.	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Wheelchairs (organisation owned). Refer to local protocol.	Ward/Dept Clinical team	N/A	Ward/Dept Clinical team
Patient fans - with accessible blade. Refer to local risk assessment and protocol.	Ward/Dept Clinical team	N/A	Estates
Patient TV and bedside entertainment systems including head pieces.	Cleaning Team	N/A	Cleaning Team
Notes and drugs trolleys and patient clipboards.	~~Cleaning Team~~ Ward /Dept Clinical team	~~Cleaning Team~~ Ward /Dept Clinical team	~~Cleaning Team~~ Ward /Dept Clinical team
All chairs and couches (soft furniture).	N/A	Cleaning Team	N/A
Patient beds - frame, wheels, castors, head, foot, cot sides, nurse call and control panels, including carers beds in the clinical area. Non patient beds including on-call beds - clean as per local protocol.	Cleaning Team	Cleaning Team	Cleaning Team
Patient bed and trolley mattresses. Refer to local protocol for inspection of mattress integrity and ingression.	~~Cleaning Team~~ Ward /Dept Clinical team	N/A	~~Cleaning Team~~ Ward /Dept Clinical team
Patient trolleys and treatment couches. Trolleys with x-ray storage and oxygen cylinders clean according to local protocol.	~~Cleaning Team~~ Ward /Dept Clinical team	N/A	~~Cleaning Team~~ Ward /Dept Clinical team
Patient toys (premises owned). Refer to local protocol and risk assessment.	Ward/Dept Clinical team	N/A	Ward/Dept Clinical team
Switches, sockets and data points, trunking, handrails and wall fixtures.	N/A	Cleaning Team	Cleaning Team
Walls - accessible up to 2 metres.	N/A	Cleaning Team	Cleaning Team
Ceilings and walls - not accessible above 2 metres and ceiling lights.	N/A	N/A	Cleaning Team
Floor - hard including skirtings.	N/A	Cleaning Team	Cleaning Team
Floor - soft including skirtings.	N/A	Cleaning Team	Cleaning Team
All doors including ventilation grilles.	N/A	Cleaning Team	Cleaning Team
All windows including frames where accessible.	N/A	N/A	Estates / Contractor
All internal glazing including partitions (excluding mirrors and windows).	N/A	Cleaning Team	Cleaning Team
Mirrors.	N/A	Cleaning Team	Cleaning Team

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Element	After Patient Use or if visibly soiled	Daily Clean Responsibility	Periodic Clean Responsibility
Dispenser cleaning - hand wash, hand sanitisers, paper towel holders, toilet roll holders, all alcohol dispensers and hand dryers, including glove and apron dispensers. Replenish as required.	N/A	Cleaning Team	N/A
All elements of showers.	N/A	Cleaning Team	Cleaning Team
Toilets, bidets, urinals and toilet brushes.	Ward/Dept Clinical team Cleaning Team	Cleaning Team	N/A
Sinks and taps.	N/A	Cleaning Team	N/A
Baths and taps.	Ward/Dept Clinical team Cleaning Team	Cleaning Team	N/A
Radiators including cover.	N/A	Cleaning Team	Cleaning Team / Estates
Low surfaces - low level pipes and low level trunking.	N/A	Cleaning Team	Cleaning Team
Middle surfaces - window sills, non patient furniture, tables, desks, shelves and ledges, work surfaces and cupboards exteriors. This does not include items covered by other elements in this list, i.e. switches & sockets.	N/A	Cleaning Team	Cleaning Team
High surfaces including curtain rails, staff locker tops that are accessible, and high surfaces around patient bed areas.	N/A	Cleaning Team	Cleaning Team
Bedside lockers.	Cleaning Team	Cleaning Team	Cleaning Team
Over bed tables and dining tables.	Cleaning Team	Cleaning Team	Cleaning Team
All waste receptacles (does not include euro/wheelie bin).	Cleaning Team	Cleaning Team	Cleaning Team
Linen and general-purpose trolleys.	N/A	N/A	Cleaning Team
Replenishment of consumables.	N/A	Cleaning Team	Cleaning Team
Ventilation grilles extracts and inlets.	N/A	N/A	Cleaning Team Estates
Lighting including overhead, bedside, wall mounted examination lights both fixed and portable.	Cleaning Team	Cleaning Team	Cleaning Team
Electrical items in multi-use areas - specifically computers and phones for example at nurses' station, computers on wheels (COWs) and workstations on wheels (WOWs), computer casing only.	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Curtains and blinds (disposable and fabric).	Cleaning Team	N/A	Cleaning Team
Dishwashers. Descale as per local protocol.	N/A	Cleaning Team/Catering (to be determined locally)	Cleaning Team/Catering (to be determined locally)
Fridges and freezers (patient areas ONLY).	N/A	Cleaning Team/Catering (to be determined locally)	Cleaning Team/Catering (to be determined locally)
Fridges and freezers clinical (including but not limited to bloods fridges, medicine fridges, ice freezers for physio departments)	Ward/Dept Clinical team	Ward/Dept Clinical team	Ward/Dept Clinical team
Ice machines, hot water boilers and cold-water machines including drip trays. Follow local Infection Prevention and Control guidelines. Follow local protocol for descaling.	N/A	Cleaning Team/Catering (to be determined locally)	Cleaning Team/Catering (to be determined locally)
Kitchen cupboards.	N/A	Cleaning Team/Catering (to be determined locally)	Cleaning Team/Catering (to be determined locally)
Microwaves and traditional cookers/ovens.(Patient areas ONLY)	N/A	Cleaning Team/Catering (to be determined locally)	Cleaning Team/Catering (to be determined locally)
All cleaning equipment including cleaning trolley.	N/A	Cleaning Team	N/A

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Currently we clean daily 365 days of the year from 8 am to 8 pm in inpatient units and other areas Monday to Friday at agreed times. During this time there are Supervisors in all areas complimented by a Management team.

Name	Job Title	Area of responsibility
Fiona Benson	Deputy Director of Facilities	Trust Wide
David Driver	Head of Facilities	Trust Wide
Wendy Britton	Facilities Manager	Areas South Essex
Stephen Moore	Facilities Officer	Clifton Lodge, Rawreth Court, Byron Court and Community Clinics
Kirsty Savage	Facilities Officer	Basildon MHU, Rochford
Robbie Deeming	Facilities Officer	Brockfield, Thurrock
Julie Allum	Facilities Manager	Areas North Essex
Anita Wightwick	Facilities Officer	Landermere & North Essex Community Clinics
Tom Blake	Facilities Officer	Kingswood, St Aubyn Centre, The Lakes
Theresa Salha	Facilities Officer	Linden Centre, Crystal Centre, Edward House
Laura Newman	Facilities Manager	West Essex/Bedford and Luton
Ricky Cichon	Facilities Officer	Saffron Walden, Derwent Centre, West Essex Community Clinics
Jackie Thorpe	Facilities Officer	St Margaret's Hospital
Paul Adams	Estates & Facilities Officer	Robin Pinto/Woodlea

Being a Mental Health Trust cleaning in some areas is difficult and the team need to be respective of the patients and staff needs. There has been a huge shift in the last few years to accommodate patients likes and dislikes in regards to vacating their bedrooms at agreed times. This means that the teams have to be flexible and work very closely with our clinical colleagues to ensure that all works are completed as required. There is also an added risk for all cleaning operatives using both their equipment and their cleaning materials and through training and supervision is ongoing to ensure that both equipment and materials are stored and used appropriately and do no present any harm to the patients. Regularly auditing and monitoring takes place and recently we have just introduced a new Auditor into the team whose principle role will be to audit, unannounced, in all areas across the Trust.

Annual Summary	North	South	West	Averages
Functional risk cat 2	96%	97%	97%	96.67%
Functional risk cat 3	97%	97%	96%	96.67%
Functional risk cat 4	95%	96%	96%	95.67%

The Trust has had sight of the new National Cleaning Standards and is aware that some of the requirements have yet to be funded. These include wall washing, cleaning at extreme heights, perimeter cleaning, and a regular curtain change and clean programme. There is also a requirement to provide a rapid response team to attend when an incident has happened, both within working hours, and outside as well. We are also reliant on our Estates colleagues

to complete some of the works such as vent cleaning, insectocure, light fittings and the removal of some of the heavy equipment especially in kitchens. As by agreement, there are also items that are cleaned by our nursing colleagues such as mattresses on discharge and on a PPM. We therefore try to work with an all inclusive framework and regularly meet with our other colleagues if there is an issue whereby we feel that our standards are being reduced.

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship (AMS) is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. Antibiotics should never be prescribed or supplied for viral infections.

Antimicrobial prescribing continues to be monitored in the organisation on an annual basis, as part of the code of practice, which supports compliance with the Health and Social Care Act (2008). All prescriptions of antimicrobials within the organisation are governed by national and local prescribing guidelines, which advocate the use of specific antimicrobials for a specified period of time. Non-formulary antimicrobials are only available following advice from consultant microbiology colleagues in the local acute trusts. These are not dispensed by pharmacy unless assurances are received that the prescription has been discussed and agreed. Prescriptions for inpatient settings are clinically screened by a pharmacist for:

- Appropriateness including route, dose, duration, frequency taking into account patient co-morbidities
- Selection of antimicrobial according to guidelines for specific clinical indications and any microbiological samples
- Length of treatment and potential switches from IV to oral 9only applicable in community health services)

Education relating to antimicrobial stewardship is promoted by the Annual Audit on antimicrobial prescribing and taught in the mandatory Medicines Management training courses for both medical and nursing staff.

During Q4 of 22//23, an Antibiotic Stewardship Group has been formed which will sit separately to the existing IPC group. This group will report directly to the relevant medicines management group with a responsibility to feed any relevant decisions into the IPC group. Membership will include the DIPC for the Trust, a microbiologist, Pharmacist lead, Head of IPC, Quality leads and representation form nursing and medical. The remit of the group will align with the Health and Social Care Act 2008, criterion 3: antimicrobial use, and will focus on:

- Monitoring the use of antimicrobials across the Trust to ensure inappropriate and harmful use is minimised, drawing on local or national guidance where appropriate
- Education and training to medical, nursing and pharmacy staff, promoting constant review of prescriptions and embedding an awareness within the Trust
- Promotion of European Antibiotic Awareness Day

Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The trust provides a variety of information leaflets for patients, carers and relatives along with posters, which help explain their responsibilities relating to reducing the risk of infection transmission. As the trust returns to a business as usual approach in the pandemic, all IPC posters will be under review to ensure they reflect current guidelines.

The visiting guidelines have been updated regularly as changes in national guidelines have occurred throughout the pandemic period in order to protect both patients, visitors and staff

Although the continued impact of the pandemic on the workload of the IPCT has necessitated reprioritization of work on a regular basis throughout the year, plan are in place to celebrate and educate both patients and staff during Global Hand Hygiene week in May 2023 as an integral element of an IPC back to basic campaign. Discussions are already underway with the Trust antimicrobial stewardship Pharmacist to ensure an education event is planned for Antibiotic Awareness week and Infection Control week later in the year

Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
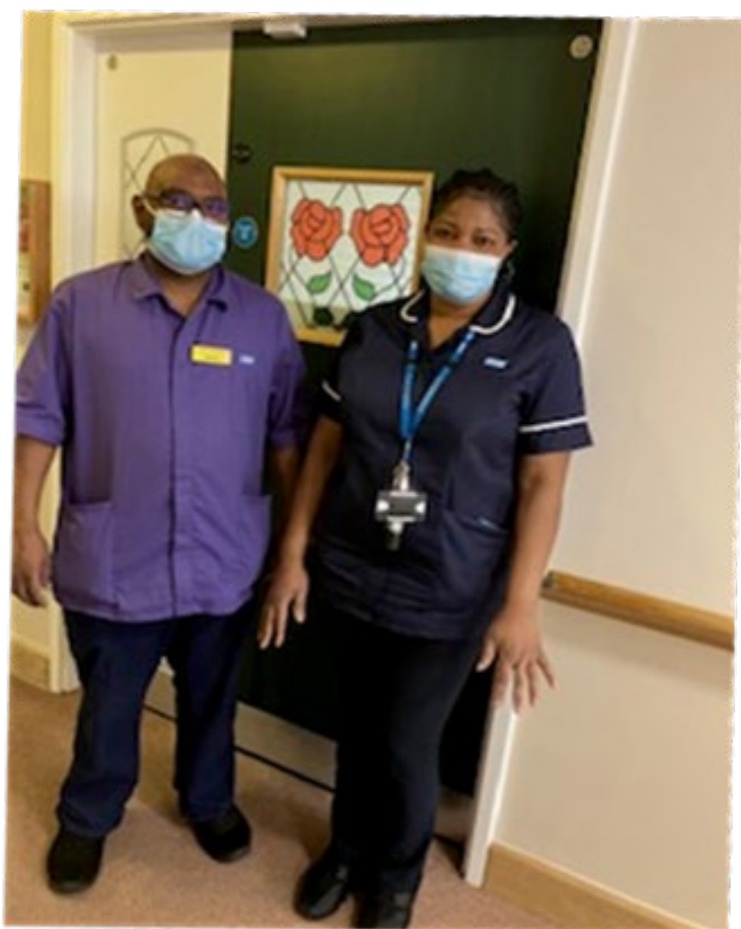
IPC policies:

The trust has a policy in place detailing isolation requirements for specific infectious illnesses and the management of outbreak situations. All policies are reviewed on a three yearly basis or as national guidance changes

A summary of policy updates in the reporting period can be seen below;

Month 22/23	Policy
April	Covid guidelines updated

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May	Covid guidelines updated Monkey pox guidelines created
June	Covid guidelines updated
July	Covid guidelines updated TB policy
August	Covid guidelines updated
September	Covid guidelines updated MRSA policy- reviewed and is part of a community collaborative piece of work to finalise screening in community settings
October	Covid guidelines updated Pets and Pests
November	Covid guidelines updated
December	Covid guidelines updated
January	Covid guidelines updated
February	Mattress decontamination Infestations
March	Covid guidelines updated

Cases of Reportable Health Care Associated Infection:

All cases of mandatory reportable health care associated infection are fully investigated with the clinical team involved and a post infection review process to identify any learning follows:

MRSA blood stream infection:

Two residents in a non EPUT care home were identified as having and MRSA blood stream infection during March 2023. Each resident was provided with care by EPUT District Nursing teams

A collaborative post infection review meeting was held with the care home, clinical team and ICB colleagues following the investigation, the cases are summarised below:

Pt 1-

Patient situation	Care home resident with long term catheter, developed moisture lesion on buttocks. Known to be MRSA positive on several previous occasions, although urine negative on testing Patient sadly passed away
Reason for admission to acute trust	Deterioriation following identification of covid 19
Good practices identified	Diligent MRSA screening by district Nursing team Timely decolonisation treatment prescribed and given

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	Provision of decolonization regime to care home team Appropriate pressure relieving equipment in use Appropriate use of incontinence cleanser and barrier cream
Root cause of bacteraemia	Possible root causes Skin damage Chest Urinary catheter Death certificate sited old age and frailty as causes of death

Patient 2-

Patient situation	Care home resident being visited by DN team for monitoring of blood sugars and insulin administration. Developed a small wound on heel which was assessed as no clinical signs of infection
Reason for admission to acute trust	Sudden deterioration following a period of unstable hyperglycaemia NEWs score of 10. Noted to have strong smelling urine at this time Prolonged stay in emergency department. Diagnosed with community acquired pneumonia and unstable blood sugars. Found to have superficial moisture damage on warding but this healed quickly
Good practies identified	Clinical decision not to screen heel for MRSA as clinical judgement made that it was a healthy non infected in appearance wound
Root cause of bacteraemia	Possible root causes Chest Urinary tract Moisture damage Patient returned to care home following antibiotic treatment, all wounds healed

Laboratory samples from both cases were sent for ribotyping to investigate whether they may be indentical strains. However, this has not been confirmed. The post infection review identified some further information was required from the acute trust involved. However, in both cases the care home and DN team

were thanked for their diligence with each resident and their engagement in the process. The Trust has identified some lessons learned as follows and an action plan will be established between the IPCT and clinical team

- The Community Collaborative MRSA screening policy is under review due to the complexity of MRSA screening within the community settings
- Review of IPC audit tools for community settings is underway
- The IPC team will spend time shadowing the DN team in order to gain greater understanding of the complexity of the role
- Workplace based refresher training will be provided to the DN team in relation to back to basics IPC subject matter

Neither case will be attributed to the organisation.

Clostridoides Difficile:

An inpatient at EPUT was identified as having *C.diff* present in her bowel within 48hrs of admission to Trust services. This case is still under investigation at time of writing. However, the clinical team sent a further stool sample when the patient developed an increase in frequency of loose stools a few days later. This second sample detected the *C.diff toxin.* The team are being supported through the root cause analysis process by the IPCT and an internal post infection review will be held in order to determine aspects of good practice and opportunities for improvement. The patient was isolated appropriately and treatment instigated.

Outbreak management:

The definition of outbreak is two or more connected cases of infectious disease in either patients, staff or visitors. Outbreaks in EPUT services over the period 2022/2023 were predominantly, but not exclusively, COVID 19. The prevalence rate within services often were commensurate with community prevalence rates.

During this reporting period, there have been significant changes to national guidelines relating to isolation, PPE use and patient and staff testing.

IPC have been instrumental this year in ensuring that all outbreaks have been reported in line with national policy, and local, and regional requirements. This also includes reporting to UKHSA. The submission of IIMarch reports has continued although the frequency was reviewed towards the end of the reporting period and submission is no longer required at weekends. IPC have coordinated regular Incident Management Team (IMT) meetings for all suspected and confirmed outbreaks at identification, at appropriate intervals during the course of the outbreak and at closure. In addition to being fact finding, these meetings are supportive in nature. The discussions and additional analysis have helped reiterate IPC measures, define good practice and lessons learned. At the closure of an outbreak, teams are asked to complete a learning lessons slide.

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Themes we have learned from our outbreaks:

What happened?

- Patients have tested positive following transfer from other hospitals, transfer within EPUT, returning from leave and having more social contact.

- Observed rapid spread of infection and positive cases in some instances

- Observed shorter incubation period than with previous variants and in general patients seeming to experience milder symptoms

- Difficulties in isolating patients

- Staff continued to attend work when experiencing symptoms

Themes we have learned from our outbreaks:

Why did it happen?

- Review of national guidelines and reduction of measures such as social distancing and PPE requirements.

- At times at risk patients were unable to be isolated effectively leading to increased risk of transmission to others. Ward environments foster closer contacts for patients

- Outbreaks often reflected community transmission levels. Staff and patients are more able to interact with reduction in measures for general population

- Reduction in social restrictions external to the healthcare settings meant more possibility of contact with positive cases for staff and patients

- Sometime no apparent cause or breach in guidelines found

- Circulating variant remains highly transmissible with a reduced incubation period

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Themes from our outbreaks:

What are we doing about it?

- Reinforcement of IPC principles and outbreak measures
- Encouraging patients to isolate and utilising alternative management strategies where this is not possible
- Ensuring all EPUT policies and guidance documents are reviewed regularly in line with national guidance, local prevalence rates and lessons learnt
- IPC support for all staff ongoing
- Encouraging reflection throughout the outbreak process to identify lessons learned and sharing the learning regularly throughout the organisation
- Ensuring temporary staff have full and comprehensive induction to units

Themes from our outbreaks:

What did we do well?

- Teams are more able to recognize signs and symptoms and acted quickly meaning that testing was carried out and isolation was implemented fast.
- IPC team support and guidance
- Followed IPC outbreak precautions, often at the identification of the first case and before outbreak considered
- Maintained excellent communication with relatives and friends so that everybody was fully advised of the situation
- All patients' physical health closely monitored and appropriate action taken in the event of any deterioration
- Continued provision of support during isolation for patients with the use of isolation packs

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Themes from our outbreaks:

What have we learned?

- That the circulating variants of the virus are highly transmissible with a shorter incubation period

- Following national guidance to reduce testing, PPE and social distancing had an impact

- Staff absence lead to higher use of bank and agency than normal, with associated risks of not knowing the patient. One service noted increased acuity of the ward as a direct result.

- Fast decisive action and implementation of outbreak measures reduces impact and risk of further spread.

- IPC measures help reduce spread

- Good communication and information sharing is key

- Team working ensures provision of safe and effective care

- Isolation is not easy and at times needs innovative management.

The table below provides a summary of the outbreaks during this period:

Care unit area	Number of Outbreaks	Number of patients affected	Number of staff affected	Number of deaths
Mid and south Essex community	8	16	27	
North east Essex community	1	0	5	
Specialist services	14	62	41	
Urgent care and inpatients	37	184	87	
West Essex Community	10	50	44	
TOTALS	70	312	204	

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The graph below shows the pattern of COVID outbreaks over the reporting period and that they reflect the regional prevalence picture
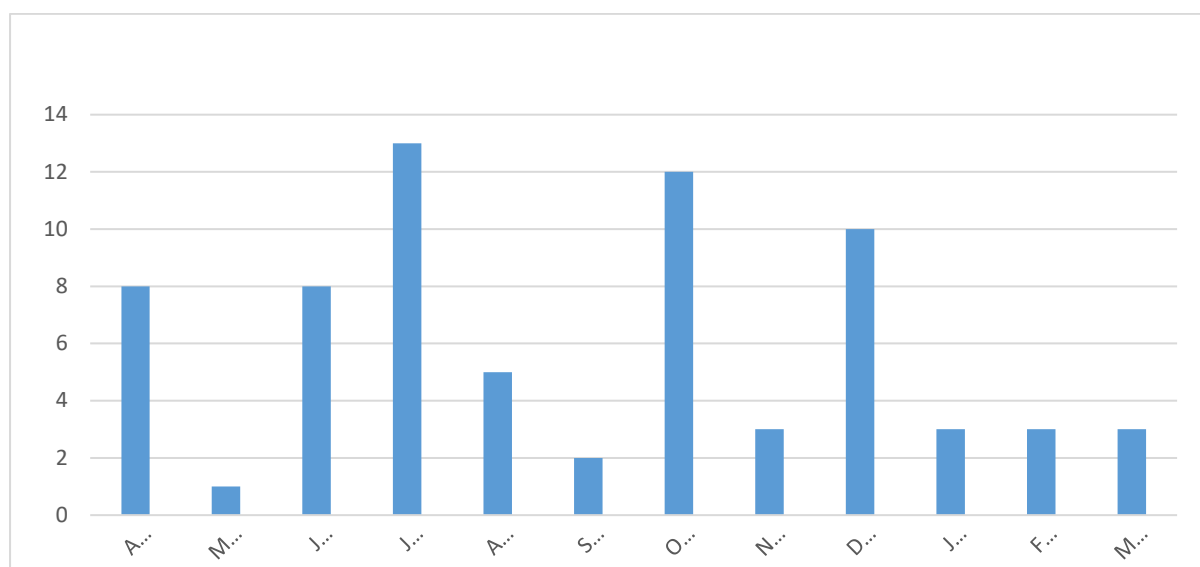
Lessons learned from the COVID outbreaks have been shared in various formats throughout the organization as part of EPUT's culture of learning. These formats include five key messages and lessons identified newsletters. Below is a summary of lessons learned:

Diarrhoea and Vomiting outbreak

At the beginning of March 2023 seven patients in total and three staff experienced symptoms of diarrhoea and vomiting on Meadowview ward with the first three patients becoming symptomatic over a weekend. Staff immediately isolated the symptomatic patients, implemented appropriate IPC measures, and increased monitoring of all patients. IPC advised caution as, initially, an infective cause could not be ruled out. Admissions were based on balance of risk. Stool samples were obtained where possible but there was no infective organism identified and the ward resumed regular activity once all patients had been symptom free for 48 hours and a deep clean was completed.

Invasive Group A Strep Outbreak

In October 2022, a number of cases of iGAS/ GAS were identified on Tower Ward and an outbreak was subsequently declared. IPC provided support to the clinical team and patients on a daily basis, via either phone call, teams meetings or visits to the face-to-face visits to the unit. Regular IMT meetings were organised and chaired by IPC with representation from UKHSA and the relevant ICB. An IPC specialist nurse provided daily email communication to all stakeholders.

Two patients in total received a diagnosis of iGAS infection and a further patient was diagnosed with GAS in a wound. Typing of samples from all three patients identified that they were all emm 58.0. UKHSA confirmed that there were very few cases of this type nationally so it was highly likely that all three cases were linked.

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IPC measures were implemented immediately on identification of the initial positive result and, upon receipt of further positive results, the ward was closed to admissions for 28 days. After the re-opening of the ward, protective measures have remained in place to reduce any potential risk to new admissions. The ward is still in a six-month period of surveillance.

The outbreak had an impact on patients, families and friends and the staff on the ward

One patient with iGAS sadly passed away. The remaining two patients recovered.

Of note, there was a concurrent COVID outbreak on the ward and a number of patients were experiencing symptoms of diarrhoea and vomiting

The root cause of the outbreak remains unclear with no identification of such. However, it is of note that patients share communal spaces in the ward, which may have been a contributory factor.

IPC have conducted an after action review of the management of the outbreak with a view to identifying areas of good practice and also where improvements can be made. A summary of the lessons learned can be seen below:

EPUT iGAS Outbreak Learning Summary

Outbreak Date: October 2022
Teams/ward: Tower Ward

What Happened?
*2 patients diagnosed with iGAS and 1 patient diagnosed with GAS in a wound. All type emm 58.0, very few cases nationally so likely to be linked.

*Concurrent COVID outbreak and patients with symptoms of diarrhoea and vomiting.

Why did it happen?
*Unclear as to how exactly transmission occurred.

*Patients share communal spaces

What have we learnt?
*Communication is sometimes lacking between organizations and systems

*Importance of communicating results within the wider team; may have been due to lack of understanding of potential implication

*Tower is an isolated unit so support from senior management, IPC and wider organization is important. Managing such an outbreak with the client group is challenging but strong leadership from ward manager helped immensely

*Working in collaboration with nursing, medical colleagues, AHPs and support services staff is key there was no provision for swabbing staff in OH contract

*Not to assume that people know exactly where to clean and how to clean.

*Support from UKHSA enabled us to reflect on outbreak management; earlier swabbing of environment and swabbing of all patients (not just wounds/ symptomatic) may have been prudent

*Identifiable impact on patients, families and staff.

What are we doing about it?
*Head of IPC and ICB working together to secure contract with commiseo for staff swabbing

*Deep clean checklist has been reviewed and updated.

*Communication channels being reviewed
IPC to identify whether swab training is required

*iGAS literature being updated

*Wider learning lessons event will be organised and learning will be included in newsletter

*New monthly IPC newsletter featured iGAS

What did we do well?
*Excellent leadership from ward manager.

*Prompt actions from nursing team when contacted by UKHSA

*Team managed difficult situation extremely well, utilizing many problem solving ideas

*Staff huddles; kept iGAS on the agenda

*Information sharing with staff and patients/ families (both verbal and written)

*Communication regarding outbreak within EPUT and to wider stakeholders

*Good adherence to IPC guidance/ outbreak measures

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Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

All Trust job descriptions have IPC responsibilities included within them as detailed below

INFECTION CONTROL

The post holder is accountable and responsible for the prevention of healthcare associated infections by complying with all Infection Prevention & Control policies and procedures in line with legislation (Health Act 2006; Code of Practice for the Prevention and Control of Healthcare Associated Infections.)

All staff are encouraged to professionally challenge colleagues and be challenged themselves if they are not compliant with IPC policies. Additional training for staff is provided by the IPCT ad hoc within the workplace as a need is identified in order to support best practice

As per criterion 1; All staff attend Trust induction where an IPC session is delivered by the team and all staff are to complete their on line mandatory training whether they be clinical or non-clinical. The trust provided staff with the national skills for health e-learning module, which is auto, updated as national changes in practice occur; ensuring the programme is current

All staff can access IPC contact details, guidance and policies on the staff intranet, where IPC has its own page. At present, a covid page remains to allow staff easy access to all the latest information they might need.

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Audit programme:

The yearly IPC environmental audit programme has been re-established in the latter part of 2022 as changes in the covid 19 pandemic and recruitment into the IPCT gave rise to increased capacity within the team.
The team audited all relevant departments with feedback provided to the clinical staff both verbally at the time and by way of an audit report and action plan created using the ICAT electronic auditing platform. The IPCT facilitated discussions with the multi-disciplinary team members to encourage clinical leaders to feel empowered to share feedback and raise any concerns they have.

A summary of inpatient IPC environmental audit scores can be seen below. Please note a zero denotes not applicable for that area;

Location	All Sections	Governance & Documentary Evidence	Staff Records	Expertise	Kitchen – Servery	Kitchen – Therapy/Activity	Dining area/ Bistro/Beverage Area	Clinical Environment	Clinical Practice	Clinical Equipment	Hand Hygiene	Sharps Management	Waste Management	Decontamination of Environment	Linen Management	Vaccine Management including Transport and Storage	Pressure Sore Management and Chronic Wound Care	Respiratory Care	Urinary Catheter Management	Enteral Feeding
All locations	**93**	97	77	100	91	96	92	81	99	93	94	95	95	96	93	100	99	100	100	0
439 Ipswich Road	87	100	60	100	74	91	75	71	100	100	89	100	85	92	89	0	0	0	0	0
Alpine	97	100	100	100	100	100	85	91	100	100	100	100	100	100	100	0	100	0	0	0
Ardleigh Ward	82	94	75	100	88	0	88	59	100	67	78	73	79	92	91	0	71	0	0	0
Assessment Unit	89	100	80	100	96	96	95	65	100	100	100	100	100	92	10	0	100	0	0	0
Aurora	98	100	100	100	100	100	100	88	100	100	100	100	100	100	100	0	100	0	0	0
Basildon 136 suite	94	100	80	100	0	0	0	0	100	100	100	100	0	0	0	0	0	0	0	0
Beech Ward	93	100	80	100	81	0	95	91	100	90	90	100	100	92	100	0	100	0	0	0
Byron Court	97	100	75	100	100	96	100	91	100	100	90	100	100	100	100	0	100	0	0	0
Causeway	98	100	60	100	100	96	100	97	100	100	100	100	100	100	100	0	100	0	0	0
Cedar Ward	95	88	100	100	88	0	100	97	100	100	80	100	100	100	100	0	100	0	0	0

Location	All Sections	Governance & Documentary Evidence	Staff Records	Expertise	Kitchen - Servery	Kitchen - Therapy/Activity	Dining area/ Bistro/Beverage Area	Clinical Environment	Clinical Practice	Clinical Equipment	Hand Hygiene	Sharps Management	Waste Management	Decontamination of Environment	Linen Management	Vaccine Management including Transport and Storage	Pressure Sore Management and Chronic Wound Care	Respiratory Care	Urinary Catheter Management	Enteral Feeding
Chelmer Ward	88	94	60	100	88	0	84	76	93	89	89	87	93	100	89	0	0	0	0	0
Cherrydown	99	100	60	100	100	100	100	100	100	100	100	100	100	100	100	0	100	0	0	0
Clifton Lodge	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	100	100	0
Dune Ward	99	100	100	100	100	100	100	100	100	100	100	87	100	100	100	0	100	0	0	0
East Wing	99	100	50	100	100	96	100	100	100	100	100	100	100	100	100	0	100	0	0	0
Edward House - West	98	100	50	100	96	100	95	100	100	100	100	100	100	100	100	0	100	0	0	0
Finchingfield ward	97	100	100	100	96	96	100	100	100	100	100	100	93	100	64	0	100	0	0	0
Forest Ward	99	100	100	100	96	100	100	97	100	100	100	100	100	100	100	0	100	0	0	0
Fuji Ward	97	100	100	100	100	100	90	84	100	100	100	100	100	100	100	0	100	0	0	0
Galleywood ward	90	100	100	100	88	83	100	77	100	100	100	100	71	100	64	0	100	0	0	0
Gloucester Ward	97	94	60	100	100	100	100	97	100	100	90	93	100	100	100	100	100	0	100	0
Gosfield Ward	84	94	50	100	92	0	78	62	93	88	89	87	85	75	91	0	100	0	0	0
Hadleigh PICU	95	100	100	100	81	0	100	79	100	100	100	100	100	100	100	0	100	100	0	0
Henneage Ward	75	94	50	100	80	0	50	50	100	50	61	87	79	83	82	0	0	0	0	0
Kelvedon	100	100	80	100	100	100	100	100	100	100	100	100	100	100	100	0	100	0	0	0
Kitwood Ward	86	100	60	100	80	0	80	69	93	70	100	100	100	77	100	0	100	0	0	0
Lagoon	98	100	75	100	100	96	100	97	100	100	100	93	100	100	100	0	100	0	0	0
Longview	87	100	40	100	84	0	100	74	93	88	89	93	86	92	91	0	0	0	0	0
Meadowview Ward	99	100	100	100	96	100	100	100	100	100	95	100	100	100	100	100	0	0	0	0
Poplar ward	95	100	80	100	88	96	90	97	100	100	85	93	100	100	100	0	100	0	0	0
Rainbow Unit	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	0	0	0
Rawreth Court	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100	100	100	0

Location	All Sections	Governance & Documentary Evidence	Staff Records	Expertise	Kitchen - Servery	Kitchen - Therapy/Activity	Dining area/ Bistro/Beverage Area	Clinical Environment	Clinical Practice	Clinical Equipment	Hand Hygiene	Sharps Management	Waste Management	Decontamination of Environment	Linen Management	Vaccine Management including Transport and Storage	Pressure Sore Management and Chronic Wound Care	Respiratory Care	Urinary Catheter Management	Enteral Feeding
Robin Pinto Unit	74	75	50	100	74	0	50	40	93	86	72	87	80	75	91	0	0	0	0	0
Roding Ward	85	94	100	100	73	74	75	71	100	80	89	93	92	100	0	0	0	0	0	0
Ruby ward	87	100	50	100	80	0	100	67	93	89	89	93	79	92	91	0	100	0	100	0
S136 Suite	95	94	100	100	0	0	0	81	100	100	100	87	100	100	100	100	0	0	0	0
Stort Ward	85	76	60	100	88	0	76	61	100	78	100	87	93	92	91	100	0	0	0	0
Topaz ward	88	88	80	100	88	83	94	80	93	88	95	80	79	100	100	0	0	0	0	0
Tower ward	85	100	40	100	72	0	75	72	93	60	89	87	92	92	100	0	100	0	100	0
Willow ward	99	100	100	100	96	100	95	100	100	100	100	100	100	100	100	0	100	100	100	0
Woodlea Clinic	90	94	50	100	81	0	100	62	100	100	100	93	100	92	100	0	0	0	0	0

The IPCT also provided additional support in between formal audits by way of ad hoc site visits

The Care Quality Commission requested evidence submission relating to IPC environmental audits following their inspections in October 2022 along with narrative relating to rationale for reduced auditing over the preceding two years. This was provided within the allocated timeframe and no further requests relating to IPC were submitted at that time

The challenge of auditing sites which are shared with other provider organisations and those that are rented from external contractors continues. The IPCT team encourage communication and partnership working with the other providers and building landlords in order to address areas for improvement.

The addition of the DDQS role within care units has reinforced the need for accountability and provided the additional experiential support for clinical teams to take timely improvement action.

The IPC newsletter aims to include positive feedback when teams have demonstrated engagement and compliance with IPC standards both in the environment but also when purchasing equipment and so on;

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This team purchased a mobile linen trolley that is covered and wipeable to reduce the risk of contamination of clean linen in their ward

Work continues with the IPCT and the external audit tool contractor to review and develop the audit tools used in preparation for the new financial year

Commissioning colleagues and the Trust Compliance team undertake quality assurance visits as part of their annual plans of work and feedback to the IPCT and care units following these

The DIPC and Head of IPC were interviewed by the Care Quality Commission during their well led inspection in January 2023. Information was provided relating to management of the pandemic, gap analysis relating to the Code of Practice and future plans for the IPC service. Positive feedback was received at the end of the interview and no further requests for information relating to IPC have been submitted to date.

The Trust annual IPC audit programme continued over the year with submissions made by clinical teams as per the audit programme below;

Inpatients	Outpatient clinics	Community Services	Care homes
Hand hygiene-quarterly Mattresses- 6 monthly	Hand hygiene – 6 monthly via patient observed	Hand hygiene – 6 monthly via patient observed	Hand hygiene – 6 monthly via patient observed

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MRSA- monthly community wards Invasive devices- quarterly older adults Full IPC audit- yearly	Hand hygiene- quarterly Podiatry and leg ulcer clinic audits Full IPC audit- yearly	Full IPC audit of OPD services- yearly	Hand hygiene – quarterly Mattresses- 6 monthly Invasive devices- quarterly Full IPC audit- yearly

This audit programme is under review in preparation for 2023/2024 in order to provide more robust assurance of compliance with national standards and aligment with the care unit approach; the IPCT will be working closely with clinical teams in order to support closure of the audit cycle by identifying training and practice improvement opportunities

The reviewed audit programme will include more frequent monitoring of hand hygiene, decontamination of equipment including commodes and mattresses. These audits will be combined in an overarching IPC audit tool for inpatient services and the hope is to mirror this for our other services, whilst acknowledging different challenges with auditing community services.

IPC Link Workers:

The Trust has a network of IPC link workers. The covid pandemic has meant the suspension of the link worker programme. However, in order to reinvest in these vital colleagues across the Trust; a full review of the role, programme of education and provision of support has been undertaken in preparation for the year ahead. This will include a conference for these champions of best IPC practices later on in the year.

Criterion 7

The provision or ability to secure adequate isolation facilities.

Trust inpatient services are provided using both bays of beds and individual side rooms. Many of which have ensuite bathrooms. This means that patients who requires isolation can be accommodated in this sense across our services. However, it must be noted that not all side rooms are ensuite. Individual risk assessment should be carried out by the clinical team to ensure a safe approach is taken in situations where patients require isolation due to infectious reasons.

It should also be noted that due to the provision of rehabilitation services provided across the Trust EPUT inpatient services have communal social, activity and eating areas allowing patients to participate in active rehabilitation. However, if a patient is required to isolate due to infection, provision is made for them as individuals following risk assessment undertaken by the clinical team with the support of the IPC nurses.

Ward closure decisions may be made as part of outbreak management. Outbreak meetings specify that wards will not admit patients during the emerging and critical stages of an outbreak of infection. However, it is acknowledged that for a variety of clinical reasons the risk of not admitting would be greater than the risk of transmission of covid. A clinical risk assessment is to be carried out and fully documented by the clinical team with support of IPC if required.

Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

EPUT services are provided across a wide geographical area, as a result of this contracts are in place with accredited pathology services provided by the acute NHS trusts across the geographical area.

Over the period of the pandemic a contract has been in place with Broomfield Hospital laboratory to provide services relating to the processing of covid 19 polymerase chain reaction samples send via EPUT services

Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

An overarching IPC policy is accessible to all staff via the intranet page, it includes the following subject matters by way of individual sections as seen below:

- Common Infectious diseases
- Standard precautions
- Infection Control in clinical practice
- Communicable diseases and outbreak control
- Prevention and management of MRSA
- Prevention and management of *clostroidoides difficile*
- Prevention and management of Tuberculosis
- Prevention and management of infestations
- Prevention and management of sharps injuries and contamination incidents
- Pets and pests
- Care and decontamination of mattresses
- MPox

Each policy is subject to review on a three yearly cycle or as national guidance changes. The policy is informed by the National Infection Prevention and Control Manual for England.

All policies reviews include comment from expert colleagues who form the Infection Prevention and Control Group; following this update all polices are taken for final approval to the Trust policy ratification group

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

The trust employee Occupational Health (OH) services are contracted via an external provider.

Staff can access their services and advice using a range of methods including via telephone, posters, guidance on the staff intranet page. Line managers have information in order to signpost their staff to these as required as well as access to make referrals and view reports for their team members via the OH portal.

OH policies and procedures can be accessed on the staff intranet pages. The Trust Human Resources team work together with OH in relation to the

organisation sickness policy

Immunisations:

The OH team collect and keep records of staff immunisations as part of the new joiner risk based screening assessment. Any immunization recommendations made by them align with the national Green Book. Although a regular review of immunisation status is not currently undertaken, if staff members change their role whilst working with the organization, immunization status is checked again at that point by OH services.

All staff are offered a free influenza vaccination each year and were also offered all relevant covid vaccinations as part of the national vaccinations programmes. These were provided by Trust vaccination and IPC teams with the support of OH services

Over the last year, our COVID-19 and flu vaccination teams have continued to show remarkable dedication and readiness to innovate and collaborate to deliver vaccines.

Alongside two seasonal booster campaigns to vaccinate people at increased risk, efforts continued to target those who have not yet had their full course of vaccine.

In addition to our vaccination centres, our Community Vaccination Buses and pop-up clinics stopped by shopping centres, supermarkets, parks, colleges, libraries and more. Our Health Outreach Team continued to work with partners across healthcare, local authority and the community and voluntary sector to vaccinate hard-to-reach groups. Allergy clinics, needle phobia clinics, and children's vaccination sessions all ensured a positive vaccination experience for people with specific needs. We also supported primary care colleagues with vaccinating the most vulnerable in our community: care home residents and people who are housebound.

In line with national guidance from the Joint Committee on Vaccination and Immunisation (JCVI), we offered all EPUT staff the opportunity to have both their COVID-19 booster and flu vaccination together. These were offered in our vaccination centres, as well as by peer vaccinators and teams visiting sites across the Trust. Videos with our Executive Team and Head of Infection Prevention and Control emphasised the importance of vaccinations in keeping people safe over the autumn and winter period.

These sustained efforts take our COVID-19 vaccination total to more than 1.57 million as of early March 2023.

The IPC team provide general principles relating to staff becoming unwell; during the delivery of the Trust induction programme, these are also covered in the national mandatory training skills for health E-learning module that all staff undertake.

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Sharps injuries:

OH services lead on the risk assessment of sharps injuries sustained by staff providing expert advice for staff, calling on the IPC team if required. An in-hours and out- of -hours telephone number is provided for staff to call should they sustain a sharps or bodily fluid contamination injury.
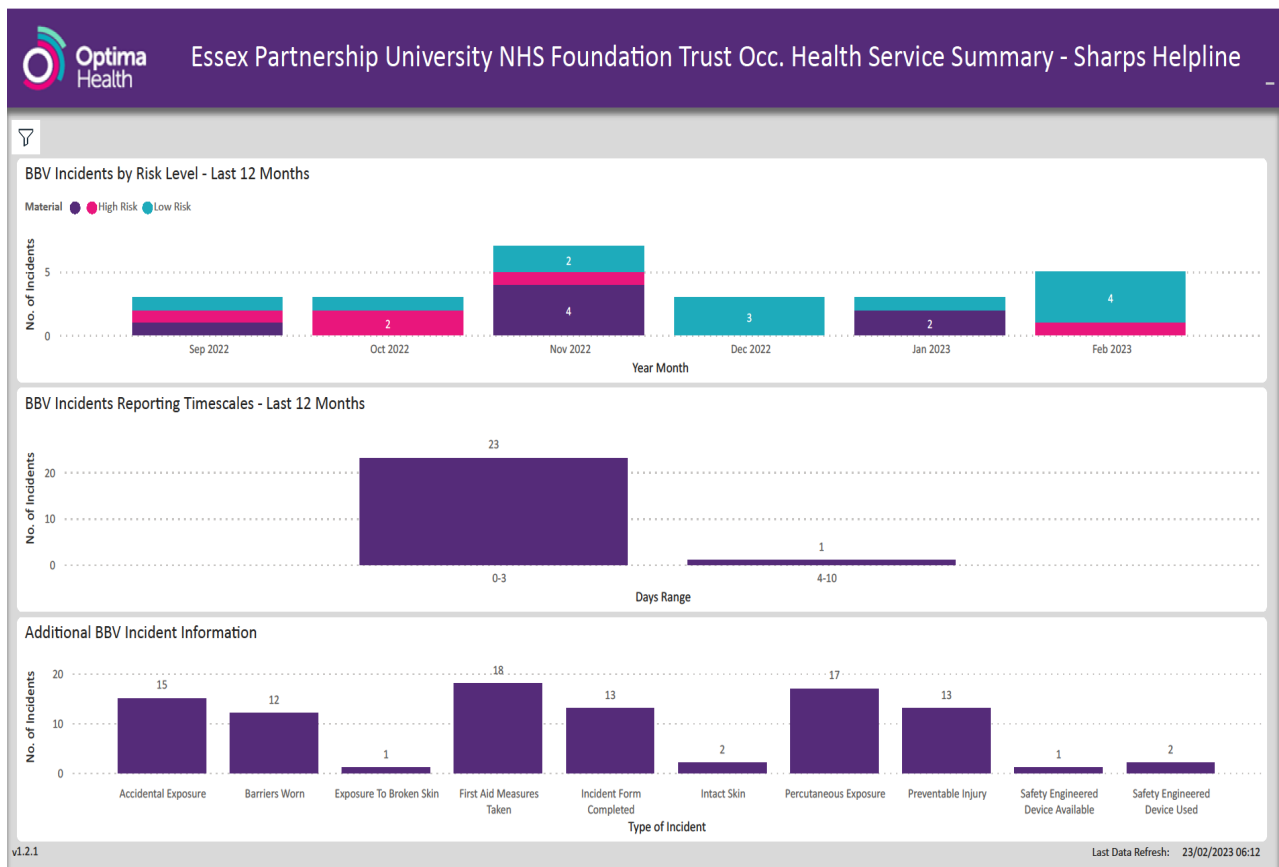
Wellbeing resources:

All staff working within the organization can access free wellbeing services

Examples of these include:

Support following incidents

Psychological support

Financial

Physical health checks

Staff swabbing during outbreaks of infection:

Work is underway to secure the services of an external contractor for the swabbing of staff in outbreaks of infection such as group a strep as these services are not currently provided by the current OH service provider.

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Annual IPC Work Programme 2023/2024:

CODE CRITERIA	ACTION	TIMETABLE	LEAD	REVIEW/PROGRESS	HOT SPOTS	COMPLETE			
						IN PROGRESS			
						INCOMPLETE			
						Q1	Q2	Q3	Q4
Criteria 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	• Provision of an IPC team that is of appropriate size in order to provide expert advice, training and support for colleagues which in turn will assist in increasing patient and staff safety	Ongoing	KH						
	• Review and arrangement of IPCT access to relevant electronic patient record systems and laboratory reporting systems	End June 2023	SL- IPCT Administrator						
	• Submission of the Annual Infection Prevention and Control Report to Board • Provide information for the Trust annual report and quality account as requested	June 2023	AW	Completed by KH on behalf of AW					
	• Infection Prevention and Control Group meetings. • Chaired by DIPC Attendees include Occ. Health, ICBs, UKHSA, Deputy Directors of Quality and Safety for each care unit, Consultant Microbiologist	Quarterly	AW	First meeting for current financial year May 2023 DDQS to provide clinical update at each meeting which covers their care unit					
	• Access to a Consultant Microbiologist via a service level agreement	Ongoing							

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	• Integral part of Trust Clinical Governance structure with attendance at meetings and provision of IPC updates		AW/KH	Attendance at Clinical Governance and Senior Management meetings					
	• Review of the IPC audit programme for inpatient and community services to ensure the Trust and commissioners have assurance of robust practice and evidence of changes in practice when required	By end June 2023	IPCT/ RP clinical audit lead	Overarching IPC audit tool created April 2023 for use on Tendable by inpatient services IPCT environmental audit tool under review with external provider April 2023					
	• Quarterly quality reports submitted externally to the appropriate commissioners	Quarterly	Compliance Team	Sent via Performance team – IPC info incorporated within Quality Reports.					
	• Creation of an IPC power BI dashboard to replace the current manual KPI reporting system	End September 2023	KH/AW/ Business informatics team	IPC dashboard under discussion Jan 23 Project taken to appropriate committee March 2023					
	• Estates led water quality and safety group to be held with IPC attendance. Consultant Microbiologist invited • Authorised Engineer to be part of the group	Bi Monthly	Estates Lead	Established and running bi- monthly					
	• Investigation into a Trial of electronic application for evidencing flushing of water outlets	August 2023	ST/ Estates Compliance Lead						
	• Continue review of clinical hand wash basin compliance and provision across the organisation with development of replacement programme	Ongoing	Estates/ IPCT						
	• Undertake review of water risk assessment process	August 2023	ST						
	• Estates led Ventilation Safety Group to be held with IPC attendance and Consultant Microbiologist input when required	Bi Monthly	Estates Lead	Established and running Bi- monthly					

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	• Authorised Engineer to be part of the group								
	• Lead provider in Mid and South Essex Community Collaborative IPC work stream • Chaired by AW/ KH	Monthly	AW/ KH	At present monthly meetings held with IPC colleagues					
	• Support collaborative working with commissioning colleagues	Ongoing	IPCT						
	• Provision of expert advice and risk assessment relating to the transfer of patients between or within health care provider organisations	Ad hoc	IPCT						
	• Review of IPC policies as part of 3 yearly review programme or as national guidelines change	As required	KH/ RC / Policy compliance team						
	• Raise awareness and inclusion of risks on appropriate Risk Registers	Reviewed at IPCG	AW/ IPCT						
	• Work collaboratively with the Trust Facilities team to carry out joint IPC and environmental cleanliness audits to monitor standards and support changes in evidence based best practice when required	Ongoing	IPCT/ Facilities Management Team						
	• Cleaning audits undertaken by the Facilities team and action planned as required. With evidence of themes to be fed into IPCG		FB						
	• Take part in and support action planning following compliance and commissioning colleague quality visits	Ad hoc	IPCT						

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	• Build strong collaborative working relationships with DDQS colleagues and their clinical teams to support IPC best practice and patient safety	Ongoing	IPCT/ DDQS / clinical colleagues						
	• Provide expert advice on the management of outbreaks of infection in accordance with national and local guidelines	Ongoing	IPCT						
	• Carry out review of individual cases of mandatory reported cases of health care associated infection with the clinical teams and commissioners and ensure lessons learned are shared appropriately across the organisation and externally as appropriate	As required	KH/ IPCT						
	• Provision of information relating to patient infections in a timely way on all electronic patient records	End July 2023	IPCT/ Head of Clinical Systems						
	• Investigation of and access to a robust IPC electronic surveillance system to support timely monitoring of cases and promote early intervention if an increase in cases is noted relating to specific alert organisms	End March 2024	KH						
	• Provision of evidence to CQC requests for information if required	Ad hoc	AW/ KH						
2: Provide and maintain a clean and appropriate environment in	**Environmental Cleanliness and Hygiene** • Monitoring and maintaining a clean and safe patient	Ongoing	IPCT/ Facilities team/						

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managed premises that facilitates the prevention and control of infection		environment and cleanliness culture through audit and partnership working with Clinical Leads and Facilities team colleagues		External Contractors					
	•	Support of Facilities Management Team in the tender process relating to contracts for waste, laundry and catering services	Ad Hoc	KH/ RC/ CM					
	•	Ensure IPCT inclusion in planning for new builds and refurbishments by attendance at Capital Projects and Refurbishment Project Meetings – to include environmental issues as well as purchase of suitable equipment that aligns with national healthcare technical memorandum and best practice	Ad Hoc	AW/ IPCT/ AF projects team/ FB/ Clinical teams					
	•	An annual programme of environmental cleanliness audits led by FM team reporting progress into IPCG	Ongoing	FB					
	•	Review of cleaning products used across the organisation to include cost benefit analysis of using disposable or re-usable equipment	March 2024	FB/DD/KH/ Head of Sustainability					
	•	Monthly FM managers meetings to be held for review and update of current situation	Monthly	FB/ FM managers/ B6&7 FM team members					
	•	Attendance by FM services at Health Safety and Security Committee		FB					
	•	Attendance at Clinical Quality and Safety Meetings to increase partnership working between E+F and clinical		FB/ IPCT					

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	teams							
	• Undertake rolling environmental cleanliness audit as per E+F audit programme	Rolling Annual Programme	E+F audit leads/ supervisors					
	• Yearly IPC environmental audit of each clinical department, with provision of timely feedback and support of teams to action any reduced compliance	Rolling audit programme	IPCT/ clinical team colleagues/ DDQS					
	• Review of commode equipment in use/ products used for decontamination and training requirements relating to commodes in inpatient areas		HD/ TW					
	• Mattress audit incorporated into overarching IPC audit tool for inpatient wards for completion by the clinical teams, supported by IPCT	Monthly	IPCT/ Clinical teams					
	• Support the Medical Devices Management Team with the delivery of the medical devices management transformation project	March 2024	KH					
	• Provision of a planned preventative maintenance programme with regular review as requirements change	Ongoing	E+F Leads/ FB /RU					
	• Adherence to national guidance relating to water safety and quality	Ongoing	ST/ RU/ Authorised Engineer					
	• Trust cleaning policy to align with national standards of cleanliness evidencing specific definition of roles and responsibilities for cleaning, cleaning routines, sufficient		FB/ with IPCT support					

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	dedication of resources, accessing increased cleaning when required, cleaning of fixtures and fittings or a vehicle									
	• Relevant decontamination issues relating to be discussed at trust medical devices meeting which is attended by IPCT	Bi Monthly	NA/ KH							
	• Evidence of appropriate provision of laundry services	Ongoing	FB							
	• Evidence of provision of suitable waste services	Ongoing	FB							
3: Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Systems to manage and monitor use of antimicrobials		MMT							
	• Antibiotic Stewardship Committee/ Group – with appropriate clinical and medical membership supported by IPCT reporting into meds management and is incorporated as part of the IPC Group Agenda	Quarterly	AD/ MMT/ IPCT							
	• Local antimicrobial stewardship policy	Ongoing	MMT							
	• Prescriber induction and training in prudent antimicrobial use, antimicrobial resistance and stewardship competencies	Ongoing as part of trust induction programme	MMT							
	• Work with and assist Meds Management team to raise awareness for European Antimicrobial Awareness Day		AD/ IPCT							
	• Support of ICB Urinary tract Infection/ Gram Negative reduction work streams	Ongoing	IPCT/ Continence team/ MMT/ ICBs							

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	• Ensure all relevant staff have access to timely pathology reporting of laboratory results via an appropriate electronic system	December 2023	KH/ Physical Health Committee						
4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	• Review and distribution of IPC posters for use by Trust teams to include hand hygiene	End May 2023	IPCT/ Communications team						
	• Review of information leaflets aimed at patients, carers and relatives currently in use- to check for relevance and accuracy • To include hand hygiene, use of antimicrobials, information relating to specific infections	End of August 2023	BB/ VC/ Communications team/ AD						
	• Provision of cleaning expectations and audit scores to be on display across the organisation	Ongoing	E+F team						
	• Support clinical areas in the updating of audit action plans to close the audit cycle	Ongoing following audit	IPCT						
	• Telephone advice for clinical staff in relation to treatment for identified infection and preventative measures to minimise risk from infection.	As required	IPCT						
5: Ensure prompt identification of people who have or are at risk of developing an infection so that they	• Review of policy/guidelines to support infection outbreaks	End June 2023 and Ongoing as required	RC/KH						
	• Co-ordinate (in liaison with clinical leads) and provide expert advice management of outbreaks	As required	IPCT						

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receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	• Mandatory reporting of *Clostridioides difficile* infection cases and MRSA bacteraemia cases.	Monthly	IPCT							
	• Carry out/support Root Cause Analysis studies on all Clostridium *difficile* and MRSA bacteraemia infections, and any other major infection incident. • Support lessons learned cascade process. • Provide lessons learned teaching to clinical staff	Ad Hoc	IPCT							
	• Attend scrutiny panel and Post Infection review Meetings as and when required.	Ad Hoc	IPCT							
	• Finalise review of MRSA screening policy as part of MSE community collaborative	End July 2023	RC/ IPCT							
	• Support and advise clinical staff with known colonised/infected patients.	Ongoing as cases arise	IPCT							
6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• All trust job descriptions to include IPC as standard for all staff	Ongoing	Human Resources							
	• Delivery of trust induction IPC training including new starters, international recruits and students	Monthly	IPCT							
	• Records of all training to be maintained	Ongoing	Training department							
	• Review of Aseptic non technique training, competencies and practices to align with national guidance	December 2023	IPCT/ Education team							
	• Provision of and engagement with IPC training in the workplace as need identified	Ad hoc	IPCT/ Clinical leads							

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	by teams or the IPCT									
	• Review of IPC link worker role, programme and provision of conference and training opportunities across the origination	End October 2023	HD/ IPCT							
	• Care Units to report on uptake of IPC e-learning training programme	Quarterly as part of IPCG feedback	DDQS							
	• Support facilities team on the training of domestic staff in the organisation	As requested	FB/IPCT							
	• Support the Physical Health Leads in raising awareness of sepsis recognition and treatment	September 2023	IPCT/ Head of Deteriorating Patient/ Physical Health Leads	.						
	• Coordinate and deliver activities relating to Global Hand hygiene day	May 2023	IPCT							
	• Develop and deliver activities relating to IPC back to basics campaign across the organization	July 2023 and Ongoing	IPCT							
	• Attend individual team meetings to cascade information and training.	Ad Hoc	IPCT							
7: Provide or secure adequate isolation facilities.	• Support patient risk assessment and placement when infection is suspected or confirmed	When required	IPCT							
	• Provide education to clinical staff relating to the management of patients with loose stools including the use of stool charts, sending of stool									

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	•	samples and side room prioritization							
	•	Ensure the provision of suitable PPE for teams as required	Ongoing	Procurement team					
8: Secure adequate access to laboratory support as appropriate.	•	Ensure appropriate contracts are in place with accredited laboratory services across the geography of the organization	Ongoing	Contracts team					
	•	Advise on the collection, storage, transport and interpretation of specimens/samples, including Covid-19 swabs.	Ongoing	IPCT					
	•	Promote collaborative working with acute trust laboratory and microbiological partners, particularly with regard to effective antimicrobial stewardship.	Ongoing	AD/MMT					
9: Have and adhere to policies designed for the individual's care and provider organisations, which will help to prevent and control infections.	•	Review and update IPC policies/ guidelines as national guidance alters or new guidance is issued. Ensuring information is cascaded Trust wide.	Ongoing and part of 3 yearly review	IPCT					
	• - Policy	Lead the IPC community collaborative approach to the prevention and management of invasive group A infections by use of aligned: - Audit tools - Communication strategy - Surveillance systems - Collaboration with system partners	Ongoing	IPCT and community collaborative					

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10: Providers have a system in place to manage the occupational health needs of staff in relation to infection.	• Provision of Occupational Health Services for all staff within the organization with information on how staff can access services and the level of services required	Ongoing	Human Resources							
	• Provision of risk based screening as part of the recruitment process and on an ongoing basis for those identified as those who require advice on fitness to work	Ongoing	Recruitment/ OH contractor							
	• Provision expert of Sharps injury / body fluid exposure incident management and advice for staff	Ongoing	OH contractor							
	• Collection and maintenance of staff immunization records		OH contractor							
	• Provision and delivery of the annual staff influenza vaccination campaign	October 2023	Vaccination services supported by IPCT							
	• Provision of fit testing for staff on the use of FPF3 masks for use during aerosol generating procedures	Ongoing	IPCT/ Training team							
	• Provision of external staff swabbing services during times of outbreaks of infection	End May 2023	KH/ Contracts team/ICB							

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LEARNING FROM DEATHS ? MORTALITY REVIEW Q4

● Information Item　　👤 NH　　🕐 5 minutes

REFERENCES

Only PDFs are attached

📄 Learning from Deaths Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1		26 July 2023	
Report Title:	Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 4 2022/23)			
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse			
Report Author(s):	Michelle Bourner, Deaths Co-ordinator			
Report discussed previously at:	Learning from Deaths Oversight Group (Chair: Dr Nuruz Zaman) Learning Oversight Sub-Committee (Chair: Moriam Adekunle) Quality Committee (Chair: Dr Rufus Helm)			
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report

Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	Not applicable	
Describe what measures will you use to monitor mitigation of the risk	Not applicable	

Purpose of the Report

In line with the National Guidance on Learning from Deaths, the attached report presents to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result;
- Information relating to the context of mortality data and surveillance under the Trust's new Learning from Deaths arrangements (Appendix 1);
- Data relating to deaths recorded on Datix (the Trust's incident management system) for Q4 2022/23 (1st January – 31st March 2023) and updated data for previous quarters 2022/23 (Appendix 2); and

Updated data for deaths relating to previous years (Appendix 3).

Recommendations/Action Required

The Board of Directors is asked to:
1 Note the contents of the report; and
2 Request any further information or action.

Summary of Key Issues

1. The Trust implemented a new Learning from Deaths Policy and Procedural Guidelines from 1st April 2022.

2. The attached quarterly report provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. This learning is presented on a monthly basis to the Trust's Learning Collaborative Partnership, Learning from Deaths Oversight Group and Learning Oversight Sub-Committee. There are a number of immediate actions that are being taken as a result of the learning identified, as well as longer term actions that will form part of the Trust's Safety Improvement Plans.

3. The attached report also presents data that the Trust is nationally mandated to report to public Board of Director meetings on a quarterly basis – ie the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. There are no issues of concern to note from the Q4 data, which is in line with that of previous quarters.

4. The new scope for deaths included within the Trust's Learning from Deaths arrangements has brought a larger number of deaths into scope, enhancing the Trust's ability to learn from deaths. As at the date of preparation of the report, a total of 481 deaths from 01/04/22 – 31/03/23 have been subjected to a Stage 1 learning from deaths review by a local service manager to ascertain learning and identify those for further detailed review. This is a local review stage that did not form part of the previous Mortality Review arrangements and has thus increased local reflective practice and the Trust's ability to identify learning locally.

5. As part of the Trust's mortality surveillance arrangements, a comparison to the categories under the previous Mortality Review arrangements is also being undertaken whilst a longer period of comparative data under the new arrangements is built up. This enables identification of any increases in death numbers against the previous scope categories which are outside of Statistical Process Control limits and should thus be investigated further. Again, there are no issues of concern to note.

6. It should be noted that all data in this report is taken as at 25/05/23. Any updates to information after this date will be included in future reports.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	✓
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	

Service impact/health improvement gains			✓
Financial implications:		**Capital £** **Revenue £** **Non Recurrent £**	N/A
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report

LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	EDAP	Essex Drug and Alcohol Partnership
ICB	Integrated Care Boards	DNA	Did Not Attends

Supporting Reports/ Appendices /or further reading

Attached –

Report: Learning from Deaths – Quarterly Overview of Learning and Data (Quarter 4 2022/23)

Appendix 1 – Context of mortality data and surveillance under the Trust's Learning from Deaths Policy

Appendix 2 – Summary of 2022/23 mortality data

Appendix 3 – Summary of previous years mortality data

Links -

"National Guidance on Learning from Deaths" *Quality Board March 2017*
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*
PowerPoint Presentation (england.nhs.uk)

Lead

Natalie Hammond
Executive Nurse

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTER 4 - 2022/23

Learning from deaths

PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (March 2023);

- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1st April 2022 (Appendix 1);

- Data relating to deaths recorded on Datix for Q4 2022/23 (1st January – 31st March 2023) and updated data for previous quarters this year (Appendix 2); and

- Updated data for deaths relating to previous years (Appendix 3).

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT

The aims of the Trust's Learning from Deaths Policy are to provide a robust governance framework for undertaking mortality review in order to:

- improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it;

- further develop systems of care to continually improve their quality and efficiency;

- improve the experience for patients, their families and carers wherever a learning issue from the review of deaths is identified;

- improve the use of valuable healthcare resources; and

- improve the working environment for staff in relation to their experiences of reviewing deaths and associated reviews / investigations.

The Trust sets out to achieve these aims by:

- ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice, or conversely problems in care, to be identified on an individual basis;

- ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;

- ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; and

- ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action.

LEARNING FROM DEATH REVIEWS 01/04/22 – 31/03/23 (focus on learning identified since last report)

This section on learning details:

- Sources of learning

- Examples of good practice identified

- Learning emerging from Stage 1 reviews

- Learning emerging from Stage 2 reviews

- Learning emerging from PSIRF reviews

- Examples of actions being taken to address and action learning from learning from deaths reviews

Sources of learning (01/04/22 – 31/03/23):

- Deaths for which Stage 1 local service review completed– **481**

- Deaths for which Stage 2 clinical case note reviews completed - **19**

- Deaths for which PSIRF reviews completed – **51**

- EDAP reviews – **34 underway / completed**

- LeDeR reviews - **17 underway / completed**

Examples of good practice identified in reviews since last report

- Although client had refused all support they were still robustly monitored and engagement constantly sought.

- Appropriate support plan made in agreement with patient.

- Communication between staff and family member to update events and recording of seeking family's view in patient's management.

- Effective identification and management of physical health deterioration on Ward.

- Good engagement with treatment plan and reviews.

- Case notes document good contact, clearly documented in SBAR format. No apparent indications of poor physical health beforehand. Patient routinely being seen and supported by team.

- Resident had all necessary paperwork in place.

- Excellent job completed by nursing staff and GP.

- Patient did not meet threshold for secondary MH services – appropriate support plan made in agreement with patient.

- Patient was receiving appropriate care and support at the time of her sad passing both for her physical and mental health.

- Natural progressive deterioration of patient – the patient's family requested that the patient remain on the ward as they felt supported and comfortable with the care provided to their loved one and this is in line with our GSF Accreditation for End of Life Care on the ward.

- High levels of support had been made available, staff had been responsive and proactive.

NHS
Essex Partnership University
NHS Foundation Trust

Learning themes emerging from Stage 1 reviews since last report [1]

CONTINUING THEMES:

- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues re timing of PSIRF / Stage 2 reviews)

- Opportunities to **strengthen communication** to improve care of service user and following death (eg notification of death):
  - Within teams (ie across team members)
  - Between Trust teams (inc between inpatient and community settings, between providers of mental health and physical health care)
  - With partner agencies – acute, GP, social care, voluntary sector

- Majority of the deaths reviewed are from **physical health causes** (both rapid deteriorations and long term conditions) - opportunities to strengthen management of physical health issues:
  - Management of physical health of patients on EPUT inpatient units
  - Monitoring of physical health of patients in community
  - Supporting clients to ensure they have their physical health checks, see their GP for physical health issues and comply with prescribed meds and treatments plans

- **Record keeping** – eg ensuring next of kin details updated at every contact

- Need to ensure **proactive follow up of disengagement** – eg non-concordant with medications

Learning themes emerging from Stage 1 reviews since last report (2)

- **Clients not open to services at time of death –** eg Coroner Do You Know? enquiries

- Individuals **awaiting appointment** at time of death (eg appointment date in future)

NEW THEME:

- Ensuring **timely identification and management of the deteriorating patient (physical health)**:

  - Immediate sharing for care team in regards to appropriate diet and fluid intake for physically deteriorating patients and to be aware of the increasing choking risks with this issue

  - Recognition of a deteriorating patient and ensuring the timely completion of DNARCPR peace documentation and supply of anticipatory medication/authorisation

Learning themes emerging from Stage 2 reviews [7 approved) since last report [1]

CONTINUING THEMES:

- **Record keeping** (4/7) – eg documenting detailed risk assessments; scanning medications charts onto clinical system; strengthening format of documenting contacts with Duty service; ensuring previous discharges are recorded on clinical systems.

- **Ensuring proactive follow up to disengagement** (1/7) – eg importance of clarifying the reason why the patient did not engage – for example, if the patient finds telephone communication difficult then alternatives should be explored prior to discharge.

- **Dual diagnosis learning** (1/7) - eg ensuring active encouragement to engage with alcohol services where this is identified as an issue.

- **Personality disorder specialist service** (1/7) – eg for patients with diagnosis of EUPD, seeking specialist input from PD Service and how this can be accessed.

- **Communications** (2/7) – eg ensuring clearer communications between teams (EPUT and hospital) and to the patient / family of patient to provide more support; strengthening communication between community mental health teams and acute Trust wards when patients are inpatients in acute Trust / discharged back to community

Learning themes emerging from Stage 2 reviews [7 approved) since last report [2]

NEW THEMES:

- **Physical health monitoring** (3/7) – eg importance of physical health checks and evidencing liaison with GPs, ECGs etc; timely identification and management of deteriorating physical health condition of patients on EPUT inpatient units (eg BP monitoring, recording actions, escalations, face to face review etc)

- **Management and timings of transfers of care** (1/7) **-** eg transfers should be timed to ensure staff in the receiving team are on duty to provide continuity of access; content of handover should include all known risks

- **Management of waiting lists to access services and of clients whilst on waiting lists** (1/7) **– eg setting e**scalation thresholds, contingency and safety planning and assessing the impact of vacancy levels in community teams

- **Assessments** (1/7) – eg ensuring initial assessments are carried out when a patient is referred

Learning themes emerging from PSIRF reviews

Similar themes continue to emerge from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Communications

- Record keeping

- Involvement of families and carers

- Clinical care

- Referrals

- Medications

- Staffing

Examples of actions being taken in response to learning from deaths (1)

- Local immediate actions by services – eg strengthening internal processes such as monitoring and oversight of completion of welfare checks; and strengthening of caseload management for support workers

- Learning presented to and considered monthly by Learning Collaborative Partnership – included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate

- Learning used to inform topic areas for "Learning Matters" MST development sessions – eg record keeping, identification and care of the deteriorating patient (physical health on inpatient wards)

- Thematic learning being used to inform the Trust's Safety Improvement Plans. The approach to developing these plans, as detailed in the previous report, has been approved and the schedule for development is underway. Updates on progress will be provided in separate reports to the Quality Committee.

- Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. Also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

Examples of actions being taken in response to learning from deaths (2)

- Specific actions arising from reviews that have been pursued and concluded include:
  - o Confirmation via central Trust governance team that a project to review the Trust's systems for holding policies, procedures and local protocols to ensure consistent availability to access by all staff is to be progressed.
  - o A reminder to staff of the process to be followed within EPUT to enable escalation of concerns of possible incorrect dosage prescribing by an external primary care provider, and agreement of escalation process with the Integrated Care Board medicines management teams if matters remain unresolved.
  - o Communication linkages for sharing from deaths and agreeing actions strengthened between EPUT and the acute Trusts; ICBs looking to set up multi-partner learning groups by ICB area to facilitate sharing of learning and strengthening whole system working.

- Multi-disciplinary work being facilitated to address Trust wide issues - eg :
  - o Physical health – learning from deaths lead continues to link with Trust leads for physical health and the care of the deteriorating patient to ensure learning informs work in these areas
  - o Time limited task and finish group being established with membership from EPUT and the Prison Healthcare Services to consider how processes to ensure re-engagement with clients following a period in prison could be strengthened
  - o On-going Dual Diagnosis Learning Implementation Group being established to consider specific learning emerging from the review of deaths of dual diagnosis clients

MORTALITY DATA – Context

- The context for the collection and reporting of mortality data under the Trust's Learning from Deaths arrangements (2022/23) is outlined in **Appendix 1**. This includes details of the deaths which are mandated for report on the Trust's incident management system (Datix) and review.
- However, regardless of the mandatory requirements for a formal review detailed in Appendix 1, services are being encouraged to report on Datix <u>all</u> deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for Q1 – Q4 2022/23.
- It should be noted that data in this report was extracted as at 25/05/23. Any updates to information after this date will be included in future reports.
- Detailed mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee for review and approval.
- A summary of mortality data for 2022/23 is attached at **Appendix 2**; and for previous years at **Appendix 3**.
- To comply with the National Guidance on Learning from Deaths, this details:
  - the number of deaths in scope
  - the number of these deaths subjected to review
  - the level of review to which the deaths are being subjected; and
  - the determination of whether or not the deaths were more likely than not to have been due to problems in care.

- A review of mortality data processes and reporting is underway within the Trust in order to streamline and automate the current manual processes and utilise more advanced technologies now available to the Trust since implementation of the current processes. The aim of this review is to ensure efficiency, accuracy and resilience in the production of meaningful data.
- As part of this review, an analysis of the Trust position against the findings of the recently published report of the review by Grant Thornton of mortality recording and reporting in Norfolk and Suffolk Foundation Trust is being undertaken. Initial findings are that there are strong governance processes in place in terms of reporting the data; that there is service and corporate level involvement in the data and actions taken as a result; and that the requirements of the National Guidance on Learning from Deaths are met. However the production of data is reliant on complex manual processes and is limited by the lack of national or regional systems for sharing information relating to deaths across different NHS providers involved in care. The learning from this analysis will be used to inform the new arrangements to be put in place in the Trust. It is hoped that new arrangements will be in place for Q1 2023/24 reporting.

Summary of Quarter 4 2022/23 mortality data (1) – refer Appendix 2

- **Total number of deaths reported:** There were a total of 161 deaths reported on Datix for Q4 2022/23 (including those not falling within the scope for mandatory reporting). There were also an additional 69 deaths reported as occurring in Q1 – Q3 2022/23 since the last report to the Quality Committee (new totals: Q1 – 114 Q2 – 115 Q3 – 130). The additional deaths in previous quarters will have been reported for a number of reasons – including notification of deaths from 3rd party eg Coroner as well as two retrospective reporting exercises to 1) capture deaths of patients who had had historic contact with the Therapy for You services and 2) record onto Datix deaths in scope of the Policy which were identified from clinical information systems. Whilst there is no significant variance in total numbers of deaths reported for Qs 1–3, the total number of deaths reported for Q4 is 31 deaths higher than the total of any previous quarter. This is a result of the retrospective thematic review of patients who had had historic contact with Therapy for You services, which accounts for 51 of those deaths (approximately 40 deaths higher than ordinarily reported in a quarter by this service).

- **Total number of deaths in scope for mandated reporting:** Whilst there are differentials in the total number of deaths reported on Datix as detailed above, the number of deaths confirmed as within the scope for mandated reporting is broadly consistent across each quarter (Q1 – 62 Q2 – 61 Q3 – 55 Q4 – 58). The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

- **Inpatient / Nursing Homes deaths:** Of the 161 deaths reported in Q4, 4 were inpatient deaths and 4 were nursing home deaths. 3 of the 4 inpatient deaths and all 4 of the nursing homes deaths have been confirmed as due to natural causes. One inpatient death was sadly an unexpected unnatural death and is currently subject to a Patient Safety Incident Investigation under the PSIRF arrangements.

- **LeDeR reporting validation:** All reported Learning Disability deaths in Q4 (and previous quarters) have been reported to the national LeDeR programme.

- **Level of review:** The increase in the proportion of deaths being subjected to a Stage 2 Clinical Case Note Review or Stage 2 Thematic Review (15% for full year) and decrease in those being closed at Stage 1 review (53%) or at Stage 3 full PSIRF arrangements (15%), as compared to the previous mortality review arrangements, has continued. This is an intended outcome of the new arrangements as it enhances the ability to learn from deaths. However, it has had resourcing implications as more staff have been required to undertake these reviews.

Summary of Quarter 4 2022/23 mortality data (2) – refer Appendix 2

- **Stage 1 reviews:** A total of 143 deaths out of the 161 deaths reported for 01/01/23 – 31/03/23 have been subjected to a Stage 1 learning from deaths review by a local service manager. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. Table 1 indicates an improvement in the timeliness of completion of Stage 1 reviews with only 18 Stage 1 reviews for Q4 (39 for full year) awaiting completion at the point of extracting the data. Those requiring completion are being pursued with relevant managers, with the support of Quality and Safety Group chairs.

- **Stage 2 reviews:** A total of 13 deaths in Q4 have been identified for Stage 2 mortality clinical case note review / thematic review thus far. A new small sub-group reporting to the Learning from Deaths Oversight Group was established in January and is undertaking the scrutiny and approval of completed Stage 2 reviews. Since the last report to the Quality Committee, 7 have been considered by this Group and thereafter approved by the Learning from Deaths Oversight Group. The remaining Stage 2 reviews are underway and will be completed / presented for scrutiny over the coming weeks.

- **Completion of Stage 2 and Stage 3 (PSIRF) reviews:** Significant progress has been made over the quarter with completion of Stage 2 and Stage 3 reviews, with 70 now completed set against a total of 34 completed in the Q3 report to Quality Committee. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews and there is some slowing of progress of completion of Stage 2 reviews due to capacity. Mitigating actions to increase the numbers of clinicians able to undertake these reviews are being explored.

- **Problems in care assessment –** There are 0 deaths for Q4 (3 deaths for full year) thus far in 2022/23 that have been assessed as being more likely than not due to problems in care by EPUT. The assessment is still to be determined for 147 out of the total of 520 deaths for the full year. This data will be updated in future reports as reviews are completed and the likelihood is determined.

Assessment of Q4 data against historic scope (for mortality surveillance)

- An analysis has been undertaken of the Q1 – Q4 data using the previous "scope" categories and reporting groupings, in order to identify any trends of potential concern in relation to death numbers in established categories (as substantial historic data under the new groupings does not yet exist). This indicates that reported numbers of deaths are in line with numbers reported under the previous arrangements for periods not impacted by COVID-19 and that the service breakdown also remains consistent with previous months.

- Currently the number of deaths falling within the previous scope is lower for Q3 and Q4 than previous quarters. This is potentially related to the fact that there are a larger number of Stage 1 reviews requiring completion for those two quarters and thus these deaths awaiting Stage 1 review have not been assigned to a confirmed category. However, even if all those awaiting completion indicated a death that would fall within the previous scope categories, this would result in figures significantly within the upper control limit thus figures do not indicate a cause for concern. Figure 1 in Appendix 2 indicates that the number of deaths in scope in Q1 – Q4, using the previous scope, fall within control limits.

Summary of previous years' mortality data (2017/18 – 2021/22)

- A summary of mortality data for previous years (2017/18 – 2021/22) is attached at **Appendix 3** detailing the mandated requirements of the National Learning from Deaths Guidance.

- This indicates that there are only a small number of deaths remaining open (n. 2020/21: 3 2021/22: 21).

- All are being actively progressed and at least 9 of the reviews are scheduled to be completed in July. Full details included in Appendix 3.

- The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

CONCLUSIONS AND ACTIONS REQUIRED

- This report provides information in relation to the learning emerging from reviews of deaths being undertaken under the learning from deaths arrangements; as well as mandated mortality data and data to support mortality surveillance.

- It also provides assurance that the learning emerging is being acted upon. A temporary risk has been identified in terms of the available capacity within the learning from deaths workstream to drive forward some of the developmental work identified. Mitigating actions are being put in place to address this risk and build capacity as soon as possible. In the meantime, there is a likelihood that the progress in these developmental areas for learning may be slower than previously.

- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q4, as differentials can be identified as associated with the retrospective thematic review of deaths of patients with historic contact with Therapy for You services.

- Given the outcomes outlined, it provides the Trust Board of Directors with assurance that there are robust processes in place in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing and ensuring that patients are receiving safe, high quality care. It also highlights the work underway to review mortality data reporting processes and implement refined processes.

- The Board of Directors is asked to note the information presented; and request any further information or action.

APPENDICES

APPENDIX 1 Mortality Data – Context (1)

From 1ˢᵗ April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust. This is as follows:

- All deaths that have occurred within Trust inpatient services (this includes mental health, community health and learning disability inpatient facilities).

- All deaths in a community setting of patients with recorded learning disabilities or autism. *All deaths of patients with recorded learning disabilities or autism, whether in an inpatient or community setting, will be referred into the national LeDeR programme and are thus subject to different review processes than other Trust deaths.*

- All deaths meeting the criteria for mandatory review under the Trust's Patient Safety Incident Response Framework (PSIRF) – both the nationally and locally determined categories. The review undertaken under the PSIRF constitutes the review of the death for the purposes of the Learning from Deaths Policy and Procedural Guidance.

- Any other deaths of patients in receipt of EPUT services not covered by the above that meet the national guidance criteria for a Stage 2 Clinical Case Note Review. These deaths will be any deaths where:
  - Family, carers or staff have raised concern about the care provided; or
  - The death was unexpected and the individual:
    - had a diagnosis of psychosis (including schizophrenia, bi-polar, episode of non-organic psychosis, personality disorder, complex and severe depression) or eating disorder during the last episode of care;
    - was an inpatient at the time of death or had been discharged from EPUT inpatient care within the last 30 days;
    - was under the care of a Crisis Resolution Home Treatment Team at the time of death.

APPENDIX 1 Mortality Data – Context (2)

- In addition, deaths of clients under the care of services provided by EPUT as part of the drug and alcohol services care pathway (EDAP) are subject to specific reporting and mortality review processes including a collaborative multi-agency review. These deaths are therefore also included within mortality surveillance data.

- Regardless of the above mandatory requirements for a formal review, services are being encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for Q1 – Q4 2022/23. It should be noted that this will not reflect negatively on the Trust in terms of potential to appear as an "outlier" set against other Trusts mortality figures. The national guidance was clear that, given there is no standard national definition for deaths that should be included in Trust mortality data, no comparison or benchmarking should take place between Trusts – the data should be used solely internally to the organisation to support mortality surveillance and quality development. We are however attempting to explore with other local mental health trusts their approach to reporting deaths and data provision to establish whether it is possible to locally determine benchmarks etc.

- As the scope of deaths included has changed from the previous mortality review arrangements, there is no historic data prior to Q1 2022/23 against which to make comparisons. As a result, the data for Q1 – Q4 has been analysed in its totality under the new arrangements, as well as using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data. A decision will need to be taken in due course in terms of the period of time analysis will be undertaken under both methodologies (ie at what point the Trust is satisfied that there is sufficient historic data under the new arrangements to provide assurances).

APPENDIX 1 Mortality Data – Context (3)

- Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. Deaths reviewed under the Patient Safety Incident Response Framework (PSIRF) from 01/05/21 were not subject to this determination as the methodology encourages focus on quality learning outcomes. However a methodology has now been put in place for deaths from 01/04/22 being considered via PSIRF and a retrospective exercise is being undertaken to ensure all deaths from 01/04/22 have been subject to this determination. This approach to PSIRF deaths is reflected in the data in Appendix 2 & 3.

- The Trust's established mortality data dashboard was amended from 1st April 2022 to enable recording of data in line with the new arrangements, whilst still retaining the ability to use the process as a validation exercise to ensure deaths are reported on both Datix and clinical information systems and that learning disability deaths have been reported to the national LeDeR mortality review programme. A validation exercise between Datix and Clinical Information Systems is undertaken each quarter and actions taken to ensure deaths are reported appropriately on both systems – this work is being undertaken for Q4. Work is taking place with the Trust systems and information teams to review the mortality data reporting processes to streamline and automate the current manual processes based on developments over the past year and new technologies available to the Trust since establishment of the current arrangements.

- It should be noted that data in this report was extracted as at 25/05/23. Any updates to information after this date will be included in future reports.

APPENDIX 2 2022/23 mortality data (1)

The table on the following page provides a summary of mortality data for 2022/23. The following "Notes" are referenced in the left hand column of the table.

Notes:

1) Figures for in-patient and nursing homes deaths were unfortunately transposed in the Q3 report to the Quality Committee – the correct positioning of the figures are included in the above table. The reduction in the number of deaths in Q1 and Q2 results from an end of year validation of narrative on Datix reports to determine deaths occurring on an in-patient unit and deaths occurring following discharge to eg acute Trust. The additional two inpatient deaths reported for Q3 are deaths which were identified via the quarterly Datix and Clinical systems validation process and for which Datix reports have now been recorded.

2) In the Q3 report a joint total of deaths referred for Stage 2 review either via case note review or thematic review was denoted. In the above table, these figures have been separated.

3) In the Q3 report a joint total of reviews completed under Stage 2 review and PSIRF review was denoted. In the above table, these figures have been separated.

4) In the Q3 report, the EDAP and LeDeR death review figures were included within the "assessment of likelihood of death being due to PIC still underway". In the above table, the figures for the EDAP and LeDeR deaths have been separated.

Table 1: SUMMARY OF 2022/23 MORTALITY DATA	Q1 (stated in Q3 report)	Q1 current	Q2 (stated in Q3 report)	Q2 current	Q3 (stated in Q3 report)	Q3 current	Q4 current	YTD (stated in Q3 report)	YTD current
DATA ON NUMBER OF DEATHS									
Total deaths reported on Datix	99	114	96	115	95	130	161	290	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	60	62	61	61	68	55	58	189	236
Total inpatient deaths *Note 1*	5	4	7	6	7	9	4	15	23
Total nursing homes deaths *Note 1*	6	6	6	6	3	3	4	19	19
DATA ON LEVELS OF REVIEW									
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes)	93	110	91	110	66	118	143	250	481
Total deaths awaiting completion of Stage 1 review	6	4	5	5	29	12	18	40	39
Total deaths closed at Stage 1 and learning ascertained	45	55	42	56	36	71	92	123	274
Total deaths referred on for Stage 2 clinical case note review *Note 2*	20	20	23	17	13	5	2	56	44
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis) *Note 2*		5		1		15	11		32
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	14	18	16	28	5	12	22	35	80
Total deaths for which Stage 2 review complete and learning ascertained *Note 3*	19	12	15	5	0	2	0	34	19
Total deaths for which PSIRF review complete and learning ascertained *Note 3*		17		22		7	5		51
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	11	4	4	9	9	10	24	34
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	3	4	4	1	5	5	8	17
Total deaths for which level of review under determination	6	5	7	5	31	13	20	44	43
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION									
Assessed as more likely than not due to PIC	0	3	0	0	0	0	0	0	3
Assessed as not more likely than not due to PIC	59	78	45	73	36	75	93	140	319
Assessment of likelihood of death being due to PIC still underway	40	19	51	34	59	41	53	150	147
Not applicable (EDAP and LeDeR reviews utilising different methodology) *Note 4*		14		8		14	15		51

APPENDIX 2 2022/23 mortality data (2)

Table 2: Comparison of confirmed levels of review Q1 – Q4 2022/23 to previous years

Level of review	Number of deaths Q1 – Q4	As a percentage of total deaths Q1 – Q4	Average percentage in previous years
Total number of deaths	520		
Closed at Stage 1	274	53%	64%
Stage 2 review underway (Clinical Case Note Review or Thematic Review)	76	15%	6%
Stage 3 review underway (PSIRF)	80	15%	29%

APPENDIX 2
2022/23 mortality data (3) – comparison against historic scope

Figure 1 below shows the total number of deaths that fell within the scope of the previous Mortality Review Policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. The two months where the number of deaths fell above the upper control limit were peaks of COVID-19. Figure 1 below indicates that the number of deaths in scope in Q1 – Q4, using the previous scope, fall within control limits.
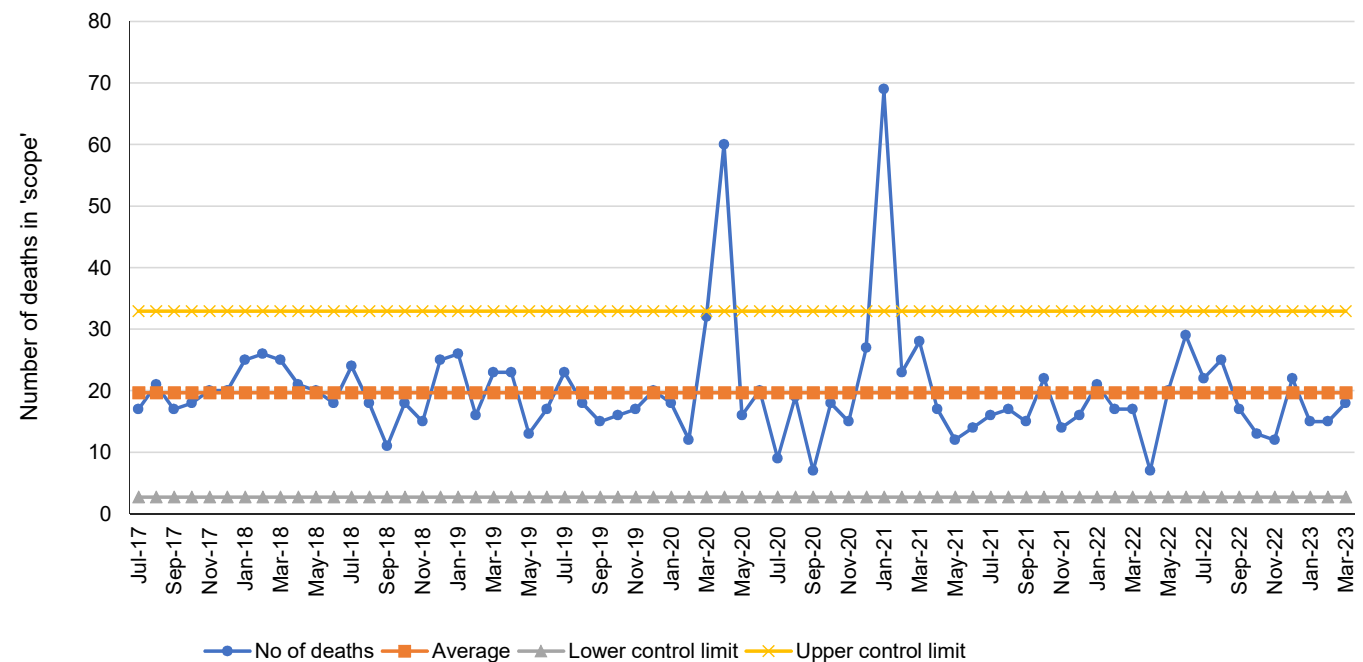
APPENDIX 3 – Previous years' mortality data

Table 3: Summary of deaths closed

Year	Number of deaths in scope *	Number closed	% closed at Grade 1 desktop review	% closed at Grade 2 clinical case note review	% closed at Grade 3 critical incident review	% closed at Grade 4 serious incident review	% deemed more likely than not due to PIC
2017/18	248	248	60%	5%	0.5%	35%	1%
2018/19	235	235	63%	8%	0%	29%	4%
2019/20	228	228	64%	7%	0.5%	29%	2.5%
2020/21	311	308	73%	3%	0%	23%	**0.3%
2021/22	195	174	62%	1%	0%	26.5%	**0%

* **Note:** Scope in place 2017/18 – 2021/22 under Mortality Review Policy was different to scope from 2022/23 onwards under Learning from Deaths Policy

** **Note:** From 01/05/21 on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements until 01/04/22 (introduction of Learning from Deaths arrangements), the Trust did not undertake this determination for deaths reviewed via PSIRF arrangements as the focus of this methodology was on quality learning outcomes. The determination was made for all other deaths in scope. From 01/04/22, methodology has been put in place to undertake this determination for PSIRF deaths as well as all other deaths in scope.

APPENDIX 3 – Previous years' mortality data

Table 4: Breakdown of open deaths

2020/21: The 3 deaths remaining open are part of a thematic review currently underway of non-Patient Safety Incident deaths of patients with a Severe Mental Illness diagnosis. This thematic review is due to be completed in July 2023; and it is therefore hoped to provide feedback and closure in the next quarterly report to the Quality Committee.

2021/22: The 21 deaths remaining open are as follows:

- 6 deaths are part of the thematic review currently underway of non-Patient Safety Incident deaths of patients with a Severe Mental Illness diagnosis. As above, this thematic review is due to be completed in July 2023; and it is therefore hoped to provide feedback and closure in the next quarterly report to the Quality Committee.
- 4 deaths are open under PSIRF, 3 of which are anticipated to be closed shortly. One investigation report is with the family for comment prior to finalisation and two investigation reports are undergoing finalisation following comment by the Clinical Review Group. The remaining one review relates to a deaths for which the investigation was held ("stopclocked") due to police involvement; this hold has recently been released and the review has commenced.
- 11 deaths not Datix reported but identified via clinical information systems as non-Patient Safety Incident deaths of individuals with Severe Mental Illness diagnosis have now been Datix reported and are being subjected to initial Stage 1 review prior to determining whether they should be subjected to more detailed review.

MENTAL HEALTH ACT ANNUAL REPORT

● Information Item   👤 NH   🕐 5 Minutes

REFERENCES

📕 Mental Health Act Annual Report 26.01.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023

Report Title:	**Mental Health Act Annual Report 2022/23**				
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse				
Report Author(s):	Lynn Proctor, on behalf of Tendayi Musundire, Associate Director of Safeguarding				
Report discussed previously at:	Quality Committee				
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A	
Describe what measures will you use to monitor mitigation of the risk	N/A	

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the Mental Health Act & Safeguarding Sub-Committee to inform of the Mental Health Act activity in 2022/23.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors are asked to: 1 Note the contents the report 2 Discuss the content of the report 3 Request any further information or action

Summary of Key Issues
This is the sixth Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Committee operates, provides an overview of its activities in 2022/23 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2023/24.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

This report reviews the operation of the Mental Health Act for the year 1st April, 2022 to 31st March, 2023. It will provide an overview of the work undertaken in the administration of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detention (i.e. Section 5(4), Section 5(2) etc.) and instances of detained patient's absence without leave (AWOL). The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range.

The CQC carried out seventeen Mental Health Act inspections during the period April 2022 – March 2023. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of examples of good practice.

The Trust's Target Compliance figure of 85% for Mental Health Act mandatory training, covering both registered and un- registered staff, was met for the period April 2022 – March 2023

The Mental Health Act Office continues to provide Mental Health Act administration support to several local acute care partners for patients detained to them under a Service Level Agreement. As part of the agreement the Mental Health Act Office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Going forwards, work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act and prepare for any changes in legislation resulting from the Mental Health Act White Paper.

The Mental Health Act Team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	

Financial implications:			
		Capital £	
		Revenue £	
		Non Recurrent £	
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			
MHA	Mental Health Act	AWOL	Absent without leave
CQC	Care Quality Commission		
AHM	Associate Hospital Manager		

Supporting Reports/ Appendices /or further reading
Mental Health Act Annual Report 2022/23

Lead

Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MENTAL HEALTH ACT ANNUAL REPORT 2022-23

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

MENTAL HEALTH ACT ANNUAL REPORT

2022-23

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FOREWORD

Providing high quality, safe and compassionate care continues to be our absolute priority at Essex Partnership University NHS Foundation Trust (EPUT). This year's Mental Health Act Administration Annual Report (2022/2023) sets out our performance in relation to the Mental Health Act but also our ongoing commitment to providing the best possible care to those who need us most.

Central to this is our new Strategic Plan. Launched earlier this year, it sets out our priorities and how we will improve, develop and innovate to 'be the leading health and wellbeing service in the provision of mental health and community care.'

It links closely with our inpatient safety strategy, 'Safety First, Safety Always' which recognises our commitment to be an organisation that consistently places patient safety at the heart of everything it does. Now entering its third year, colleagues across the Trust have embraced the 'Safety First, Safety Always' message but we know there is more to do - earlier this year we launched an update to the strategy, reflecting on the improvements we have made and our plans to drive forward further change.

We continue to focus on providing the best inpatient care when it is needed. Since May 2020, we have seen an 88% reduction in prone restraint and supportive observations are enabling staff to build therapeutic relationships with patients in our care and manage risk and safety on our wards. The use of Oxevision remote monitoring technology has also expanded as

part of a £20 million investment in our wards, helping patients to feel safer and supporting staff to provide high quality care.

This year we have also made huge progress in cementing EPUT as a learning organisation. In July a new Lessons team was formed as part of our Culture of Learning, a commitment to excellence and willingness to learn from the experience of others. Learning is an 'Always Event' where all colleagues are responsible for striving for improvement, learning from mistakes and good practice and adopting positive changes to provide safe and excellent care.
All that we have achieved this year is testament to hard work and dedication of colleagues across the Trust and I would like to take this opportunity to thank everyone for their continued efforts.

#WhatWeDoTogetherMatters

Natalie Hammond
Executive Nurse

EXECUTIVE SUMMARY

Context and introduction

This is the sixth Annual Report prepared on behalf of EPUT's Mental Health Act & Safeguarding Sub-Committee. It sets out the framework within which the Committee operates, provides an overview of its activities in 2022/2023 and the outcomes of its deliberations, and looks ahead to developments and challenges anticipated in 2023/2024

The Board recognises that high standards of governance throughout the Trust are essential for the delivery of the identified strategic objectives, the safety of its services, the quality of service user and carer experience, and the long-term protection of stakeholder interests. Good governance emanates from the Board but pervades the entire organisation, being reflected in its operating practices, policies and procedures.

The Mental Health Act & Safeguarding Sub-Committee ensures the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005.

Scope of the report

This report reviews the operation of the Mental Health Act for the year 1 April 2022 to 31 March 2023. It provides an overview of the work undertaken in the administration of the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

The Mental Health Act Office continues to monitor Mental Health Act activity across the Trust, including the number and type of detentions (i.e. Section 5(4), Section 5(2) etc.) and instances of detained patients' absence without leave. The Mental Health Act Office also monitors detentions by ethnicity. Whilst there is some fluctuation in data, it remains consistent with previous years and in the expected range.

CQC inspections

The CQC carried out seventeen Mental Health Act inspections during the period April 2022 – March 2023. Overall, the feedback from the CQC reviews was positive with a small number of points of learning/themes identified and addressed. Following these inspections, the CQC also commented on a number of good practices.

Mandatory training

The Trust's target compliance figure of 85% for Mental Health Act mandatory training, covering both registered and un-registered staff, was met for the period April 2022 – March 2023.

Partnership working

The Mental Health Act Office continues to provide Mental Health Act administration support under a service level agreement to several local acute care partners. As part of the agreement, the Mental Health Act Office also provides training to our acute care colleagues which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

Looking forward

Work will continue going forward in continuing to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act and prepare for any changes in legislation resulting from the Mental Health Act White Paper.

The Mental Health Act team remains committed to providing a quality, supportive function to EPUT clinicians to ensure that we work collectively to ensure that those individuals detained under the Act are in receipt of their rights as a detained patient.

DETENTIONS UNDER THE MENTAL HEALTH ACT 2022 -2023

Data source

As there are currently two clinical systems being used for the administration of the Mental Health Act in the Trust – Mobius in the Basildon/ Rochford/ Thurrock Area and Paris in the Chelmsford/ Colchester/ Harlow Area, this report provides details for both systems, which are provided by the Trust's Information and Performance team.

People may come into hospital under a detention order or they may have been admitted informally then assessed and detained. It is possible for one person to have been subject to numerous detention orders for example; Section 5(4), Section 5(2), Section 2 and Section 3. It is each of these individual sections that make up the detention figures.

The main facts and figures in this report has been benchmarked against national government figures reported in October, 2022

National data – Mental Health Act statistics (annual figures 2021–2022) published October 2022

The key findings of the statistical report which was published on the 27 October, 2022 reports that there were 53,337 new detentions nationally under the Mental Health Act were recorded, but the overall national totals will be higher as not all providers submitted data and some submitted incomplete data. Trend comparisons are also affected by changes in data quality. For the subset of providers that submitted good quality detentions data in each of the last six years, it is estimated there was a decrease in detentions of 5.7% from last year.

Comparisons can still be made between groups of people using population based rates, even though the rates are based on incomplete data. Known detention rates were higher for males (93.8 per 100,000 population) than females (86.4 per 100,000 population). Amongst adults, detention rates tend to decline with age. Known detention rates for the 18 to 34 age group (144.2 detentions per 100,000) were around 67% higher than for those aged 65+ (86.3 per 100,000 population).

Amongst the five broad ethnic groups, known rates of detention for the 'Black or Black British' group (341.7 detentions per 100,000 population) were over four times those of the White group (7.2.4 per 100,000 population).

Known rates of Community Treatment Order (CTO) use for males (12.4 per 100,000 population) were higher than that for females (7.3 per 100,000 population). Across age groups, those aged 35 to 49 had the highest rate of CTO use (16.4 known uses per 100,000 population compared to 9.8 uses per 100,000 population for all age groups).

Amongst broad ethnic groups, known rates of CTO use for the 'Black or Black British group (75.5 uses per 100,000 population) were over eleven times the rate for the White group (6.8 uses per 100,000 population).

Detention Rates by Ethnicity

A more detailed breakdown of the five broad ethnicity groupings shows that the detention rate was highest for those with 'Any other black background', which forms part of the 'Black and black British' group.

At 760.0 detentions per 100,000 people, this was over ten and a half times the rate for the 'White British' group (69.3 detentions per 100,000 people) in 2021-22.

The 'Any other ethnic group' had the second highest rate of detention (491.9 detentions per 100,000 population) followed by 'Any other mixed backgrounds' group at 405.6 detentions per 100,000 population.

National Data – Mental Health Act Statistics – Annual Figures. Published October 2022. Standardised detention rate per 100,000 population for the UK
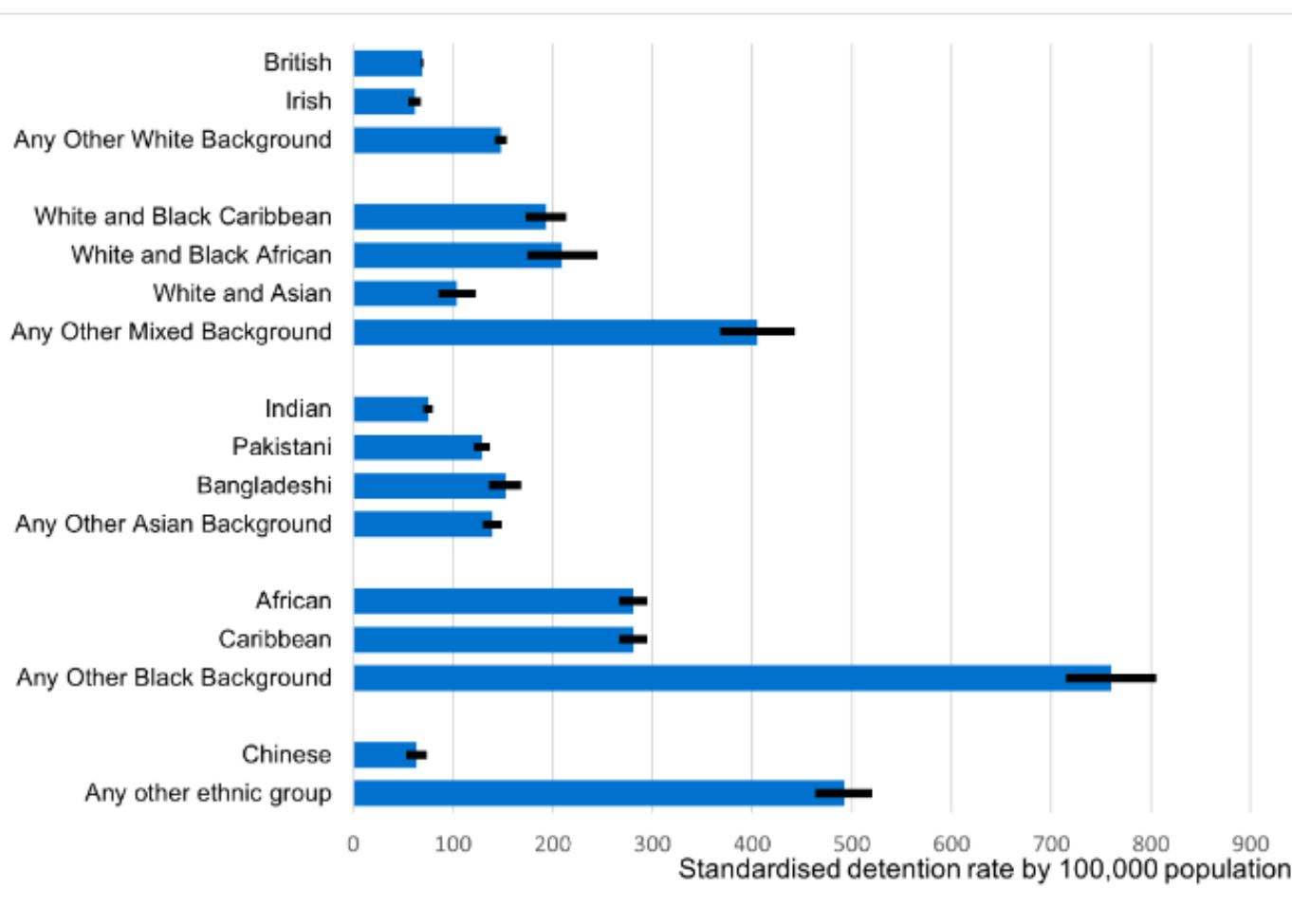
EPUT detention rates by ethnicity

The table below details the ethnic grouping of detained patients in receipt of care from EPUT. Although the data indicates a slight decrease in the detentions of black individuals and a slight increase in the detention of white individuals, the data, as in previous years, remains relatively stable and appears to be consistent with the demographic profile of EPUT's geographical area. The Mental Health Act Office will continue to monitor and analyse the data for emerging trends and will review and adapt policy and procedure, as well as training to ensure cultural and ethnicity needs are reflected.
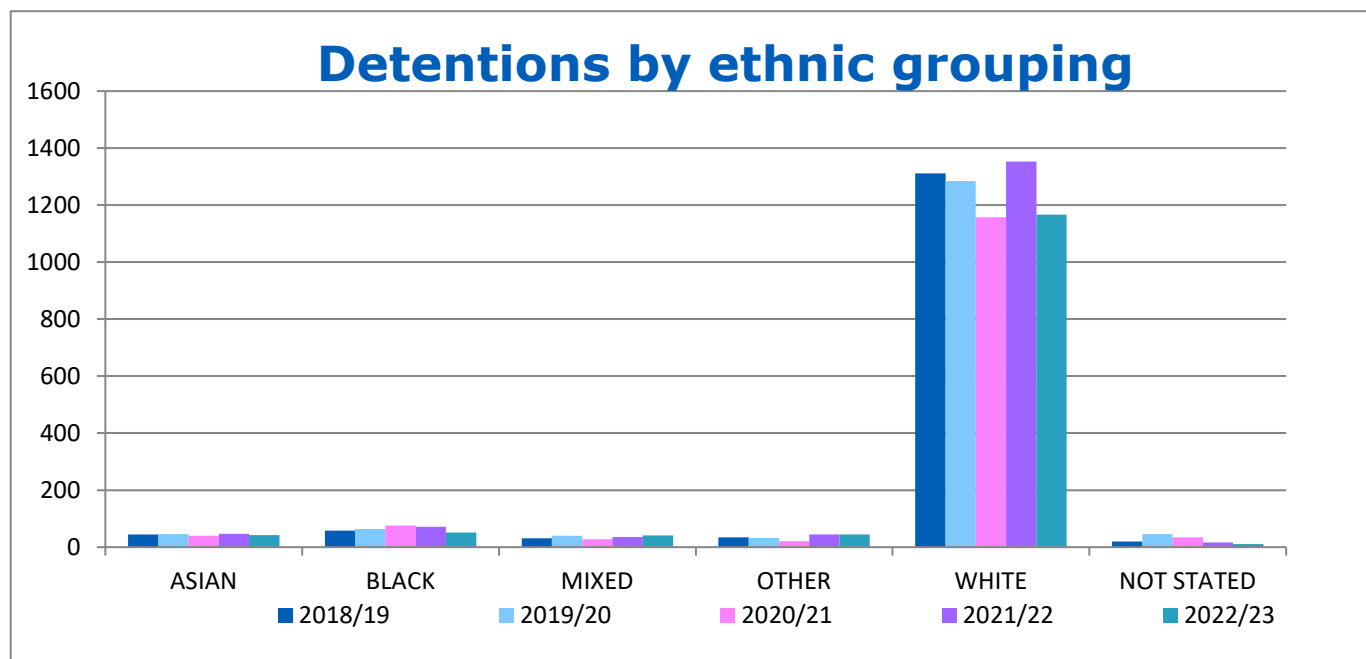
Data provided by EPUT Information Department

EPUT Mental Health Act Detention Activity data

Mental Health Act Activity (number of detentions) is monitored on a monthly basis in order to identify emerging trends and any anomalies and presented at the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub-Committee. Any anomalies and emerging trends identified are further investigated to understand the context and circumstances; and remedial action taken as appropriate.

The below SPC Charts provides an overview of Mental Health Act Activity. Whilst there is some fluctuation in the use of some of the detentions, they are all within the expected range.

Section 5(4)

A Section 5(4) allows a nurse of the 'prescribed class' to detain an in-patient who is already receiving treatment for mental disorder. The definition of 'prescribed class' is any nurse registered in sub-parts 1 or 2 of the register maintained by the Nursing & Midwifery Council (NMC) whose entry on the register indicates that their field of practice is either mental health or learning disability.

A Section 5(4) lasts for up to six hours or until the doctor attends to assess the patient to ascertain if the patient requires further detention. The use of Section 5(4) whilst fluctuates remains low and within single figures.

Where there is an increase in numbers, the Mental Health Act Office will undertake further investigation to ascertain rationale and identify any practice or training issues.

In addition to this, the data is reviewed and discussed at the Mental Health Act Business Meeting and the Mental Health & Safeguarding Sub Committee.
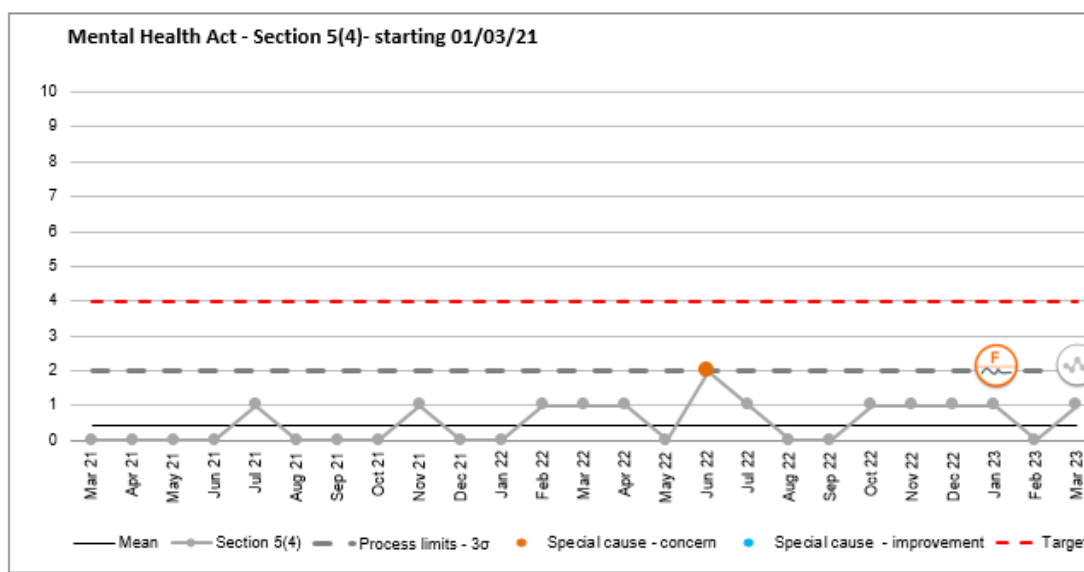
Data for both graphs provided by EPUT Information Department
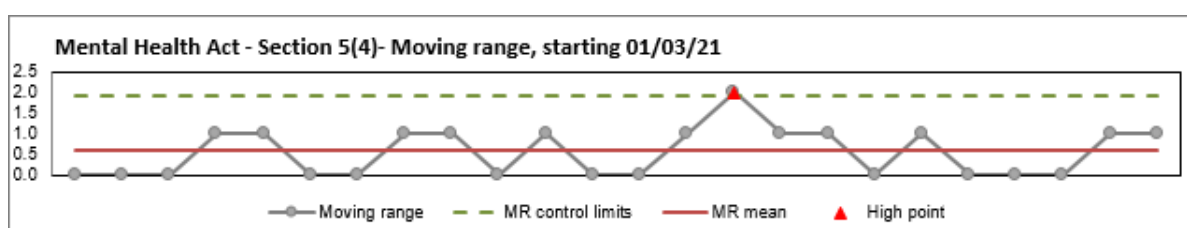
Section 5(2)

Section 5(2) is a holding section of an informal or voluntary patient on a mental health ward in order for assessment to be arranged under the Mental Health Act 1983. A Section 5(2) is only used where the patient has expressed the intention to discharge themselves and there is an assessed risk to themselves or others should they do so. The usage of a 5(2) can therefore fluctuate from month to month demonstrated as common variation. This data is monitored and any unexpected increases are reviewed by the Mental Health Act Office. Where necessary, the office will undertake further investigation to ascertain rationale for increase and identify if there are any practice or training issues that need to be addressed. To date for the period covered by the annual report, no issues have been identified.
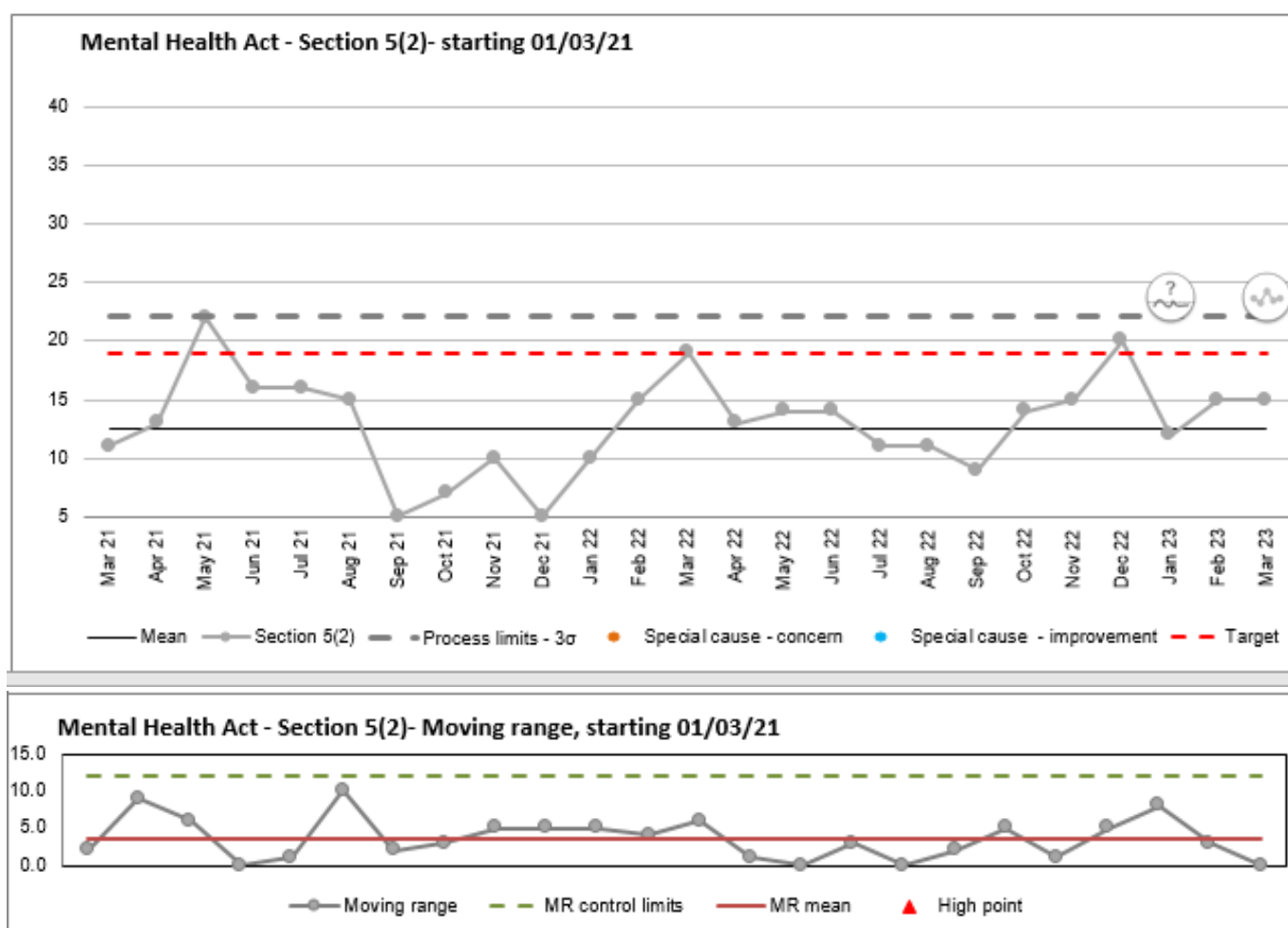
Data for both graphs provided by EPUT Information Department

Section 2

Section 2 is an assessment and treatment section for detention up to 28 days. Clinicians during the period of assessment will be looking for an improvement in the patient's mental state and would towards the end of the twenty eight day period be looking for the least restrictive option of the patient remaining in hospital informally rather than being detained further under Section 3. The use of Section 2 (as highlighted in the chart below) has fluctuated over the last twelve months, however it is now within the expected range.

Whilst it is difficult to provide a definitive rationale for this fluctuation, it could be attributed to a number of factors including client presentation, impact of COVID-19 and the impact of and success of crisis services negating the need for admission.
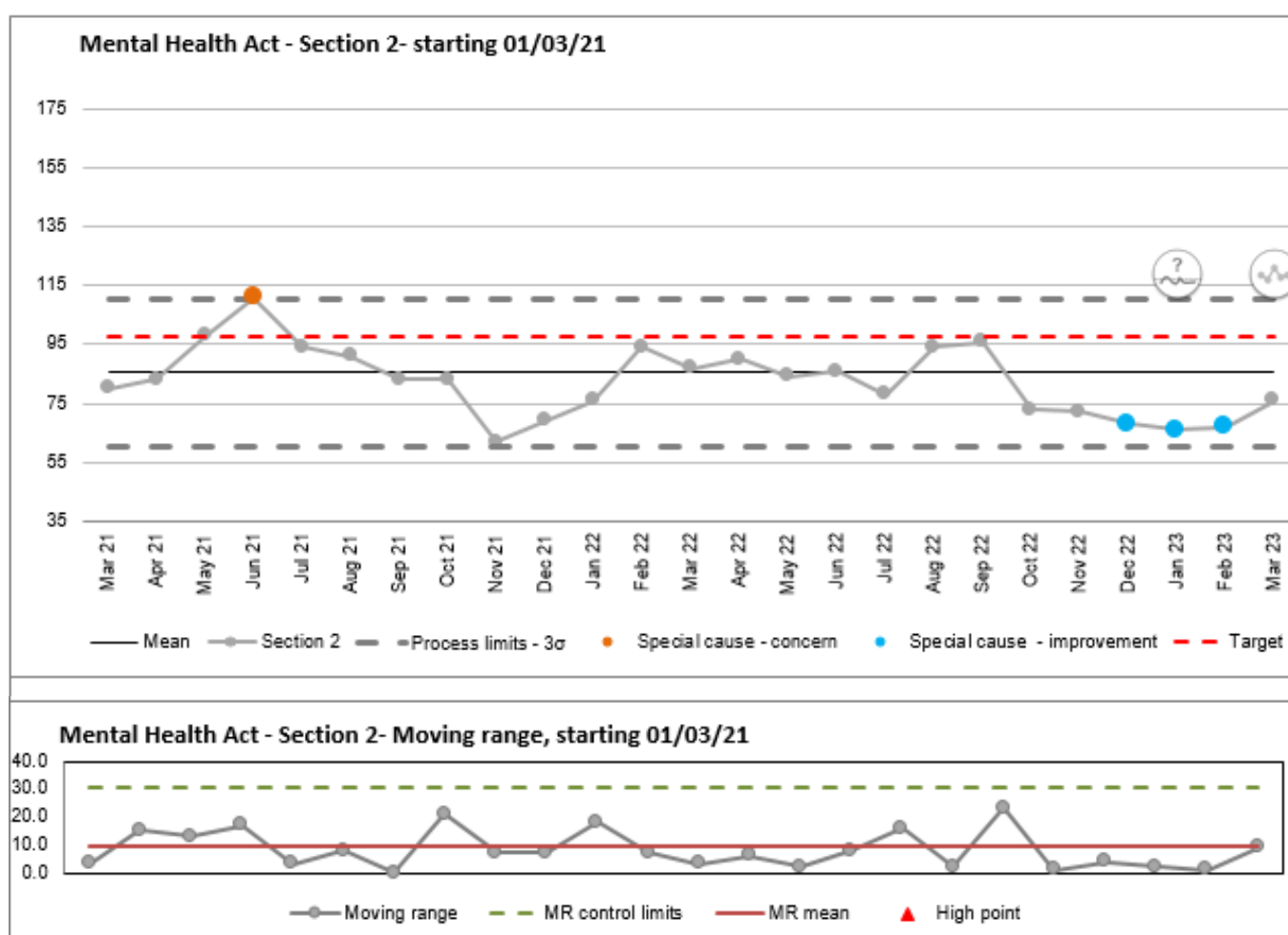
Data for both graphs provided by EPUT Information Department

Section 3

Section 3 is a longer term treatment section for up to six months, renewable at six months and then yearly. The data fluctuates, with an increase in May 2021 and slight increases in October, 2021 and February 2022. However these increases are still within expected range, and could be attributed to patients being transferred from a Section 2 to a Section 3 if they are assessed as requiring long term treatment, or being admitted to hospital under Section 3, (Those patients who have previously been assessed under Section 2 or detained under Section 3).
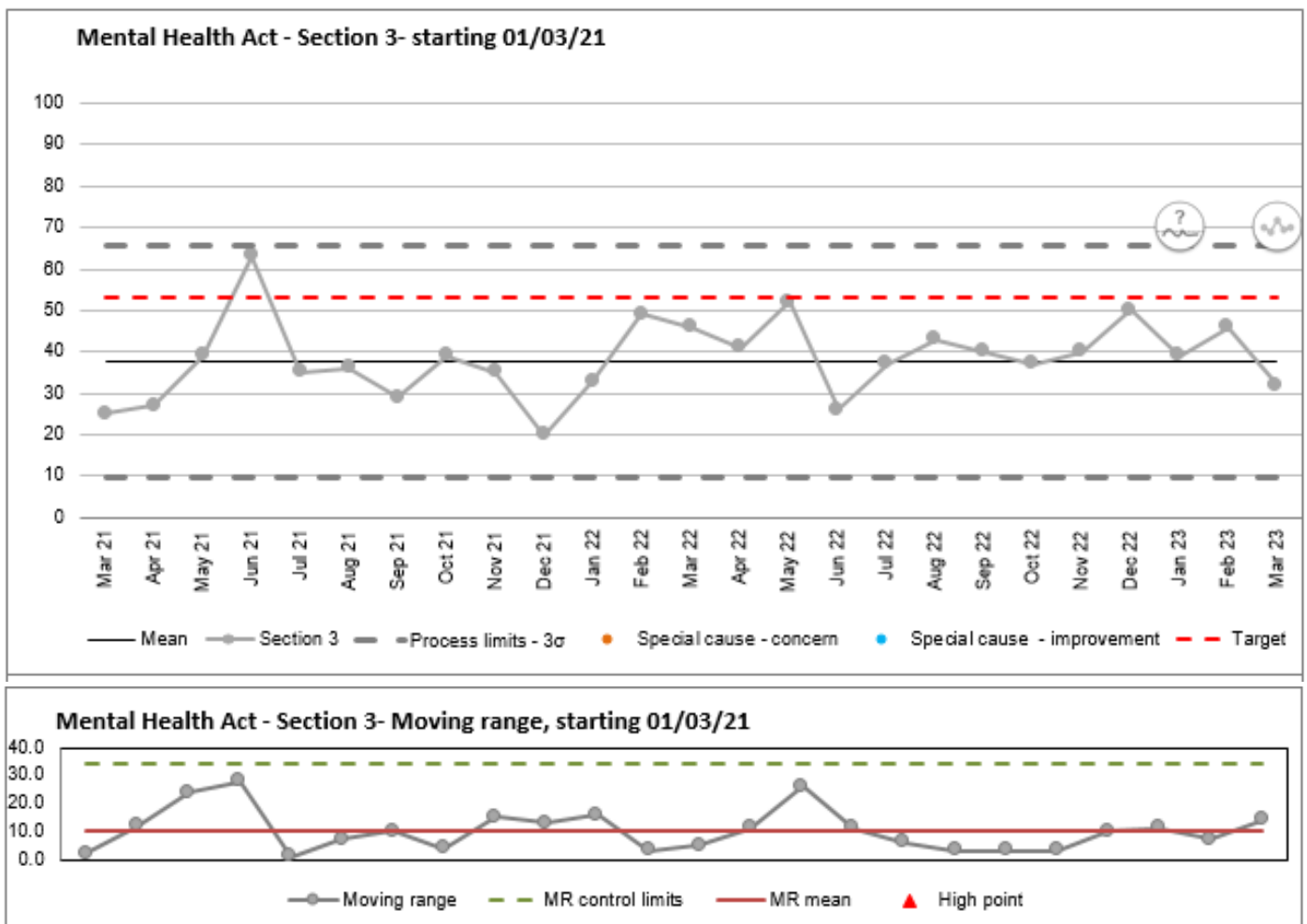
Data for both graphs provided by EPUT Information Department

Absence without leave

Section (18) of the Mental Health Act sets out the definition and the powers available when a person is absent without leave. A high percentage absence without leave relate to a small number of patients in Child and Adolescence Mental Health Services. Measures are being put in place to secure the physical environment and manage the patient's leave to mitigate against them going absent without leave, e.g. escorted as opposed to un-escorted leave.
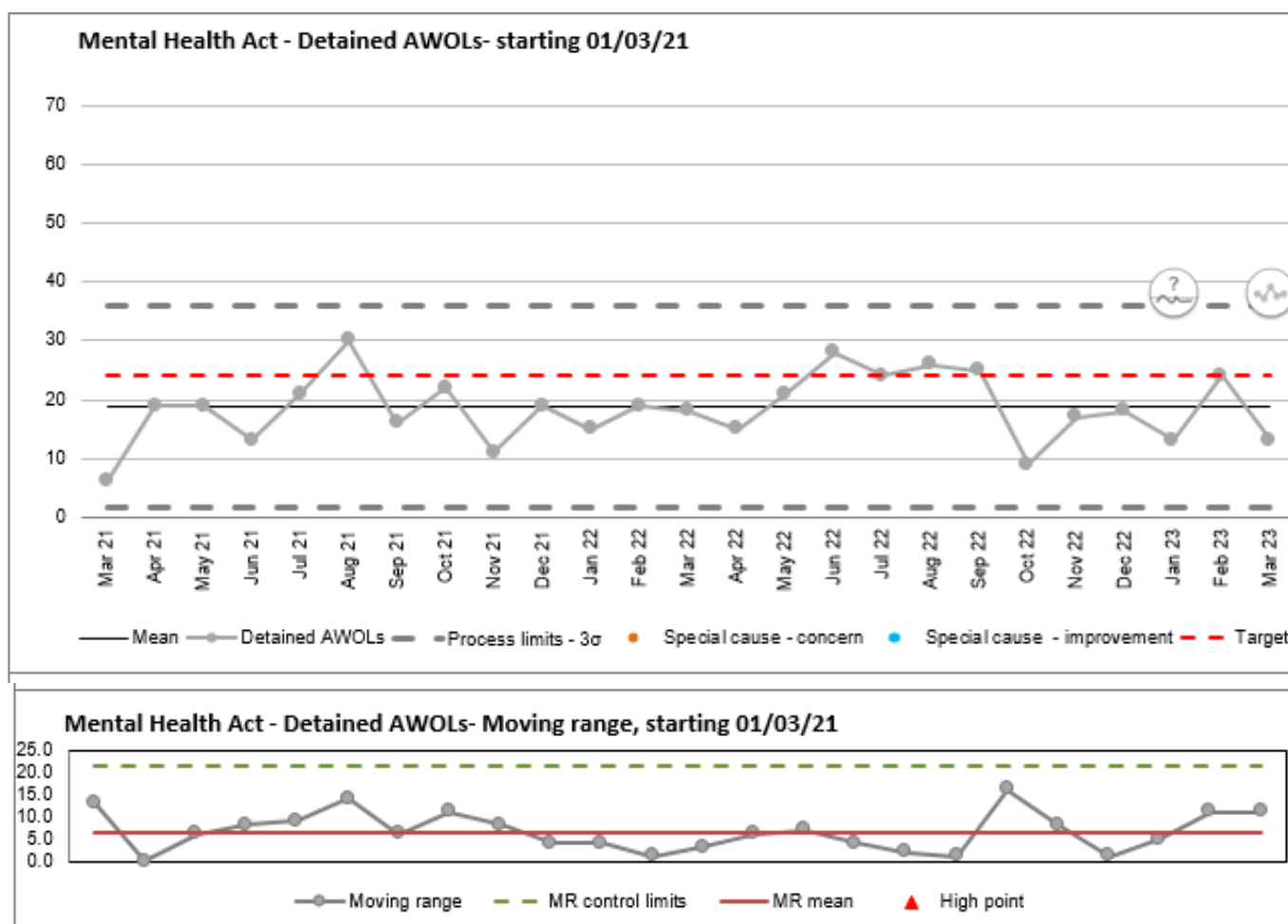
Data for both graphs provided by EPUT Information Department

SERVICE LEVEL AGREEMENTS WITH OTHER PROVIDERS

The Trust continues to have in place service level agreements with Princess Alexandra Hospital, Harlow, East Suffolk and North Essex NHS Foundation Trust who are responsible for services in Colchester General Hospital and Mid & South Essex NHS Foundation Trust who are responsible for services in Broomfield Hospital, Basildon General Hospital and Southend General Hospital.

The service level agreements provide Mental Health Act Administration expertise and support with patients detained to an acute hospital under the Mental Health Act. All three service level agreements have recently been renewed by these organisations for another twelve months into 2024. The service level agreements provide Mental Health Act Administration expertise and support with patients detained to an acute hospital under the Mental Health Act. A vital part of the service level agreement is the provision of Mental Health Act training to our acute care colleagues, all of which helps ensure those individuals detained under the Act are in receipt of their rights as a detained patient.

CARE QUALITY COMMISSION

The Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 to provide a safeguard for individual patients whose rights are restricted under the Act. They do this by looking across the whole patient pathway experience from admission to discharge.

The Mental Health Act Office provides a supportive process for the wards to help co-ordinate the visit. In the main during the last year, visits from the CQC have been unannounced. The Mental Health Act Office provide support to the ward staff for any responses that may be required to the CQC, during or following their visit. To date, this has proved very successful.

CQC Mental Health Act Reviewers undertook the following:

1. Identify services that require monitoring based on emerging concerns and their previous contacts with the service

The CQC have given formal provider action plans and monitoring reports detailing the outcome of the visit indicating any points where they would expect action to be taken. The Care Quality Commission made the following visits to the Trust from the 1 April 2022 to the 31 March 2023:

11 April 2022	Hadleigh Ward
11 April, 2022	Cherrydown Ward
13 April 2022	Tower Ward
13 April 2022	Willow Ward
14 April 2022	Poplar Ward
19 April 2022	Fuji Ward
11 May 2022	Kelvedon Ward
18 May 2022	Ipswich Road
19 May 2022	Larkwood
23 May 2022	Topaz Ward
1 August 2022	Meadowview Ward
13 September 2022	Ruby Ward
4 January 2023	Willow Ward
4 January 2023	Cedar Ward
17 February 2023	Aurora Ward
10 March 2023	Alpine Ward
28 March 2023	Woodlea Clinic

Overall the feedback from the CQC reviews was positive, however a number of themes were identified. The general themes identified have been shared both at the Mental Health Act Business meeting and the Mental Health Act & Safeguarding Sub Committee and action taken to mitigate against recurrence. It was pleasing to note that in addition to areas for improvement a number of positive general comments from patients, relatives and carers were provided to the CQC reviewers during their visits. Some of the themes identified were as follows:

- Access to fresh air
- No evidence of discharge planning
- Medication not authorised by an appropriate treatment form
- Medication charts disorganised with obsolete medication forms being retained.

Discussion with patients and carers:

Three patients spoke with us in private. They told us they felt safe on the ward, they were aware of the MHA detention and the process to appeal to the Tribunal or the associate hospital managers. On admission they were given orientation and welcome packs with useful information about the service. They were aware of their treatment plan and participated in composing of their care plan. *(Hadleigh Unit)*

They spoke extremely highly of the nursing staff, they made comments like, "this is the best place" and that staff "give you their time" they are "caring, patient and understanding" they "listen and respect your privacy, dignity not too intruding". *(Hadleigh Unit)*

We were informed staff recognise the importance of taking positive risks and were not averse to this, for example, a patient who recently attempted to ligature was not unduly prevented from accessing potentially (risky) equipment for their physical health needs. The patient told us this meant a lot to them. *(Hadleigh Unit)*

Staff provided patients with information about their legal position and rights at the time of their detention/admission, as required under Section 132 of the MHA. *(Hadleigh Unit)*

Medical/ nursing staff gave physical health as much attention as mental health needs. *(Topaz Ward)*

One patient told us that the occupational therapy groups are good and the occupational therapy staff are excellent. He stated they provide appropriate and gently pressure to patients to encourage them to participate without alienating them. *(Ipswich Road)*

Throughout our visit we saw staff interacting and responding to patients in a caring and respectful way. *(Meadowview Ward)*

Patients requiring enhanced observations were able to partake in activities and access the garden. *(Meadowview Ward)*

Care plans were informative and provided information about the care needs of the patients. We noted patient's involvement. Patients we spoke with were involved with their care planning. *(Ipswich Road)*

The MHA detention paperwork was in order. Staff had the support from the team of MHA administrators. The Trust had a system in place for

receiving and scrutinising detention legal paperwork. *(Ipswich Road)*

Patients spoke highly of the staff working on the ward and how they made time for them. We heard that staff listened to the patient and were kind and caring. All patients told us that they felt safe on the ward. One patient described the ward as the best place he had been, and he attributed his improvement to the care he received from the clinical team. Patients were complimentary about the activities and education session they could participate in. They said that they valued the opportunity to buy their weekly shopping and manage their own cooking. Patients told us that they were able to be independent, and that their privacy was respected. One patient spoke positively about how well the staff engaged with their relative, ensuring they were invited to Care Programme Approach meetings and to the carer's events that were organised on the site. *(Aurora Ward)*

They could see their Responsible Clinician (RC) at ward review at least once a week, and the RC had fully explained their treatment to them, including several treatment options. One patient commented, "In other hospitals the doctor doesn't usually give you so much details and options, but they are good here". *(Willow Ward)*

A patient told us their faith was important to them, they had access to spiritual care support. *(Hadleigh Unit)*

The Independent Mental Health Advocate (IMHA) (provides objective independent advice to detained patient) feels that staff are very

caring and they have a difficult job. She has observed positive attitudes from staff to patients even when some of the staff have been verbally abused or assaulted by the patients. She stated a lot of the staff are very skilled and work very well. *(Larkwood Ward)*

Patients commented negatively about the use of agency staff, particularly during night shift. Comments included, "there are loads of agency staff especially at nights" and "they (agency staff) don't speak to you". *(Hadleigh Unit)*

All patients told us that there were a range of activities available during the week, however two patients' report that weekends were boring as there were less staff available and there was nothing to do. *(Ipswich Road)*

We have some concerns under this guiding principle (Purpose and Effectiveness principle) in relation to prescription charts which we comment on in the action required section. *(Larkwood Ward)*

The ward had a good-sized garden with seating. We observed several patients enjoying the pleasantly presented green space. Patients could vape in the garden. Staff and patients told us access to the garden was restricted at set times of the day to encourage patients to take part in planned ward activities. Although none of the patients had an issue with the arrangement, we had concerns about this restriction. *(Willow Ward)*

We noted discharge planning was sketchy. We had some concerns about compliance with this guiding principle (Empowerment and

Involvement principle) that we have raised in the actions section. *(Willow Ward)*

We found that one patient had been given a medication on one occasion that was no longer prescribed but the team were already aware of this and we were pleased to see there is a weekly audit of the medication charts. We did however have some concerns with prescription charts and Section 58 Consent to Treatment authorisation forms. *(Tower Ward)*

One relative told us she raised concerns about her daughter's previous placement, prior to admission to Larkwood. She feels that the food here is excellent with her daughter's vegan diet catered for. She feels that the facilities here are so much better than where she was before. She has seen the long-term segregation (LTS) area having visited. She has been kept informed about her daughter's care including the periods of seclusion and LTS. Her daughter has been having therapies including music therapy and is due family therapy soon. *(Larkwood Ward)*

Relatives/ carers were highly complementary about the ward, they were happy with the care and treatment the staff provided to their relative. They spoke positively about care and treatment their relative received since admission, these admissions varied from eleven days to three weeks. They told us "the service is brilliant" and the staff are "absolutely wonderful", they were kept updated with care and treatment and they were involved in ward reviews. There were no barriers with visiting the ward. *(Meadowview Ward)*

A relative told us that she has spoken to the staff who were very helpful. She has felt supported. She was given a booklet and was asked to send photos for her mum's bedroom. Her daughter (grand-daughter) visited the ward and saw her Nan in the visiting room off the ward (after doing an LFT test). She stated the staff were lovely and her Nan stated everyone was very nice there. *(Tower Ward)*

One relative told us that although he has not been able to visit as he lives many miles away, he has been happy with the care for his sister based on his conversations with the staff. *(Tower Ward)*

The carer we spoke with said that her son was admitted in Dec 2019 and he has been in and out of acute hospital wards on and off over the last 10 years. She stated that the unit has been brilliant for him. He was not able to care for himself before coming to this unit but now has made progress and his self-care has improved enormously. *(Ipswich Road)*

Staff are very helpful and respectful. She stated she could not be more thankful to the team for everything that they do. She did highlight some concerns over Section 17 accompanied leave with family. She stated this is her only concern. But she wanted to re-emphasise that she is very pleased with his care. *(Ipswich Road)*

Carers did not receive information packs with important information *about the ward. (*Meadowview Ward)

EPUT GOVERNANCE

Mental Health Act Training in EPUT

Mental Health Act Training is an online training module and is mandatory to both registered and un-registered staff. Compliance with training requirements is monitored monthly and where compliance falls below the target, this is escalated to the Mental Health Act Business Meeting and Mental Health Act & Safeguarding Sub Committee. The Trust compliance figure is 85%.

Training needs are highlighted through results from ongoing Mental Health Act Audits, Mental Health Act Care Quality Commission visits and requests from ward managers to address team or individual needs. Where training needs are identified the Mental Health Act Office provided bespoke training either via Microsoft Teams, or supported one to one telephone discussions.

Overall competence		
Total target	Trained	
	No	%
MHA Registered Staff - 1632	1474	90%
MHA Non Registered Staff - 1364	1246	91%

Mental Health Act team development

As an organisation, EPUT supports development of its workforce and supports staff to offer the best possible care to our patients and service users.

Members of the Mental Health Act team have continued to enhance their knowledge of the Mental Health Act by receiving regular distributions regarding changes to the Mental Health Act through Mental Health Law Online, the Care Quality Commission and The London Mental Health Network and the Law Society. This knowledge enhances the skills within the team and helps to ensure the team can support clinicians to continue to provide high quality care within the legal framework of the Act.

Mental Health Act team – staffing

Senior managers in the Mental Health Act team regularly review the career pathways of the team during annual appraisals. Following the resignation of one of the Band 4 Mental Health Act administrators in June 2022, the team welcomed a new Band 4 Mental Health Act administrator in November 2022. This member of staff is currently being supported through a detailed induction plan and robust training around Mental Health Act Administration.

ASSOCIATE HOSPITAL MANAGERS

Section 145 of the Mental Health Act gives the designated hospital managers various powers and duties. In an NHS Trust or NHS Foundation Trust, the hospital managers will be the Trust or Foundation Trust as a body. In practice many duties within the Act for which Hospital Managers are responsible will be delegated.

Delegation is authorised within the Mental Health Act Regulations and in the case of discharge powers, under Section 23 of the Act. Many of the functions will usually be delegated to Mental Health Act Administration. Organisations may delegate the Section 23 role to a group of people referred to as associate hospital managers. Hospital managers retain overall responsibility for any delegated duties. Associate hospital managers are lay individuals who work on a voluntary basis and they receive a small remuneration for their time.

The key function of the associate hospital manager is to consider patients' requests for discharge from detention under certain Sections of the Mental Health Act in accordance with Section 23 of that Act, (including from Community Treatment Orders) and reviewing detention following renewal of such Sections or following the barring by the Responsible Clinician of an application for discharge by the patient's nearest relative.

The Trust currently has twenty two associate hospital managers who undertake hospital manager hearings and to ensure that their Mental Health Act knowledge remains current, they participate in regular relevant training and professional development is made available.

The associate hospital managers meet three times per year. Because of COVID-19, these meetings were held virtually and continue to do so. It is fair to say that having the meeting virtually continues to be successful and increased attendance at the meetings remains visible. Whilst the plan is to continue with virtual meetings, there are some plans going forward for associate hospital managers to meet face to face over the coming year.

Nine associate hospital managers resigned during 2022/2023. Reasons for resignations include work/ life balance and other commitments. The Mental Health Act Office, in conjunction with the Independent Chair and Vice Chair, regularly review the number of associate hospital managers to ensure there is sufficient capacity to facilitate hearings in a timely manner.

AUDITS 2022-2023

Audits are undertaken either annually or monthly to ensure and monitor EPUT's compliance with the Mental Health Act and to ensure that patients are legally detained and their rights protected

Associate hospital manager audit

The Independent Chair of the Associate Hospital Mangers, in conjunction with the Mental Health Act Office, undertake two audits a year; a decision form audit and a full panel audit.

Decision Form Audit

This audit involved scrutinising a number of decision forms (12 in total) to ensure that the forms give sufficient evidence to justify the decision to discharge or not, the patients' detention under the Mental Health Act. The decision form audit took place during December 2022. The 12 decision forms audited were dated between the period; March 2022 to November 2022. In the vast majority of cases, forms were completed in line with expectations. The following observation was made at the conclusion of the Decision Form Audit:

As identified at the audit that took place December 2021, the attendance boxes for 'nearest relative and others' are rarely completed if no one is present, and the 'decision communicated by' box is again not always completed, this will form part of the recommendations in the Audit Report.

Full Panel Audit

The purpose of the Full Panel Audit is to reflect on what has occurred within hearings in order to learn lessons and improve practice and procedures within EPUT. The Audit team will seek to ensure that the process of the hearing complied with the principles of clinical governance and that the rights of the patient were considered and, where appropriate, protected.

This includes ensuring that reports were received in a timely fashion and were of an appropriate standard, that the notes and Associate Hospital Manager Decision Form of the hearing are clear and comprehensive and also to discuss and identify any best practice points for clinicians, administrators and associate hospital managers.

The full panel audit took place on 6 January 2023. The Audit team looked at the case of a patient who was detained on a Community Treatment Order. The Psychiatric Report, Social Circumstances Report and the Nursing Report were reviewed as part of the audit process.

It was evident that during this audit there were elements of the reports that did not provide some detail for the associate hospital managers to provide robust detail in their responses to the questions raised within the reports. It was felt that the decision form was satisfactory, with clear sufficient evidence; the language was appropriate with no jargon and was respectful when referring to the patient. A small number of other themes were

identified which formed part of the main report. With this in mind the guidance notes and revised report formats that are due to be piloted will include the necessary guidance to report authors to enable them to provide the relevant evidence.

A report identifying the themes and recommendations was presented to the Mental Health Act & Safeguarding Sub- Committee in January, 2023. An action plan has been devised to address the themes identified by the audit and developed in conjunction with the Associate Hospital Manager Chair and Vice Chair. The action plan was shared at a quarterly Associate Hospital Manager Meeting in March 2023 to ensure the dissemination of learning of all the points raised through the Associate Hospital Manager Audit to associate hospital manager colleagues as well as Responsible Clinicians and their colleagues.

Tendable Report

A monthly audit is undertaken at ward level by ward managers or nominated person, to ensure the ward's individual compliance with the Mental Health Act. Tendable, the audit tool designed to assist health and care professionals to own patient safety and conduct quicker and more efficient quality audits, is used to facilitate this audit and has proved effective in helping monitor compliance.

Audits are undertaken on a monthly basis, the results of which are produced and viewed through an Inspection Summary. The Inspection Summary is made up of various components containing previously agreed questions that are required to

be asked of individual wards regarding compliance.

The Mental Health Act Office review the Inspection Summary each month. The five wards with the lowest compliance scores are re-audited by the Mental Health Act senior manager. Based on the findings of these audits, specific support training is offered to the ward and, where applicable, individual clinicians.

The results of the Mental Health Act Tendable audits are a standing agenda item at the Mental Health Act Bi-Monthly Business Meeting as well as the Mental Health Act & Safeguarding Sub Committee. Any emerging themes and points of learning are discussed, escalated if necessary and any remedial action taken, for example, bespoke training, review of online training and review of policies and procedures.

Associate hospital manager appraisals

The Mental Health Act Code of Practice requires trusts to complete an evaluation of satisfactory performance for each associate hospital manager prior to the renewal of their agreement. Each associate hospital manager's two-year agreement includes a number of elements that they must fulfil to ensure renewal, of which the performance appraisal is a primary element. These appraisals are used to determine training, both specific to the individual as well as general training.

Appraisals for all current associate hospital managers were concluded prior to the Associate Hospital

Manager Agreement renewal date of 1 November 2022.

Responsibilities as part of the appraisal process for the Associate Hospital Manager Independent Chair and Vice Chair relevant to their job role were agreed mutually and set for ensuing two years.

The Trust would like to acknowledge the hard work and commitment of all the past and current associate hospital managers during 2022/2023.

REPORT WRITING GROUP

Concerns were raised by a number of associate hospital managers regarding the quality of some of the reports which were being submitted to Hospital Manager Review Hearings in regards to appeals by patients detained under the Mental Health Act. Following these concerns a small working party of professionals and experts in the field of report writing was formed. A number of professionals joined the group which consisted of a consultant psychiatrist, consultant social worker/ approved mental health professional, a nurse and two associate hospital managers, along with members of the Mental Health Act Administration team.

Terms of Reference for the group were agreed with the key aim of the group to produce robust guidance to professionals who are required to write reports for submission to

Hospital Manager Review Hearings. It was agreed from the outset that each discipline from the group shared with a number of their colleagues the report forms and the clinical report format feedback form for overview and comments.

Final drafts of the agreed report templates, together with guidance notes for each discipline i.e. Responsible Clinician Report, Social Circumstances Report and Nursing Report were agreed through consultation with clinical colleagues and are currently subject of a six-month pilot. During the time of the pilot, feedback on the contents of the drafts will be collated by the Mental Health Act senior manager and reported through to the Mental Health Act Business Meeting and Mental Health & Safeguarding Sub-Committee.

INDEPENDENT MENTAL HEALTH ACT ADVOCATES (IMHA)

IMHA services provide an additional safeguard for patients who are subject to the Act. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act and enable patients to participate in decision-making for example by encouraging patients to express their views and supporting them to communicate their views. They are commissioned by the relevant local authority as identified under the Act. IMHAs should be independent of any person who has been professionally involved in the patient's medical treatment (Code of Practice, chapter 6).

The Trust are currently working closely with Essex County Council and Rethink Advocacy Service regarding the provision of advocacy services across the Trust. Currently referrals are made at a detained patients' request or where a detained patient lacks capacity. Discussions are taking place to provide a more enhanced service to detained patients with a possibility of the introduction of an "opt out" option for detained patients. An "opt out" option will be that all detained patients will be referred to the IMHA service unless they had indicated that they did not wish to seek the support that the IMHA service is able to provide.

DRAFT MENTAL HEALTH BILL

The Joint Committee which was established in July 2022 published a report on the 19 January 2023 detailing its examination into the extent to which the daft Mental Health Bill would ensure fewer people are detained against their wishes, promote patient choice, address racial inequalities and end the inappropriate long-term detention of people with learning disabilities and autistic people under the Act.

It has been widely reported by MPs and Peers that the Government's draft Mental Health Bill must be strengthened to address rising numbers detained under current legislation and tackle unacceptable and inexcusable failures on racial inequalities.

It is reported that Chair of the Joint Committee Baroness Buscombe said 'We welcome the intention of the Government's draft Bill to bring about long overdue mental health reform. We hope Ministers will accept our amendments, which strengthen the Bill and deliver workable legislation. Ministers must now act swiftly to bring it before Parliament'.

PREVIOUS HOTSPOTS

Associate hospital manager appraisals

The associate hospital manager appraisals were concluded in October 2022.

Mental Health Act team Pressures

The Mental Health Act team continue to manage on a daily basis the fluctuating pressures of Mental Health Act administration in regards

to compliance that is required of the Mental Health Act. The team continue to receive robust support through one to one meetings and twice daily situation report meetings via Microsoft Teams to enable them to manage and meet the compliance required. A date for the review of the staffing requirements for the Mental Health Act team will be agreed during this next year with the aim being to further enhance the service.

FORWARD PLAN

As in previous years, work will continue to address and streamline the functions of the Mental Health Act Administration, ensuring compliance under the Mental Health Act for all patients detained within EPUT.

The Mental Health Act Team Core Competencies Booklet for Mental Health Act team staff and nursing staff has been delayed in light of the White Paper consultations and the Government's proposed reforms to the Mental Health Act. It is expected that the development of the booklet will take place following any changes to the Mental Health Act.

The Mental Health Act senior team members and the Mental Health Act team meet at regular intervals to review each respective area of practice. This provides an opportunity to discuss any changes to the Mental Health Act Code of Practice and case law as well as devising and developing monitoring tools/training packages to redress themes identified from visits carried out by the Care Quality Commission during 2022/2023.

It is acknowledged that the Trust has in place a robust 'e' learning module that provides training to all staff in

regards to the Mental Health Act. Mental Health Act managers to support individual staff and teams, provide additional bespoke Mental Health Act training regarding the required compliance of the Mental Health Act via Microsoft Teams.

The Mental Health Act team have a fully functioning Trust Intranet page which provides support to all staff in regards to the complexities of the Mental Health Act. The Mental Health Act managers and their team continue to promote lawful practice, compliant with the Mental Health Act Code of Practice 2015.

The Mental Health Act team remains committed to meeting deadlines from actions plans set following visits from the Care Quality Commission. In addition the Mental Health Act Business Meeting which is attended by senior members of the Mental Health Act Administration team along with senior operational managers will continue to adopt a comprehensive approach to identifying operational needs in regards to Mental Health Act Compliance.

CONCLUSION

The Mental Health Act Administration team will continue to support the associate hospital managers to perform their role/duties by providing robust training in relation to the Mental Health Act and Mental Health Act Code of Practice 2015.

As always, this report acknowledges the commitment of the Trust and in particular that of the Mental Health Act senior manager, Mental Health Act managers, Mental Health Act officers, Mental Health Act administrators and Mental Health Act assistant who work within the legal framework, which continues to continually improve the way, that mental health services are delivered.

ASSURANCE STATEMENT

This report provides assurance that the Trust has robust systems, comprehensive policies and robust training in place to work within the parameters of the Mental Health Act 1983 as amended by the Mental Health Act 2007. The Mental Health Act team continues to experience difficulties and duplication in relation to the current usage of the two clinical information systems Mobius and Paris to aid Mental Health Act Administration compliance.

The Information Technology department will continue to explore the introduction of a single patient clinical information system. Going forward, the Mental Health Act team will be charged to continue to embrace changes in the way they work, promotion of equal workload, a standardised way of practice and enhancement of knowledge.

Essex Partnership University NHS Foundation Trust

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LIGATURE RISK MANAGEMENT ANNUAL REPORT

● Information Item   ▲ AG   🕐 5 minutes

REFERENCES

Only PDFs are attached

📄 LRRG Annual Report 2022-23 26.07.2023.pdf

Report Title:	**Ligature Risk Management Annual Report 2022-2023**	
Executive/Non-Executive Lead:	Alex Green, Chief Operating Officer	
Report Author(s):	Gill Noble, Clinical Lead for Compliance and Ligature Coordinator Comfort Sithole, Head of Compliance & Emergency Planning Nicola Jones, Director of Risk and Compliance	
Report discussed previously at:	Ligature Risk Reduction Group Health, Safety & Security Committee Quality Committee	
Level of Assurance:	Level 1 ✓ Level 2 Level 3	

Risk Assessment of Report

Summary of Risks highlighted in this report	CRR81 - If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions

Which of the Strategic risk(s) does this report relates to:		
	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	

Does this report mitigate the Strategic risk(s)?	No
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report

This report provides the Board of Directors with the Ligature Risk Management Annual Report.	**Approval**	
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:
1. Discuss and consider the contents of this report.
2. Identify any further actions required

Summary of Key Issues

Introduction

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management. The Board of Directors has identified the potential risk associated with this agenda is recorded on the Corporate Risk Register with a robust action plan to mitigate the risk.

Independent Assurance

A patient safety audit was commissioned from BDO on patient safety. The draft report highlighted good practice areas of improvement. The Trust took forward the recommendations put forward by BDO and corrective action has been undertaken.

An action plan developed to test EPUTs processes following the publication of the Care Quality Commission (CQC) briefing guide on ligature anchor points, ligatures and other means of self-harm using fixtures and furniture for their inspection teams has now been completed.

As previously reported, EPUT undertook peer reviews with East London Foundation Trust (ELFT). An action plan was developed to address the findings/recommendations highlighted in the resultant draft report. The action plan has now been completed.

Governance
The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Executive Chief Operating Officer.

The Ligature Policy and Procedure underwent its annual review and ratification.

Ligature Environmental Risk Assessments of all MH and LD wards continued in 2022/23, facilitated by a team of professionals from H&S, Estates and the Ward. Regular review of the Ligature Risk Assessment tool continued to ensure learning from safety alerts and incidents was considered.

Continuous Learning – Ligature Safety Alerts
During 2022/23, there were 3 Safety Alerts relating to identified ligature risks that were issued to inpatient areas across the Trust.

Continuous Learning - Ligature Incident Data
Throughout 2022/23 a quarterly incident report was presented to LRRG providing an overview of ligature incidents in services across the Trust. This provides an understanding of incidents and any emerging trends in order to increase learning and adopt safer practices. There were 28 reported secured ligature incidents and 1458 reported unsecured ligature incidents in 2022/23. There has been an increase in unsecured ligatures, with CAMHS being the highest reporting teams.

Enhancing Environments
The LRRG has, and continues to, develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme.

The EPUT risk stratification programme aims to identify all environmental standards set and assess each ward against the requirement. Where gaps are found, a programme of works is agreed. In 2022/23, EPUT completed improvement works including accommodation upgrades, garden works.

Learning Culture
EPUT aims to develop a culture of risk awareness and continuous learning when an incident happens. An essential part of developing this culture is having robust training programmes for staff. Ligature training is delivered via a range of courses including Prevention Suicide by Ligature OLM training. Overall Trust compliance with this training as of yearend 022/23 was 89%. Compliance is monitored via LRRG and any potential risk is escalated should the figures be below the Trust's target.

The Trust continued to provide the bespoke ligature risk assessment training facilitated by Tidal Training in 2022/23 (TIDAL). The training will continue to be offered in 2023/2024. To date, 138 staff have been trained, 107 of which are clinical staff. The proposal to bring the training in-house continues to be taken forward.

Innovation
The Trust has continued to work in partnership with technology providers.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: Capital £ Revenue £ Non Recurrent £			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	LRRG	Ligature Risk Reduction Group
CQC	Care Quality Commission	ELFT	East London Foundation Trust
MH	Mental Health	LD	Learning Disabilities

Supporting Documents and/or Further Reading
Ligature Risk Management Annual Report 2022-23

Lead
Alex Green **Executive Chief Operating Officer**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

LIGATURE RISK MANAGEMENT ANNUAL REPORT 2022-23

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

LIGATURE RISK MANAGEMENT ANNUAL REPORT

2022-23

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1. INTRODUCTION

This year-end report provides an update of the work that has been undertaken and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

Essex Partnership University NHS Foundation Trust (EPUT) is committed to continuously improving systems and processes that facilitate robust risk identification and management; carrying out patient safety improvement works to create safer physical environments; and to creating a risk aware learning culture. The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust's strategic objectives and this potential risk is therefore recorded in the Corporate Risk Register, CRR81 Appendix 1. A robust action plan is in place to mitigate this potential risk. Reports on the action that has been taken are provided regularly to the Board of Directors. This report aims to assure members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that there continues to be a strong focus on mitigating risk and that progress continues to be made, members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning.

It also has to be recognised that the Trust's inpatient environments, consistent with many providers of mental health services, will rarely be entirely free of fixed ligature points. This is because most physical environments were not designed to mitigate the potential risks being identified currently and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2. INDEPENDENT ASSURANCE

2.1 Internal audit

In 2022 EPUT commissioned an audit from BDO on patient safety. The draft report highlighted that good practice was observed including:

- All ward managers interviewed at the 13 wards were aware of the requirements of the Ligature Assessment and Management Policy
- All wards had ligature cutters as per policy
- All wards also had ligature heat maps in all their wallets
- On each ward, staff were able to confirm that the sample of actions from ligature inspection reports were either implemented or actioned on Datix for Estates to carry out the necessary work.

However, the following was also identified:

- The ligature red tab wallets did not contain all necessary items. One ward did not have

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ligature signage sheets in their wallet.

In the draft report, the audit concluded that;

"Policies and procedures have been reviewed in a timely manner, cover all necessary information and staff have an appropriate understanding of the requirements of the policies, therefore we have provided a substantial opinion on control design. However, as not all wards have appropriately implemented all aspects of the policies such as missing items from ligature red tab wallets we have concluded a moderate opinion on contract effectiveness."

The Trust took forward BDO's recommendations and corrective action has been undertaken.

2.2   Care Quality Commission

In January 2022, the Care Quality Commission (CQC) produced an updated briefing guide on ligature anchor points, ligatures and other means of self-harm using fixtures and furniture for their inspection teams. The purpose of this publication is to support inspectors to identify the evidence required for inspections, the reporting and the policy position. The update highlights that ligature points, regardless of height, should be considered high risk and mitigated or eliminated wherever possible, especially in any room in which patients spend time in private without direct supervision by staff.

As previously reported, with the publication of the guide, an action plan was developed and an internal review of processes and procedures

tested EPUT's position against the CQC criteria within the briefing. This action plan was presented and approved by the Ligature Risk Reduction Group (LRRG) and regularly monitored. This action plan is now complete and closed.

EPUT continued to test embedding of actions and learning identified at previous internal and external inspections.

2.3   Peer Review

The approved action plan to address the findings/recommendations highlighted in the report following the peer review with East London NHS Foundation Trust (ELFT), was monitored to completion by the LRRG in 2022-23. Areas covered included:
1. Governance and working practice
2. Environment
3. Workforce
4. Training and learning.

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3. GOVERNANCE

3.1 Ligature monitoring and reporting

The Trust continues to hold a monthly Ligature Risk Reduction Group (LRRG) chaired by the Executive Chief Operating Officer (deputy chair – director of mental health urgent and inpatient services). The group reports to the Health Safety and Security Committee (HSSC) and provides a monthly assurance report to the Executive Safety Oversight Group (ESOG).

The group continues to have the delegated responsibility for developing and monitoring effective systems and processes that:

- Ensure ligature risk assessment inspections are robust and appropriate control measures implemented within mental health and learning disability inpatient wards
- Ensure the Trust remains compliant with all regulatory or legislative requirements and Safety Alerts via the NHS's Central Alerting System
- Identify, escalate risks and issues and support teams with the management of ligature risks
- Provide assurance that systems are in place internally and externally
- Ensure the Trust's governance structures are appropriate and effective.

A review of the LRRG terms of reference has been undertaken to ensure the group remains effective with the correct membership and reporting structures. A governance review is also being undertaken to

ensure that all learning, discussions and decision are considered effectively and escalated and cascaded Trust-wide as appropriate.

Quarterly ligature reports are shared with the Trust Quality Committee as a standing committee of the Trust Board of Directors to provide assurance reporting and risk escalation.

3.2 Policy and procedure changes

The Ligature Risk Assessment and Management Policy and Procedure (CP75) was launched in April 2019 and undergoes annual reviews. The policy and procedure aim to ensure there are robust ligature risk management processes across EPUT.

A summary of review and amendments in the 2022/23 annual review include:

- Updates to statement and introductory sections
- Updated definitions
- Updated guidance on ligature cutters required per ward
- Greater inclusion of community mental health service in the management of ligature risks,
- Responsibility of the Learning Oversight Sub-Committee updated
- Names of associated policies, committees and roles updated.

3.3 Ligature Risk Reduction Project

Following analysis of ligature incidents from April 2017 to December 2021, the Ligature Risk Reduction Project's primary focus was to address environmental concerns and this saw significant progress. However, it was recognised

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that the environment alone was not a significant factor in the majority of incidents and thus in April 2022, the Transformation Project Management Office was given support by the Trust's Executive team to re-scope and expand the scope of the Ligature Risk Reduction Project. The scope of the project now includes looking at staff needs with regards to both training offered and the policies in place to support staff, in addition to the environmental work. To drive this new work forward, leads were identified for each area and short life working groups established.

3.3.1 Ligature Training Short Life Working Group

- The Group reflected on the current ligature risk management training package available to staff. It was agreed that more robust, face to face and practical training was required to deliver improved ligature risk training to staff.
- An in-house training package was developed in consultation with clinical operational staff, supporting services and key experts in the Trust. A proposal was drafted.
- The proposal was presented to and approved by LRRG and HSSC.
- The group has been asked to pilot the proposed training and this will commence in Q1 of 23/24 on Topaz ward.

3.3.2 Ligature Policy and Procedure Short Life Working Group

- The Group agreed to design and pilot a brief guide to the ligature policy which highlights the key aspects of the policy and directs staff where to find further information. Thus a

'Policy at a Glance' was developed and approved by LRRG.
- The pilot of the Policy at a Glance went live across three Child and Adult Mental Health service (CAMHS) wards in March 2023.
- Feedback sessions are to be held in Q1 of 23/24 and recommendations made to the Policy Group based on information and learning from the pilot.

3.3.3 Environmental Risk Mitigation Short Life Working Group

- Work to mitigate environmental risks has continued.
- The Estates team continue with work to mitigate environmental risks.

3.4 Ligature Environmental Risk Assessment

Regular review of the Ligature Risk Assessment tool is undertaken to ensure learning from safety alerts and incidents is considered. The designed in-house tool remains effectively in use across the Trust.

A team of professionals, made up of a member of the Health and Safety team, member of the Estates team and the ward manager undertake each Ligature Risk Assessment. Each assessment is undertaken on the ward over a half day period, inspecting all un-supervised areas and supervised areas of the ward, where patients have access. Areas on the wards that patients, under normal circumstances, do not have access to, are not included in the inspection. This multifaceted approach ensures robust inspection of the environment from both a

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clinical and environmental viewpoint and any actions identified that require Estates intervention can be taken forward immediately.

A draft inspection outcome report is shared with all parties for agreement. This includes any identified actions to be taken forward and mitigations for any risks identified. Once all parties agree, a final report is issued and actions monitored until completion. Any concerns, including overdue actions, are escalated to the LRRG. Closing of actions within set timescales continued to be a challenge in 2022/23 and work continues between the Risk, Estates and Project Management teams to make processes more efficient and robust.

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4. LEARNING CULTURE

4.1 Staff training

EPUT aims to develop a culture of risk awareness and continuous learning. An essential part of developing this culture is having robust training programmes for staff.

Ligature awareness training is delivered via the following EPUT courses:
- Preventing Suicide by Ligature online training
- Clinical Risk
- Ligature cutter training included in Grab Bag training
- Ligature Risk Assessment bespoke training (external provider, Tidal Training)

All staff are required to complete the ligature awareness on-line training Preventing Suicide by Ligature which is reviewed on an annual basis and in response to national and local learning.

The training package details:
- Definitions relating to the management of ligature
- Background and trends in suicide and self-harm
- Ligature hazards and risks and their management
- Principles of good practice in the prevention of suicide
- Emergency procedures and equipment
- Policy and procedures, related training and links.

Overall Trust compliance with the eLearning training on ligature risk awareness at the end of 2022/23 was 89%. Compliance is monitored monthly via LRRG and any potential risk is escalated should the figures be below the Trust's target.

The Trust continues to offer staff the bespoke ligature risk assessment training and this is available to all EPUT staff who are Band 4 and above. The training is delivered over two days by Tidal Training. Attendees include clinical, estates and corporate staff as well as members of the Risk team, to increase ligature risk management awareness across all levels of the Trust.

This training is specifically designed for multi-disciplinary staff groups to understand the context of people using a ligature, both for self-harm or suicidal purposes; and to risk assess their own environment to establish potential fixed points that pose a ligature risk.

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

To date, 138 staff have been trained, 107 of whom are clinical. This training will continue to be offered, ensuring ongoing training support for staff while the Ligature Risk Reduction Project's proposal to bring the training in-house is taken forward. At the end of 2022/23, a pilot of the proposed training was scheduled for June 2023 on Topaz ward. Feedback from this pilot will inform the next phase of the project.

4.2 Local Learning

To facilitate shared learning, the ligature coordinator worked at instituting a regional Ligature Forum. This has continued through 2022/2023.

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5. CONTINUOUS LEARNING

5.1 Ligature safety alerts

During 2022/23, there were three safety alerts relating to identified ligature risks that were issued across the Trust. Safety alerts are issued within EPUT following either a national safety alert via the CAS system or to share learning from other organisations, internal incidents and inspections.

Once an alert has been issued, this is received by key staff, including matrons/clinical leads, who are responsible for reviewing the alert, taking the appropriate action as indicated in the alert and ensuring that learning is disseminated within teams. Matrons/clinical leads then provide assurance that the alert has been received and actioned via the Trust reporting system Datix. All ligature related safety alerts are discussed at LRRG and where estates assistance is required, referred to the Estates Expert Reference Group, EERG.

The Risk Management team continue to distribute and monitor safety alert information for the Trust through the Datix system. Additionally, ward/team managers have been requested to include safety alerts as a standing item agenda in team meetings, for discussion.

5.2 Ligature incidents

Throughout 2022/23, a quarterly incident report was presented to LRRG providing an overview of ligature incidents in services across the Trust. The report details incidents using both a secured point to fix a ligature and an unsecured ligature. This provides an understanding of incidents and any emerging trends, in order to increase learning and adopt safer practices. Comparison of figures of secure and unsecured incidents continues to indicate that there are significantly more reported ligature related incidents that do not make use of a fixed anchor point, with unsecured incidents accounting for over 97% of reported incidents from 2020/21 to date. It remains vital to consider and manage ligature risks in the wider context, taking into account patient risk assessment and care planning processes, patient observation and engagement procedures and staff skill and competency mix, as well as environmental assessments.

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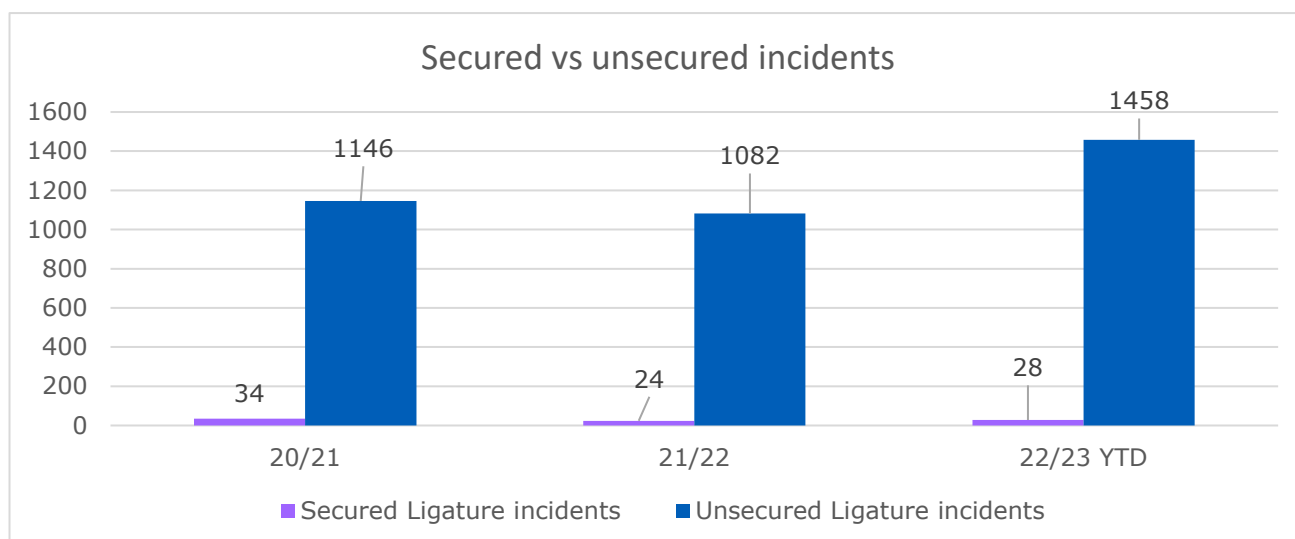
Graph 1: Comparison of reported incidents. Secured incidents account for less than 3% of reported ligature related incidents

5.2.2 Secured ligature incidents

Graph 2 below highlights the highest reporting wards over a 5 year period for secured incidents. The Trust has analysed data to identify the most commonly used anchor points and installed assistive technology to help mitigate the risks.
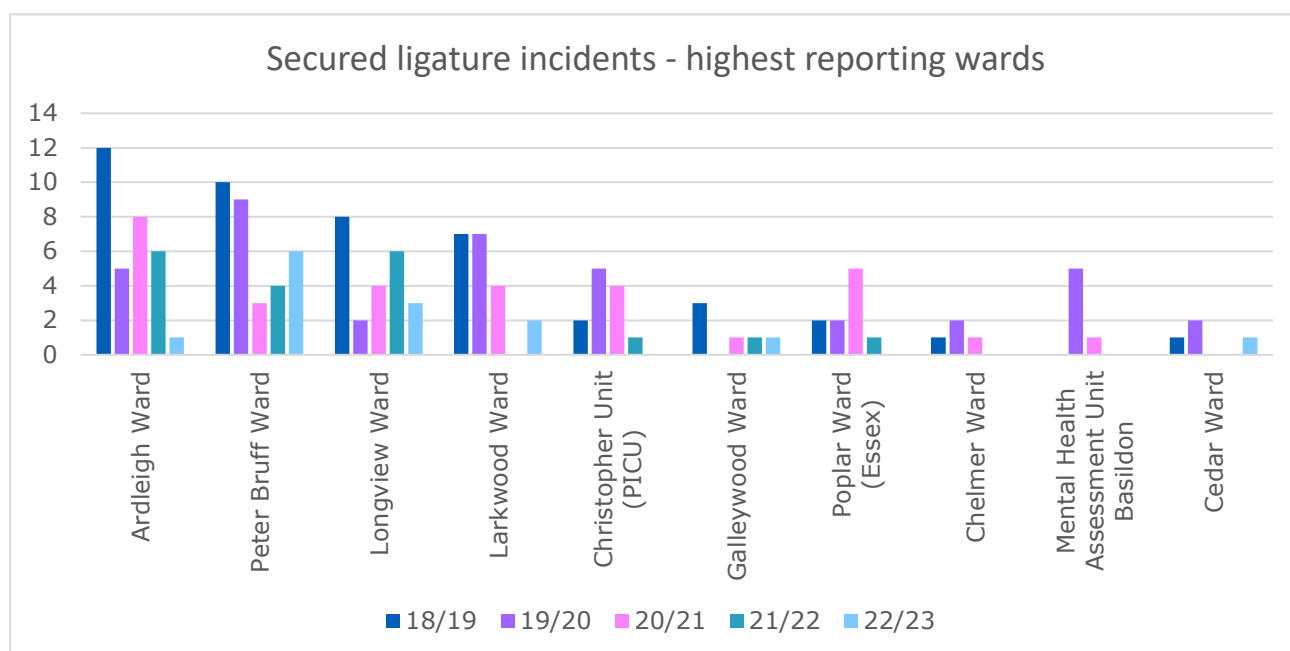
Graph 2: The 10 highest reporting wards from 2018/19 to date.

Table 2 and Graph 3 below detail the reported outcome/degree of harm to the patient as a result of the incidents as recorded on Datix. As Graph 2 highlights, an average of 87% of incidents reported over the past three years have had a reported outcome of *No Harm*.

Immediate learning has prompted changes in practice, particularly the way observations are carried out and documented. All incidents have been

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investigated by the patient safety incident team and learning identified for embedding across the Trust.

Secured Ligature (all incidents)	20/21 OT	21/22 OT	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	22/23 YTD
No Harm	29	21	6	8	6	5	25
Low Harm	4	2	-	-	-	-	-
Moderate Harm	-	-	1	-	-	1	2
Death / Catastrophic	1	1	-	-	-	1	1

Table 2: Recorded outcome/degree of harm to the patient as a result of secured ligature incidents.
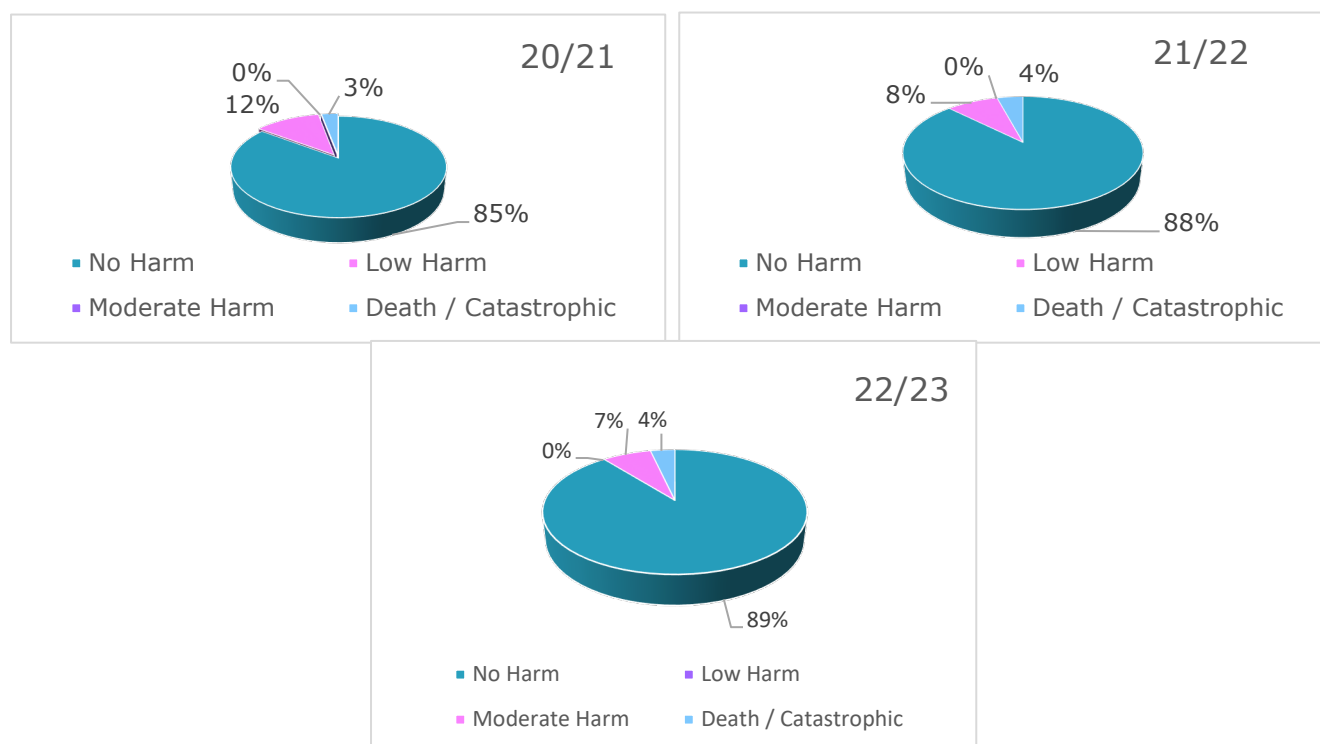
Graph 3: Percentage of outcomes reported for incidents for 20/21, 21/22 and 22/23.

5.2.3 Unsecured ligature incidents

There were 1,458 reported unsecured ligature incidents during 2022/23. Larkwood ward was the highest reporting unit, accounting for 20% of the incidents during 2022/23.

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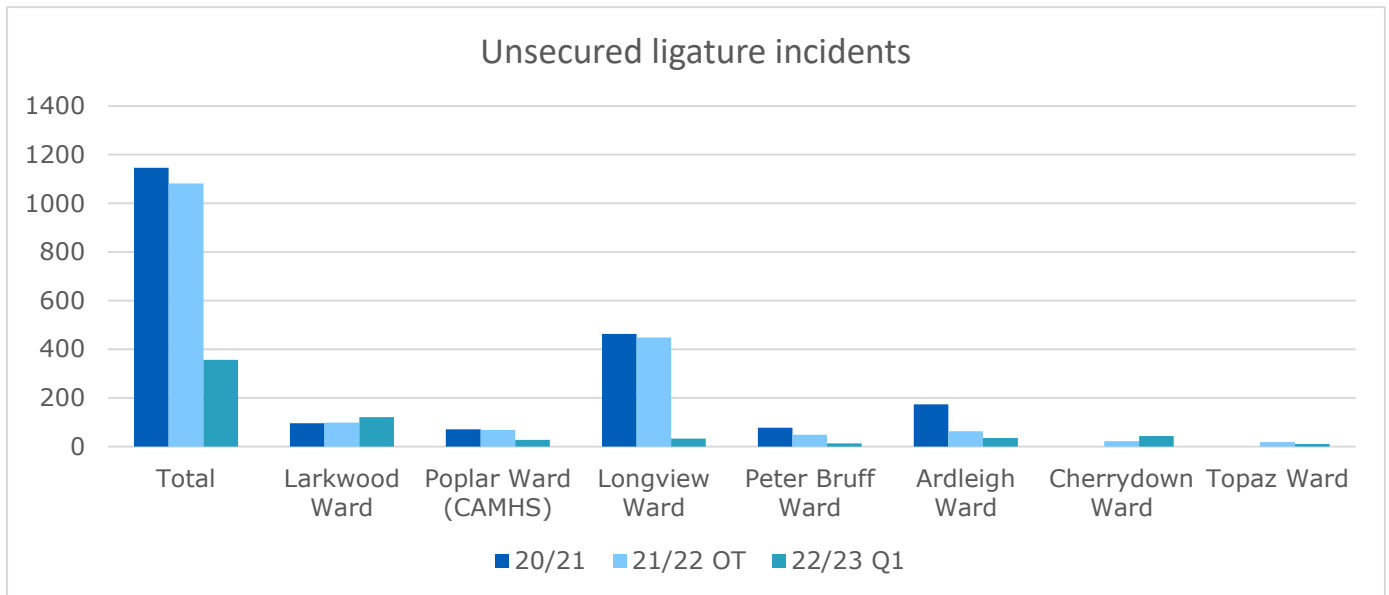
Graph 4: Breakdown of unsecured ligature incidents across the Trust over the past three years. Larkwood ward was the highest reporter, overtaking Longview.

Graph 5 below details the reported outcome/degree of harm to the patient as a result of the incidents as recorded on Datix.
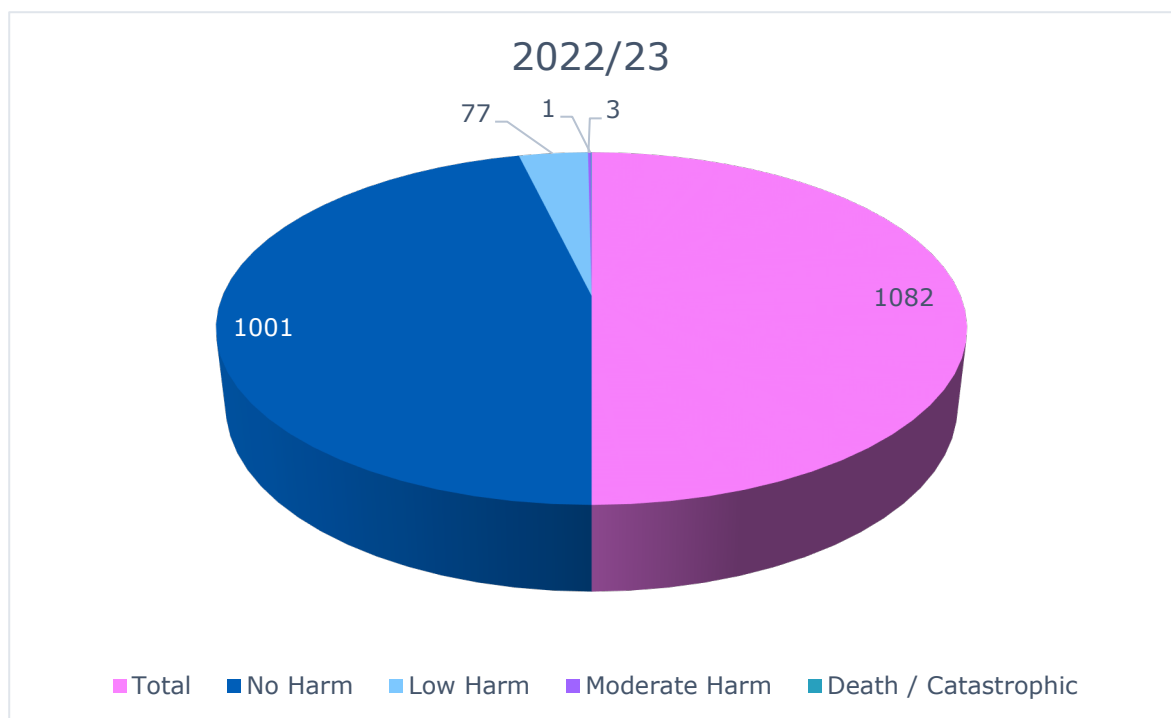
Graph 5: Recorded outcome/degree of harm to the patient as a result of an unsecured ligature incidents

The Trust has analysed data to identify the most commonly used items and ensure robust risk assessment of items available to patients is undertaken aiming for least restriction.

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6. ENHANCING ENVIRONMENTS

6.1   Setting environmental standards

The LRRG and EERG have, and continue to, develop agreed environmental risk reduced standards that inform the Trust's investment and patient safety improvement works programme.

Work has been undertaken with a number of different companies to review reduced ligature fixtures and fittings and consider new innovations.

6.2   Risk stratification programme

As per policy, the EPUT risk stratification programme continues to be owned by the director of estates and presented to the LRRG on a monthly basis. The risk stratification programme aims to assess each ward against the environmental standards, identify where gaps are found and agree a programme of works.

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6.3 Patient safety spend

The tables below outline the patient safety spend within EPUT for 2022/23 and since the Trust was established for information. Ligature risk reduction work is included within the patient safety spend:

2022/23

Capital PS Works & Other	NR Revenue General & BM	General maintenance
£0	£0	£0
£0	£0	£0
£0	£0	£0
£0	£0	£0
£0	£0	£0
£0	£0	£0
£58,032	£187,543	£0
£0	£0	£0
£0	£247,616	£0
£0	£0	£0
£0	£30,360	£0
£2,875	£0	£0
£83,223	£0	£0
£0	£0	£0
£0	£0	£0
£90,887	£0	£0
£1,236,164	£0	£0
£722,076	£0	£0
£0	£0	£0
£0	£0	£0
£331,441	£12,860	£57,609
£2,524,699	**£478,378**	**£57,609**

22/23 Total Spend		£3,060,687

Table 3: Patient safety spend for the 2022/23 financial year. Ligature risk reduction work is included within the outlined spend.

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LIGATURE RISK MANAGEMENT ANNUAL REPORT 2022-23

2017/18	2018/19		2019/20		2020/21			2021/22 - to Month 11		
Capital, CQC, BM & 3i Tasks	Capital, CQC, BM & 3i Tasks	Backlog Maintenance	Capital PS Works & Other	Capital BM	Capital PS Works & Other	NR Revenue General & BM	Capital BM	Capital PS Works & Other	NR Revenue General & BM	Capital BM
£0	£0		£81,754	£0	£15,061	£0	£0	£0	£0	£0
£0	£102,656		£0	£0	£0	£0	£0	£0	£0	£0
£0	£0		£208,403	£0	£0	£0	£0	£0	£0	£0
£3,471	£10,674		£0	£0	£0	£0	£0	£0	£0	£0
£0	£0		£189,109	£11,526	£0	£42,801	£0	£0	£0	£0
£2,157	£146,682		£59,339	£0	£0	£39,992	£0	£0	£16,901	£0
£227,227	£237,120		£10,835	£0	£0	£123,210	£0	£1,404	£234,067	£0
£144	£7,167		£0	£0	£0	£0	£0	£0	£0	£0
£0	£0		£0	£0	£35,758	£12,795	£0	£247,000	£0	£0
£123,393	£377,245		£11,862	£57,913	£46,503	£0	£11,739	£268,019	£4,799	£48,516
£20,154	£86,425		£1,252,525	£0	£643,310	£0	£7,120	£167,839	£0	£0
£0	£0		£0	£50,993	£0	£0	£0	£14,986	£0	£0
£0	£0		£37,482	£0	£0	£0	£0	£0	£0	£0
£12,925	£372,822		£464,927	£0	£422,637	£0	£0	£785,512	£0	£0
£0	£0		£93,537	£24,388	£95,911	£92,685	£0	£173,073	£0	£0
£0	£0		£144,925	£6,426	£0	£0	£0	£0	£0	£38,568
£0	£0		£29,444	£0	£0	£0	£0	£7,493	£0	£0
£0	£0		£0	£0	£0	£0	£0	£0	£0	£0
£748,686	£941,942		£0	£33,522	£70,587	£30,894	£3,231	£1,030,247	£121,232	£0
£1,138,157	**£2,282,733**		**£2,584,141**	**£184,767**	**£1,329,767**	**£342,377**	**£22,090**	**£2,695,572**	**£376,999**	**£87,084**
17/18 Total Spend £1,138,157	**18/19 Total Spend £2,282,733**		**19/20 Total Spend £2,768,908**		**20/21 Total Spend £1,694,233**			**21/22 Total Spend £3,159,654**		

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7. INNOVATION

OxeVision

The Trust has continued to work in partnership with technology provider Oxehealth to implement and utilise Oxevision. This digital tool allows for contactless monitoring of vital signs and movement to improve patient safety and quality and efficiency of care within inpatient wards. The table below details the implementation of the innovative technology at various Trust sites.

Ward	Date	Rooms
Ardleigh	03/04/2020	18
Ardleigh/Gosfield Seclusion Room	18/05/2021	1
Basildon MHU HBPoS / A&E Liaison Team	30/06/2021	2
Beech	12/07/2021	24
Cedar	18/05/2021	22
Cedar extra care room	18/05/2021	2
Chelmer	07/07/2020	21
Chelmer Swing Room	07/07/2020	2
Cherrydown	16/09/2021	16
Christopher unit	12/03/2021	10
Christopher Unit HDU	12/03/2021	1
Derwent HBPoS	10/06/2021	1
Derwent Centre Seclusion Room	10/06/2021	1
Finchingfield	08/02/2021	17
Galleywood	08/02/2021	18
Gloucester	13/09/2021	22
Grangewater		16
Gosfield	27/04/2022	17
Hadleigh Unit	13/07/2020	17
Henneage	30/06/2021	16
Kelvedon	08/08/2021	16
Larkwood	08/02/2021	15
Larkwood LTS 1 – Bedroom	08/02/2021	1
Larkwood LTS 2	15/03/2022	1
Larkwood LTS 1 - Seclusion		1
Linden HBPoS	30/06/2021	1
Longview	08/02/2021	15
Longview LTS Seclusion		2
Peter Bruff	13/07/2020	17
Peter Bruff Seclusion	13/07/2020	1
Poplar	12/03/2021	15
Poplar HDU	12/03/2021	1
Rochford HBPoS		1

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Ward	Date	Rooms
Roding	26/08/2021	14
Ruby	30/06/2021	17
Stort	27/04/2021	14
The Lakes HBPoS	18/05/2021	1
Topaz	30/06/2021	18
Willow	18/05/2021	24

Table 5: Sites and number of rooms that have OxeVision installed

8. CONCLUSION

Progress continues to be made to mitigate risks associated with ligature across the Trust. The Trust continues to appreciate that the management of any ligature risk associated with the physical environment must be considered in the wider context of care provision that includes training, staffing, security, patient risk assessment, patient engagement, observation and care planning. The ongoing review of the processes currently in place is imperative, including the annual full review of the CP75 Ligature Risk Assessment and Management Policy, to outline the process and include a clear standard operational procedure for the inspection process.

As the data included in this report has highlighted, there continues to be a significant increase in reported unsecured ligature incidents. This noted shift continues to be potentially attributed to the vital and substantial work that EPUT has undertaken to mitigate and remove environmental ligature risks. However, it also continues to highlight how vital it is to consider and effectively manage all aspects of self-harming, including ligature risks, in the wider context.

Where secured incidents and potential ligature fixed points are reported, these are investigated with support of the Health and Safety team and any recommendations taken forward. Ongoing coaching as part of six month ligature reviews in inpatient mental health and learning disability units ensures the embedding of a risk awareness culture of any Trust wide and locally identified risks. Each ward has its own developed detailed hotspot photo gallery in their ligature wallets, which depicts all identified environmental ligature risks on their unit. These can be referenced when planning individual patient care and risk management provision. Cultivating a culture of learning and continuing to foster collaborative working between teams across the Trust remains essential to patient safety. Therefore any and all identified ligature risks, as reported via the Datix system, are shared across the Learning, Patient Safety, Risk and Practice Development teams. The EPUT Culture of Learning (ECoL) will continue to be taken forward by ensuring that learning identified from reported ligature incidents is embedded and sustained at all levels within the organisation and that the Trust achieves its ambition of making learning as an 'Always Event.'

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APPENDIX 1: CRR81 LIGATURE RISK IDENTIFIED ON CORPORATE RISK REGISTER

Risk				
Cause	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions.		**Executive Committee:** LRRG ESOG **Board Committee: BSOG** Quality **Risk Register(s):** CRR	**Executive Responsible Officer:** Trevor Smith **/** Alex Green **Director Lead:** Nicola Jones / Linda Martin and Moriam Adekunle **Risk Lead:** Comfort Sithole
Effect				
Impact				
Initial risk score 4 x 3 = 12	**Current risk score 5 x 3 = 15**		**Target risk score 4 x 2 = 8 Timescale:** *Sep 23*	**Date Last Reviewed:** April 23

Context	Comments	Impact	Radar Tags
Patient safety incidents	Wording changed to encompass therapeutic aspect of ligature reduction rather than just environmental.	Safety Compliance Reputation	SO1 TS AG

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Current Status				
Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	**Gaps in controls**	**Controls Assurance**		
		Level 1 Function/ Department Management	**Level 2** Organisational Oversight	**Level 3** Independent Assurance / Internal Audit
Estates Ligature/ Patient Safety Co-ordinator H&S Team and Compliance Team LRRG / EERG Ligature Project Group		Teams established LRRG increased clinical focus Project group plan LRRG Terms of Reference – revitalised to improve clinical representation	Reporting to LRRG ESOG and BSOG dashboard of top four Trust priorities Accountability framework Annual ligature inspections Positive feedback from staff following refurbishment of MHU staff rest area 6 month reviews	Internal audit BDO 2021 ELFT Independent Review 2021 BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Policy and Procedure including environmental standards	SI on Forest Ward resulting in patient death via anchored ligature	Ligature wallet audits	Reporting to LRRS ESOG and BSOG dashboard of top four Trust priorities Accountability framework Annual ligature inspections Policy review and approval March 2023 6 month reviews	Internal audit BDO 2021 (all actions complete) ELFT Independent Review 2021 Awarded Best External Environment in Best Patient Safety initiative (for Basildon) BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Training and Tidal training	Review of tidal training to bring in house In-house training not approved in full, pilot recommended to commence in	138 staff trained (107 clinical) in TIDAL training with offer extended to all Band 4 staff and above to increase awareness March 2023 on target at 89% ligature training		

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Current Status				
Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	**Gaps in controls**	**Controls Assurance**		
		Level 1 Function/ Department Management	**Level 2** Organisational Oversight	**Level 3** Independent Assurance / Internal Audit
	June on one ward for evaluation purposes			
Trend Analysis			Ligature incident rate 45.5 Sep 22 (consistent trend in line with benchmark)	
Quality improvement project on self-strangulation	▉ not in place at Brockfield house, dependant on PFI provider	In place Heat maps with photos		Funding for North East
Review of all fixed point incidents since April 21	Ligature actions differences in Datix and 3i Overdue actions Q4 298 overdue actions from ligature inspections (Zero extreme as at March 2023)	Ligature wallet audits in place	Annual Ligature Inspection for all MH wards 6 month support visits	
Ligature incident rates will be in line with national benchmarking – adult inpatient 42 per 10,000 bed days		40.27 Jan 2023 43.98 Feb 2023 78.2 March 2023 Ligature rate adults (benchmark 42 per 10,000 beds) Ave. 52.28 for 22/23 increase from 21/22 (42.70) and above national benchmark.		

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Current Status				
Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	**Gaps in controls**	**Controls Assurance**		
		Level 1 Function/ Department Management	**Level 2** Organisational Oversight	**Level 3** Independent Assurance / Internal Audit
Learning from incidents and safety alerts via Lessons Team/ ECOL/ 5 key messages			Enhanced learning within annual reporting utilising deep dive data Governance work ensures learning identified and shared across relevant groups (LRRG/ Patient Incident Team/ Inquest Team/ Clinical Support Group)	Actions completed from BDO internal audit 2021 Actions completed from the CQC Brief Guide
ELFT Independent Review		Actions completed	Closure report approved at LRRG 11 Jan 23	
Cambridge University work on management of ligature risk		Trialled on two wards	Report presented to LRRG in March 23	
Local Area Ligature Network		Network established and first meeting held	Established and ongoing	
Mitigation Statements		Effective process in place	Mitigation statements signed off by Ward Managers on acceptance of report Monitoring by Health and Safety Team	
Awareness and ownership of ligature reduction work		Local forum established, held monthly, well attended	LRRG membership reviewed to include more clinical attendance Clinical Operations staff presenting and discussing ligature inspection findings from their areas at LRRG	

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Current Status				
Current Controls (e.g. Resources, Strategy and Policies, Training, Data/ Insight, Investment and Contingencies)	**Gaps in controls**	**Controls Assurance**		
		Level 1 Function/ Department Management	**Level 2** Organisational Oversight	**Level 3** Independent Assurance / Internal Audit
Support for staff		Support package developed – debriefing facilitated by Nursing in Charge/ Ward Manager/ Matron/ Service Manager/ Clinical Lead/ Consultant (or other member of Senior Medical Team)	Here for You – signposting for individual follow up Input from Psychological Services Patient Safety Team facilitates 'cold' debrief in the form of after action review for staff support	
KPIs and Dashboard		Highlight progress on ligature reduction	Safety priorities regular reporting to ESOG, BSOG and LRRG.	
Replacement of door hinges		Specification in place	All hinges purchased and fitted end March 23	

Action Workstreams	Timescale	Lead	Comments
Identify right electronic system for recording ligature actions (overseen by Project Group)	March 2023	Project Group	Will give a new control. Paused while reviewing Estates tasks system
Ensure EPUT environments meet environmental standards	April 23	Linda Martin/ Tracy Abbot	Project Team took forward plan for 22/23 Has included simplifying governance processes
Review environmental risk stratification document	March 23	Linda Martin Fiona Benson	Review linked to Capital programme
Pilot the training project for a year followed by evaluation	Sept 23	Project Group	In-house training not approved in full by ET. Benefit analysis pilot recommended and this will be started in June 2023 on 1 ward, with existing resources for evaluation purposes.

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Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Tel: 0300 123 0808

TRANSFORMATION TEAM ANNUAL REPORT

● Information Item   👤 ZT   🕐 5 Minutes

REFERENCES

Only PDFs are attached

📕 Transformation Team Annual Report 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1		26 July 2023	
Report Title:	Transformation Team Annual Report 2022/23			
Executive/ Non-Executive Lead:	Zephan Trent, Executive Director of Strategy, Transformation and Digital			
Report Author(s):	Alison Ives, Associate Director of Transformation			
Report discussed previously at:	Board of Directors 31 May 2023			
Level of Assurance:	Level 1	✓	Level 2		Level 3	

Risk Assessment of Report

Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	✓
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report

This report provides the Board of Directors with an update report on the contribution and progress over the last 12 months of the Transformation Team	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note and endorse the contents of the 12 month report
2. Request any further information or action

Summary of Key Issues

The attached report an update report on the contribution and progress over the last 12 months of the Transformation Team

Relationship to Trust Strategic Objectives

SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered

1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report

TSG	Transformation Steering Group	BAU	Business as usual

Page 2 of 2

Supporting Reports/ Appendices /or further reading
Transformation Team Annual Report 2022/23

Lead
  Zephan Trent **Executive Director of Strategy, Transformation and Digital**

TRANSFORMATION TEAM ANNUAL REPORT

2022/23

EPUT's transformation team was formed in March 2021 to introduce project management capabilities in support of the Safety First, Safety Always strategy. The team initially focused on projects/initiatives under five safety priorities: staffing, engagement and supportive observations, ligature risk reduction, inpatient flow and EPUT culture of learning.

Earlier this year, the team has completed the consultation to combine the transformation and the service development teams into a single team in order to better support EPUT's new operating model. The new team consists of portfolio leads, project/programme managers, business and data analysts and incorporates a "business partnering" structure aligned to the Care Units and Corporate Services.

In addition, the transformation team have further strengthened their capabilities this year with the introduction of a Deputy Director Patient Safety and Quality Improvement. They will be the clinical lead for quality improvement across the Trust and have been focusing on developing an overarching organisational framework for QI along with a QI delivery plan.

Since March 2021 the transformation team have implemented a number of significant initiatives alongside supporting the Trust's priorities:

• Implemented a Transformation Steering Group with senior leadership membership
• Embedded a consistent end to end change methodology and a 'Single Front Door' (SFD) process
• Agreed a set of founding principles which guide the way the team operates
• Supported and led the development of a number of EPUT strategies
• Built relationships with wider system partners, actively sharing best practice, tools and techniques
• Developed a "project prioritisation framework"
• Led and supported significant change programmes across the organisation
• Worked in collaboration with the executive team to develop a transformation delivery framework

Governance and Assurance

Transformation Delivery Framework

The transformation team reviewed and grouped all projects and programmes under seven newly defined portfolios, each with an executive sponsor to ensure clear accountability and strategic alignment. In addition each project and programme has a director level Senior Responsible Officer (SRO) to ensure delivery and benefits realisation.

Portfolio info		Time To Care	Workforce & Culture	Quality Improvement, Safety, Learning	Clinical Model	People & Community	Digital & Data	Estates
	Executive Sponsor	**Alex Green**	**Sean Leahy**	**Natalie Hammond**	**Milind Karale**	**Nigel Leonard**	**Zephan Trent**	**Trevor Smith**
	Transformation focus areas	Staffing models; process improvement	Changing culture; Workforce development and leadership	Quality Improvement; Safety; Learning; independent inquiry;	Clinical strategy; clinical pathways	Community engagement; lived experienced and participation	Modernisation of digital and data systems and processes	Modernisation and optimisation of estates

Methodology

The transformation team have developed and implemented a number of tools and processes to bring oversight and control in managing the overall portfolio and alignment between projects and programmes with the Trust's strategic objectives and operational plans.

Best practice has been applied to projects and programmes by introducing steering and working groups, operating to the same standards.

This agreed methodology commences with a "single front door" (SFD) and triage process to ensure that all new change activity whether initiated by our Trust or the wider health and care system is captured.

We developed a project categorisation model to assist with triage which defines an initial estimate of the overall total project cost and duration and allows us to consider resources required, the governance and approval processes, the scheme of delegation and reporting process.

Project Prioritisation Framework

To achieve our vision and ensure we put our patients, service users and colleagues at the core of our decision making we also developed a way to evaluate projects before initiation and prioritise these within the portfolio.

The framework was developed by the team and is based on an industry recognised model which is fair and transparent, minimising the potential for bias in the approval and prioritisation process. By prioritising projects, we are able to ensure we commit resource to the activities that will deliver the most value against the Trust's strategic priorities.

Transformation Steering Group (TSG)

The first TSG took place in April 2022 and has met monthly thereafter. The group, made up of senior leaders and subject matter experts consider initiatives, ideas and project recommendations that have been submitted through the 'Single Front Door' whilst also providing assurance of the Trust portfolio of programmes and projects.

TSG promotes the pace required and ensures change bandwidth is understood and communicated.

Financial approval still takes place through standing committees, however, all new change activity is submitted through the 'single front door' and presented to the TSG ahead of submission to those committees for approval.

Transformation team Founding Principles

In order to promote a culture of support, constructive challenge and continuous improvement, the team have collectively agreed a set of founding principles which guide the way they work individually and together.

Key Work

Ligature Risk Reduction

The initial scope of work to reduce ligature risks in 2021 was largely focused on the environment and estates factors.

The transformation team undertook a review in 2022 in order to lead and support our estates, training and risk colleagues to drive a reduction of ligatures by:

- Increasing a drive towards data-driven decision making
- Improving engagement with clinical, operational and estates colleagues
- Improving governance structures within the project
- Establishing estates, policy and training working groups which report to the executive and board members

Essex Wide Eating Disorders Transformation

This project is responsible for bringing together two legacy community adult eating disorders services into one cohesive team that provides safe, trauma informed support to people with moderate to severe eating disorders.

The transformation team led on a key element of this project which was the introduction of the First Episode Rapid Early Intervention for Eating Disorders (FREED) model as a rapid response service.

Mental Health Urgent Care Department (MHUCD)

This project was responsible for the development of a new service within the urgent care pathway to support increasing pressures in the MSE system. This service provides a bespoke facility for adults experiencing mental health crisis as an alternative to local emergency departments via internal and external referral, professional conveyance and self-referral.

Following a successful programme led by the transformation team the MHUCD opened its doors in March 2023.

Goal Attainment Scaling Care Plan (Pan Essex)

The Care Programme Approach was originally introduced to provide greater shape and coherence to local services' approaches to supporting people with severe mental illness in the community, based on care co-ordination, care planning and case management.

The transformation team are leading on the update to our care plan approach and are supporting the design of the new care plan to ensure Goal Attainment Outcome measure are built in, patients are aware of their care plan, staff providing interventions and people receiving care are focused on actions required to meet need.

International Recruitment of Nurses

The supply of nurses to NHS organisations is a well-documented challenge for NHS trusts in the UK. EPUT therefore investigated alternative ways of sourcing nursing staff and agreed to recruit nurses from overseas. A target of recruiting 185 internationally educated nurses was agreed by the Trust Board for 2022.

The transformation team managed the recruitment and on-boarding of 26 registered mental health nurses and 159 registered general nurses throughout 2022 before handing the project over to a new dedicated International Recruitment team.

EPUT Culture of Learning (ECOL)

EPUT Culture of learning focuses on ensuring employees and the wider organisation have the right capabilities and supportive environment to adapt and respond to challenges and recognise opportunities to learn lessons in an agile and effective way.

Since July 2022, the transformation team have led on the development and embedding of a streamlined dashboard which supports the analysis and interrogation of data in an efficient way

and a database platform that allows the investigation and documentation, management and analysis of lessons.

Safety Strategy Review

The transformation team were asked to produce an update report on the overall progress against this 'Safety First, Safety Always' strategy, for presentation to the Trust Board in March 2023.

The transformation team undertook analysis of all work related to the safety of our patients/service users. In addition, we conducted deep dives into all seven priorities within the strategy to evaluate progress made against activities and identify any additional initiatives required.

In addition, the transformation team supported the planning and content for EPUT's Safety Conference which was held in June 2023. This event included presentations from key partners such as the Civil Aviation authority and the National Patient Safety team, and was attended by senior leadership, Trust staff and over 100 AHP, Nursing and Anglia Ruskin medical students.

Medical Devices

The transformation team produced a business case to seek approval to procure an outsourced, strategic management review of EPUT's medical equipment assets. The proposals in this business case will ensure we build a safer strategy which will further enhance patient safety.

West Essex Care Coordination Centre and Virtual Hospital

The Care Coordination Centre navigates the health and care needs of adults within West Essex delivering the right care, at the right time and in the right place.

The transformation team in conjunction with system partners created and implemented the new service establishing clear governance, defined work streams and roles within the programme. The combined team developed a patient tracking system identifying the patient journey, current status of care and treatment, identified service delivery support and successfully integrated the re-designed Patient at Home (P@H) service.

Priorities for 2023/24

The transformation team will continue to grow and develop its processes and continue to support the delivery of the Trust strategy through the following objectives:

- Mature the transformation team operating model, further developing relationships and utilising the business partnering principles and promoting the role and value of the transformation team to ensure we embed a "best of all" approach to change
- Provide project, programme and transformation delivery expertise to key initiatives and further develop and improve the maturity of our processes assessing these against recognised frameworks
- Further embed and mature our processes for the new change methodology and Transformation Steering Group and collaborate with system partners on major change across all ICSs
- Continue to support the Trust to agree a complete prioritised list of projects, programmes and key change activity linked to the overall Trust priorities and strategic objectives
- Develop an outcomes and transformation dashboard, demonstrating KPIs, project and programme performance and resources assigned
- Describe to key stakeholders, including the independent inquiry, how we are delivering meaningful and sustainable change
- Ensure pace and quality of programme/project delivery and measure the effectiveness through the number of initiated projects delivered to time, cost and quality measures, stakeholder feedback and benefits realisation

SAFE WORKING OF JUNIOR DOCTORS REPORT

● Information Item   ● MK   ● 5 Minutes

REFERENCES   Only PDFs are attached

📄 Safe Working of Junior Doctors Report.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26th July 2023

Report Title:	**Safe Working Hours of Junior Doctors, Quarterly Report**
Executive/ Non-Executive Lead:	Dr Milind Karale, Executive Medical Director
Report Author(s):	Dr P Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours
Report discussed previously at:	N/A

Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report

Summary of risks highlighted in this report	

Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	Yes/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to Dr Karale.	

Purpose of the Report

This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:
1. Note the contents of the report

Summary of Key Issues

1. There are 5 Exception Reports raised by trainees between April to June 2023

2. No fines were issued in this quarter.

3. Refurbishment work in the on-call and doctor's room at all sites are now complete.

4. There are gaps in the on call rota which are filled by MTI and LAS doctors. No agency locums were used.

5. Gaps in the rota are less compared to previous years.

6. Junior Doctors participated in the industrial action in April and June 2023. In total 369.5 hours were covered by internal locums and 7 Consultants had to step down. Trust spent £32,512.50 to cover the gaps in the shifts in order to ensure patient safety and smooth running of the services.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	YES/NO	If YES, EIA Score	

Acronyms/Terms Used in the Report			

Supporting Reports/ Appendices /or further reading
Safe Working of Junior Doctors Quarterly Report

Lead

Dr Milind Karale
Executive Medical Director

Board of Directors Part 1
26 July 2023

SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

1 Purpose of Report

This report provides the Board of Directors with assurance that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Junior Doctors Contract

2 Executive Summary

This is the twenty fourth quarterly report submitted to the Board on Safe Working of Junior Doctors for the period 1 April 2023 to the 30 June 2023 The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Total of 5 exceptions reported in this period due to working overtime. Time off in lieu was given.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 5 April 2023

Doctors in Training Data

Total number of posts	**143**
Number of doctors in training posts (total inclusive of GP and Foundation)	**134**
Number of doctors in psychiatry training on 2016 Terms and Conditions	**84**
Total number of vacancies	**9**
Total vacancies covered LAS/ MTI/Agency	**7**
Total gaps	**2**

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick/COVID	124	124	0	1499	1499
Total	124	124	0	1499	1499

Junior Doctor Industrial Action

There have been two episodes of industrial action taken by junior doctors (11 to 14 April 2023 and the 14 to the 17 June 2023) The Trust ensured that patient safety was not

compromised and a shadow rota was set up so that there was both day and night cover across all five areas of the Trust.

In total 369.5 hours were covered by internal locums plus 7 consultants were stood down on each of the evenings so a total of £32,512.50 was spent on the shadow rota for both periods of industrial action.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.
3. 11 Fellows under the EPUT Advanced Fellowship programme have been appointed last year

The number of vacancies and gaps in the rota are less compared to the last 2 quarters.

Fines: None

Issues Arising:
1. Junior Doctors felt supported by the Trust in the recent Industrial Action.
2. All doctors' room and on call room refurbishment are complete. Trainees on Basildon site are waiting for printer, phone etc. to be installed in their doctor's room.
3. Trainees raised concerned that nursing staff are not trained in doing ECGs on the ward for patients who need emergency ECGs. The matter was escalated and it was agreed that training for nurses in this area will be prioritized.

3	Action Required

The Board of Directors is asked to:

1. Note the contents of the report

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

A FRAMEWORK OF QUALITY ASSURANCE FOR RESPONSIBLE OFFICERS

AND REVALIDATION ? ANNUAL BOARD REPORT

● Decision Item   👤 MK   🕐 10 minutes

REFERENCES

Only PDFs are attached

📕 A Framework of Quality Assurance for Responsible Officers & Revalidation 26.07.2023.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 July 2023
Report Title:	**A Framework of Quality Assurance for Responsible Officers and Revalidation – Annual Board Report**	
Executive/Non-Executive Lead:	Dr Milind Karale, Executive Medical Director	
Report Author(s):	Dr.Gladvine Mundempilly – Director for Medical Appraisal and Revalidation	
Report discussed previously at:		
Level of Assurance:	Level 1 ✓	Level 2	Level 3

Risk Assessment of Report		
Summary of risks highlighted in this report	None identified	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Board of Directors information on the implementation of revalidation within the Trust for 2020/21 appraisal year in order to provide annual statement of compliance provided to the higher level Responsible Officer at NHS England	**Approval**	✓
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to:

1. Note the contents of the report and approve the compliance statement
2. The Designated Body (EPUT) through its Chair or Chief Executive to submit the compliance statement to the Higher Responsible Officer at NHS England
3. Request any further information or action.

Summary of Key Issues

The Board of the Essex Partnership University NHS Foundation Trust as a designated body has a responsibility to ensure that it is compliant with the Medical Professional (Responsible Officers) Regulation 2010 (as amended in 2013) Act.

The report is expected in the format stipulated by NHS England and includes details about the quality assurance, clinical governance, Trust's performance on revalidation, actions plans to strengthen the revalidation process, audits on concerns of doctors' practice and audits on the appraisals input and output.

As of 31st March 2023, there were 174 doctors with a prescribed connection to EPUT. Of the 174 doctors, 159 had an annual appraisal (91%) during the appraisal year from 1st April 2022 to 31st March 2023. Out of the 15 incomplete appraisals, 14 were approved delays (9 started after April 2022, 3 on long term sickness, 1 has now left the Trust and the rest 2 have now completed). At the time of this report, there are no outstanding unapproved delays of medical appraisals. This is an improvement compared to last years appraisal completion rate of 86%, a plans are in place to ensure that the appraisal compliance rate continues to be above the expected 90% for next year.

EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation. We have started the steps to carry out an independent quality assurance of our medical appraisal processes, which we aim to complete in the next 6 months. We will also look to recruit and retain more appraisers and provide regular updates on training for those already in place.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

Relationship to Trust Strategic Objectives

SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered

1: We care	
2: We learn	✓
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			N/A
Involvement of Service Users/Healthwatch			N/A
Communication and consultation with stakeholders required			N/A
Service impact/health improvement gains			✓
Financial implications:	**Capital £** **Revenue £** **Non Recurrent £**		No new financial implications
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
A framework of quality assurance for responsible officers and revalidation (Annex D – Annual Board Report and Statement of Compliance)

Lead
(signature)   **Dr Milind Karale**   **Executive Medical Director**   **Responsible Officer (Revalidation)**

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

 a) help the designated body in its pursuit of quality improvement,
 b) provide the necessary assurance to the higher-level responsible officer,
 c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Board of Essex Partnership University NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Action from last year: **N/A**
>
> Comments: EPUT has an appropriately trained medical practitioner, Dr Milind Karale, who was appointed as Responsible Officer in 2012
>
> Action for next year: **None**

2. The designated body provides sufficient funds, capacity and other resources for the Responsible Officer to carry out the responsibilities of the role.

> Yes
>
> Action from last year: The Board to continue its support for annual appraisal and revalidation processes.
>
> Comments: The Designated Body currently provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act
>
> Action for next year: The Board to continue its support for annual appraisal and revalidation processes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> Action from last year: Continue to carry out process and amend the prescribed connection list as appropriate
>
> Comments: There is an established process to ensure the accuracy of the list of doctors with prescribed connections to the Trust. In addition to the information gathered prior to and at the time of a job offer to a doctor, the Workforce Department provides a monthly report of new starters and leavers to the Appraisal and Revalidation Support Manager. Triangulation of this information is carried out with Human Resources – Medical Staffing Department and the clinician concerned. This is cross checked with our Prescribed Connection list with the GMC and is amended as appropriate.
>
> Action for next year: Continue to carry out process and amend the prescribed connection list as appropriate

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> Action from last year: Continue to monitor and review the policies in place to support medical revalidation
>
> Comments: All new national guidance and amendments to existing documentation is read, shared appropriately and implemented where possible. EPUT's Medical Appraisal and Development policy and procedure was last updated in 2021.
>
> Action for next year: Continue to monitor and review the policies in place to ensure that these support medical revalidation.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> Actions from last year: Organise a peer review of our appraisal and revalidation processes.
>
> Comments: An independent quality assurance process of our appraisal policies and procedures is in the process of being commissioned by an external provider.
>
> We have continued to rely upon internal quality assurance processes and annual audits. The processes have been regularly reviewed by the RO and the Director of Medical Appraisals and Revalidation along with Human Resources. The information relating to appraisal and revalidation has been shared with the CQC as part of their inspection of the organisation
>
> Action for next year: To complete the independent quality assurance process

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.
>
> Comments: All doctors are supported in their continuing professional development, appraisal, revalidation and governance. The Medical Education department has regular internal CPD activities and all the doctors are encouraged to attend. The doctors are also assisted with their external CPD requirements both in terms of study leave and financial support.

The Revalidation Office provides regular support for the doctors on appraisal and revalidation, including timely reminders of appraisals, appraisal training and support in developing appraisal portfolios.

Where the doctor does not have a prescribed connection to the Organisation, such as agency locums, they are provided with the necessary supporting information to pass on to their Designated Body and include at their appraisal.

Action for next year: Continue to ensure that all doctors are supported in their continuing professional development, appraisal, revalidation and governance.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

    Action from last year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

    Comments: All doctors with a prescribed connection to EPUT are required to have a whole practice annual appraisal, which includes any necessary information on complaints and/or significant events that they have been named in for each appraisal year so that lessons learnt and reflections can be drawn upon. The Trust has a process in place to assist the doctor to collate this information held internally. The doctor is required to declare all their medical work, both with EPUT and any external, within the appraisal document.

    Where the appraiser is not the line manager of the doctor, the latter provides a medical managers report covering specific issues if any, to be discussed during the appraisal.

    Where EPUT is not the doctors' sole employer within their appraisal year, the doctor is required to provide a fitness to practice statement from all places where they were employed in a medical capacity.

> The Trust has adopted the new Appraisal 2020 model whilst still allowing our doctors to choose the standard appraisal template if they wish to. The majority of the doctors are now using the 2020 model.
>
> Action for next year: Continue to ensure all doctors on our prescribed connection list have a whole practice annual appraisal.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

> Action from last year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete the annual audit on missed or incomplete appraisals.
>
> Comments: Where a doctor does not have a whole practice annual appraisal, the reasons are explored and a plan put in place for its completion. These are further analysed to improve the process and ensure that the doctor is supported to complete these in a timely manner. The Responsible Officer and the Director of Medical Appraisal and Revalidation review the report on delayed appraisals on a monthly basis
>
> Action for next year: Continue to put in place action plans for those who do not have an annual whole practice appraisal and complete an audit on missed or incomplete appraisals.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

> Action from last year: Continue to review national policy and update the Medical Appraisal policy and procedure accordingly
>
> Comments: EPUT has a Medical Appraisal policy in place, which is in line with national policy. This was updated and ratified in 2021.
>
> Action for next year: Continue to review national policy and update the Medical Appraisal policy and procedure accordingly

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

> Action from last year: Organise new and appraiser refresher training
>
> Comments: As of 31st March 2023, there were 34 formally trained and approved medical appraisers across EPUT which is a sufficient number to carry out timely annual medical appraisals for all its licensed medical practitioners. The new and refresher training for appraisers was carried out in March 2023. The recruitment and retention of the appraisers has been challenging under the current work pressures of the doctors.
>
> Action for next year: Organise further new and appraiser refresher training. Look at options to encourage recruitment and retention of medical appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

> Action from last year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.
>
> Comments: There is on-going support for the medical appraisers by way of regular updates. The Appraisal and Revalidation Team is available to address their queries as and when they arise. Training is also made available to the appraisers periodically.
>
> Each appraisee is expected to complete an anonymised feedback of their experience, which is summated annually and provided to individual appraisers for their reflection. The individual appraisers include their appraiser role within their own annual appraisal for discussion and reflection
>
> Action for next year: Continue to support the appraisers in their role and ensure that they undergo training when required. Provide them with the necessary information in relation to their appraiser role to include in their appraisal.

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[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> Action from last year: Continue to complete annual audits and submit to the Board.
>
> Comments: Annual audits of our appraisal system are completed and shared with the Executive Team and discussed at the Quality Committee. This is submitted with the Board Report. Please see attached Appendix A and Appendix B for 2022/23 findings.
>
> Action for next year: Continue to complete annual audits and submit to Board

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	174
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	159
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	15
Total number of agreed exceptions	14

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

    > Action from last year: To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.
    >
    > Comments: The GMC Connect is reviewed regularly and recommendations are made in a timely manner.
    >
    > Action for next year: To ensure that timely recommendations are made to the GMC and that the doctors are ready for revalidation in good time to mitigate against any delays.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

    > Action from last year: Continue to ensure that revalidation recommendations are communicated promptly.
    >
    > Comments: Revalidation recommendations are communicated to the doctor at the point of the recommendation being made, if not sooner. Where the recommendation of deferral or non-engagement is made, the reasons are discussed with the doctor in advance and a plan is put in place to ensure a subsequent positive recommendation.
    >
    > Action for next year: Continue to ensure that revalidation recommendations are communicated promptly

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

> Action from last year: Continue to create an environment which delivers effective clinical governance for doctors
>
> Comments: The organisation has effective clinical governance processes for doctors in place. The Trust's Clinical Director for Clinical Governance takes the lead on learning lessons within the organisation. This is in the form of regular Trust wide learning sessions and audit presentations. In addition, reports are published regularly on the Trust intranet by the Lessons Learned Team and relevant reminders are sent to the doctors by the Medical Director. The doctors are also encouraged to contribute to the clinical governance process by undertaking investigations and reviewing the incidents.
>
> Action for next year: Continue to provide an environment which delivers effective clinical governance for doctors

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

> Action from last year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal.
>
> Comments: Monitoring the performance of all doctors working within the Trust is carried out regularly in a variety of ways. Some examples include monitoring adherence to Trust policies and procedures, recording data on complaints, significant events and service provision, compliance with mandatory training and revalidation requirements and feedback from trainees. In addition the Clinical Directors have a monthly meeting with the doctors under their line management to discuss any concerns relating to working practices or performance.
>
> Corporate data such as information on complaints, significant events, audits and attendance at internal weekly teaching sessions are provided to the doctor to include in their annual appraisal.
>
> In the appraisal, the doctors include their updated job plan, mandatory training record, probity declaration and issues relating to any suspensions/investigations that they are subjected to. This is triangulated with Trust and GMC Connect data.

Action for next year: Continue to monitor the conduct and performance of all doctors working in our organisation and provide all relevant information to include at their appraisal

3.   There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue with established process and update the policy and procedure as and when required

Comments: The organisation has a process in place for responding to concerns and has a Maintaining High Professional Standards – Conduct and Capability policy and procedure for Medical and Dental staff, which is in line with national guidance and was last updated in 2022. The Trust has an adequate number of trained Case Managers and Case Investigators. Refresher training is provided periodically.

Action for next year: Continue with established process and update the policy and procedure as and when required.

4.   The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.   Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Continue to complete annual audit and submit to Board.

Comments: Annual audit of responding to concerns about a doctor in our organisation is completed and submitted to Board with the board Report. Please see Appendix C

Action for next year: Continue to complete annual audit and submit to Board.

---

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

> Action from last year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary.
>
> Comments: Medical Practice Information Transfer forms are used to transfer information and concerns between responsible officers where necessary. This is a nationally approved form.
>
> The doctors are required to declare to the organisation, all the places where they are employed in a medical capacity and to provide a fitness to practice statement from them to include in their annual appraisal.
>
> Action for next year: Continue to transfer information and concerns in a timely manner between responsible officers when necessary.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

> Action from last year: Continue to ensure the appropriate policies and procedures in place are followed and updated to ensure that those involved in investigations are adequately trained.
>
> Comments: The organisation has a Maintaining High Professional Standards policy and procedure which has been ratified and which is in line with national guidance. Those involved in investigations are appropriately trained for the role. There is also an appeal and remediation policy and procedure, which are followed when required.
>
> Action for next year: Continue to ensure the appropriate policies and procedures in place are followed and updated and to ensure that those involved in investigations are adequately trained.

---

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

    > Action from last year: Continue with new starter processes
    >
    > Comments: EPUT has systems in place to ensure that we are compliant with the Responsible Officer Regulations Act with regards to recruitment and employment checks. Medical HR carries out the necessary pre-employment checks prior to any doctor joining the Trust. Once the doctor is in the post the Appraisal and Revalidation Team carries out further assurance checks, which include the name of the last Responsible Officer, revalidation due date, copies of previous appraisals, appraisal due date and the MPIT Form. The Medical staffing department follows an agreed process for recruiting agency locums ensuring that they meet the expected standards for their role.
    >
    > Action for next year: Continue with new starter processes

Section 6 – Summary of comments, and overall conclusion

As of 31st March 2023, there were 174 doctors with a prescribed connection to EPUT. Of the 174 doctors, 159 had an annual appraisal (91%) during the appraisal year from 1st April 2022 to 31st March 2023. Out of the 15 incomplete appraisals, 14 were approved delays. Although this is an improvement compared to last year, a plan has been put in place to ensure that the appraisal compliance rate continues to be above the expected 90% for next year.

EPUT has appropriate policies and procedures in place for appraisal and revalidation. EPUT has established good governance arrangements for medical appraisal and revalidation.

Steps are being taken to increase the recruitment and retention of the medical appraisers to ensure that appraisal process are carried out at the expected standards.

An independent external quality assurance of the medical appraisal process is now being commissioned and is expected to be completed in the next 6 months.

The Board will need to continue its support for annual appraisal and revalidation process in order to maintain and improve upon current processes, and to ensure compliance with the Responsible Officer Regulations Act.

Section 7 – Statement of Compliance:

The Board of Essex Partnership University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _   Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

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Annual Report Template Appendix A – Audit of all missed or incomplete appraisals

	Totals
Number of doctors on GMC Connect as of 31 March 2023	174
Number of Completed appraisals for 2022-23	159
Number of doctors who were not due for an appraisal by 31 March 2023 (new starters after April 2022)	9
Number of doctors who were LTS for the majority of the appraisal year	*3*
Number of Approved Incomplete/Missed Appraisals for 2022-23	*2 (both have now been completed)*
Number of Unapproved Incomplete/Missed Appraisals for 2022-23	1 *(has now left the Trust)*

Annual Report Template Appendix B – Quality assurance of appraisal inputs and outputs

Total number of appraisals completed		171[1]
	Number of appraisal portfolios sampled	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs - Is there sufficient supporting information from all the doctor's roles and places of work? (To include CPD, QIA & evidence from external roles)	34	33
Review of complaints: Have all complaints been included?	34	34[2]
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	34	34[2]
Has a patient and colleague feedback exercise been sufficiently completed by year 3 of the revalidation cycle?	34	24
Appraisal Outputs		
Appraisal Summary	34	34
Appraiser Statements	34	34
Personal Development Plan (PDP)	34	33

[1] This includes the doctors who had left the Trust prior to 31st March 2023.

[2] Based on evidence submitted within appraisal portfolio.

Annual Report Template Appendix C – Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[5]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months (Apr 2022 – Mar 2023) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	2	5	3	10
Capability concerns (as the primary category) in the last 12 months	1	3	0	4
Conduct concerns (as the primary category) in the last 12 months	1	1	1	3
Health concerns (as the primary category) in the last 12 months	0	1	2	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2023 who have undergone formal remediation between 1 April 2022 and 31 March 2023. Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice A doctor should be included here if they were undergoing remediation at any point during the year				2
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				2
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0

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5   http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	0
TOTALS	2
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April 2022 and 31 March 2023: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1

Duration of suspension:
 Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included
 	
      Less than 1 week
      1 week to 1 month
      1 – 3 months
      3 - 6 months
      6 - 12 months
	1 (3 weeks)

Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0

Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of NCAS assessments performed	3

OTHER

NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

● Standing item　　　　👤 ALL　　　　🕐 2 Minutes

REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

● Standing item   👤 ALL   🕐 5 Minutes

CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

● Standing item   👤 ALL   🕐 1 Minute

ANY OTHER BUSINESS

🔵 Standing item　　　👤 ALL　　　🕐 10 Minutes

DATE AND TIME OF FUTURE MEETINGS: WEDNESDAY 29 NOVEMBER 2023

● Standing item