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Essex Partnership University
NHS Foundation Trust

Essex Partnership University NHS Foundation Trust

Quality Account 2024-25

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Who was involved in the development of our Quality Account?

Essex Partnership University NHS Foundation Trust consulted with the following in the development of this Quality Account and the content within:

- EPUT Council of Governors
- Healthwatch Essex, Southend and Thurrock
- Mid and South Essex Integrated Care Board
- Hertfordshire and West Essex Integrated Care Board
- Suffolk and North East Essex Integrated Care Board
- NHS East of England specialist commissioning team
- Essex, Southend and Thurrock Councils Health Overview Policy and Scrutiny Committees
- Essex, Southend and Thurrock Health and Wellbeing Boards

How to provide feedback on this Quality Account

If you would like to provide feedback on this Quality Account, or would like to make suggestions for content of future accounts:

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Part 1

Quality Account –

Chief Executive's Statement


POPLARS
QUIZ NIGHTS
HISTORY WALKS
Origami
Rochford History walk
SWIMMING
KEEP
All it takes is Faith & Trust and a little bit of Pixie Dust

Statement on Quality

This is our account to you about the quality of services provided by Essex Partnership University NHS Foundation Trust in 2024/25. It looks back at our performance over the last year and details our priorities for improvement over the coming year, 2025/26.

Statement on Quality from our Chief Executive

I am very pleased to present our Quality Account for 2024/25, which reflects on our performance over the last year and highlights our priorities for improvement in 2025/26. There are many examples in the Account of the great care our teams provide for our patients every day and I want to highlight a few of them here, as well as reflect on the wider work we are doing to improve the quality and safety of all our services.

Our journey of improvement and transformation continued over the last year, starting with the launch of our new Quality of Care Strategy in April 2024. This strategy follows on from our previous quality strategy, *Safety First, Safety Always*, which ran from 2021 to 2024. Our new strategy was co-produced with people who have lived experience of our services as patients, family members or carers. It is informed by what they told us quality of care means to them, as well as the NHS Constitution's definition of quality of care. The strategy includes ten safety improvement plans which cover key areas of safety and quality, including reducing ligature and falls risks, improving clinical handovers, simplifying policies and standard operating procedures so they are easily accessible and effective and promoting awareness of neurodiversity so we always take this into consideration when planning and delivering care.

A key priority for providing safer, more compassionate care has been to reduce our use of restrictive practice and to give our patients and ward teams the respective tools they need. I am very pleased to be able to report a 12 per cent reduction in restraints over the last year, although it's clear that we still have more to do in this area. An important piece of related work is supporting our patients to reduce incidences of self-harm, which can be a key reason for using restraint and restrictive practice. Work on our young people's wards shows that, for example, encouraging a young person to remove an item being used as a ligature themselves is very effective in both reducing harm and the need for more significant interventions, with the distress that can bring.

Another element of our Quality of Care Strategy is improving care at the end of someone's life, including supporting someone to die in their preferred place, whether this is in one of our hospitals, at home, in a care home or in another community setting. We are making good progress in helping patients achieve this aim, often more frequently than the national average, but there is more to do. Our work has highlighted the often complex nature of end of life care which can involve a number of different services, and we will continue to work with our partners to ensure patients and their families and loved ones get the right support at this crucial time in their lives.

We know that people with neuro difference who come into healthcare services can be misdiagnosed or diagnosed late because of a lack of understanding of their condition and how it affects them. We have a long way to go before we can say we are fully "neurodivergent aware", but in the last year we have set up a dedicated steering group, appointed a specialist consultant with a focus on Autism and ensured our staff are more aware of neurodivergence through the Oliver McGowan training programme. We also employ a number of neurodivergent staff, and some have shared their stories with colleagues and more widely in the media over the last year.

A significant focus for the Trust continues to be involving and working with people who use our services – our patients, their families, loved ones and carers. The nature of mental health services means that patients tend to be more engaged as many have lifelong conditions. It is important to build on this foundation and bring people "in" to the organisation, not just as service users but as partners who can offer insight, experience and challenge. We have now implemented the first set of priorities from our Working in Partnership with People and Communities strategy, coproduced with patients and underpinned by NHS England guidance. We introduced a reward and recognition system at three different levels to encourage people to get involved and to help lead patient involvement, and we now have over 300 people working with us who have direct or family experience of using our services. They are supporting strategic developments such as our new joint unified electronic patient record programme, other change programmes, service improvements and funding bids.

Our involved people are also working directly with patients, families and staff in our wards and services, in roles including peer support workers, patient safety partners and family and carer ambassadors.

To date, this equates to around 5,500 paid hours of lived experience contribution. One involved patient said "Being involved is better than therapy" – so the impact for people in our care cannot be underestimated.

We know what a difference a stable workforce and stable teams make to the quality and safety of our services. Over the last year, we have continued to improve permanent staffing levels on our wards and across the Trust as a whole. Our turnover rate is now at just over nine per cent, back to pre-pandemic levels, and our vacancy rate is around 13 per cent, down from nearly 19 per cent two years ago. In 2024, 151 new healthcare assistants and 132 newly qualified nurses joined the Trust – they are all very welcome at EPUT and I know they are making a great contribution to our services and the care we provide.

As we look ahead to 2025/26, we will continue to see considerable external scrutiny as the Lampard Inquiry progresses, with several days of public hearings scheduled across the coming year. We remain fully committed to the aims and objectives of the Inquiry, and we will continue to support Baroness Lampard and her team to help ensure families and loved ones get the answers they deserve.

I want to thank all our 7,000-plus staff who work in services right across Essex and into Bedfordshire and Suffolk to care for and keep people safe, and whose work is reflected in the improvements detailed in this Account. I also want to thank our partner organisations and external stakeholders for their continued support and challenge, and for working with us to serve our local communities.

To the best of my knowledge, the information contained in this Quality Account is accurate.

Paul Scott

Chief Executive
Essex Partnership University NHS Foundation Trust

What is a Quality Account?

The NHS is required to be open and transparent about the quality of services provided to the public. As part of this process, all NHS providers are required to publish a Quality Account, as laid out in the Health Act 2009. Staff at the Trust can use the Quality Account to assess the quality of the care we provide. Patients and the public can also view quality across NHS organisations by viewing the Quality Accounts on the NHS website: www.nhs.uk

The dual functions of a Quality Account are to:

Summarise our performance and improvements against quality priorities and objectives we set ourselves for 2024/25.

Outline the quality priorities and objectives we set ourselves going forward for 2025/26.

Part 2
Quality Priorities

Quality improvement priorities for 2024/25

Priorities for improvement

Our quality improvement priorities for 2024/25 are taken from key Trust-wide areas for quality focus defined within our Quality of Care Strategy, identified through stakeholder engagement:

- Reducing Restrictive Practice
- Infection Prevention and Control (IPC)
- Safeguarding
- Reducing Health Inequalities
- Promoting Neurodiversity
- Improving End of Life Care
- Improving Physical Health
- Medicines Optimisation
- Suicide Prevention.

We identified nine specific quality priorities that we would focus on, identified from within the year 1 plans set by each quality area's steering group.

This section presents the progress we have made against each priority.

Safety - Priority 1

Reducing restrictive practice

Why was this a priority?

National guidance on reducing restrictive practices in mental health, such as the Use of Force Act, has emphasised the need for a shift towards a person-centered, trauma-informed care approach. The updated recommendations focus on minimising the use of physical restraint, seclusion and other coercive interventions, promoting alternatives that prioritise patient dignity, safety and empowerment. The guidance encourages mental health services to adopt proactive de-escalation techniques, improve staff training and increase patient involvement in care planning. The overarching goal is to foster a culture of respect, aiming to reduce reliance on restrictive practices and improve therapeutic outcomes.

What did we say we would do?

We said that any use of seclusion and long-term segregation in our services would be minimised and, if used, would be in line with the Mental Health Act Code of Practice (2015).

We said we would reduce our use of restrictive practices in our inpatient areas by year end (March 2025) by 7.5%.

We said we would achieve our ambition through quality improvement initiatives to pilot and test change ideas such multi-disciplinary team (MDT) handovers, safety huddles, Safewards interventions, ward activities, safety crosses, debriefs, sensory strategies for de-escalation, Positive Support Behaviour Plans (PBS), and Dialectical Behaviour Therapy (DBT).

We agreed to measure our impact through performance data monitored against Mental Health Act (MHA) standards, seeking assurance from peer review visits by the Reducing Restrictive Practice Collaborative Partnership, quality review visits and patient safety walkarounds.

Did we achieve this?

The number of reported incidences of long-term segregation (LTS) have remained static and within common cause variation. However, episodes of seclusion have shown a **15% reduction** in use from **266** incidences (1 January 2023 to 31 December 2023) to **227** (1 January 2024 to 31 December 2024).

We measured improvement through data reported via the Mental Health Minimum Data Set (MHMDS). We have seen increased reporting of restrictive practice incidences across our wards in 2024-25 compared to previous years. This may in part indicate an improvement in reporting cultures.

The incidences reported particularly relate to self-harm support with female patients, as well as in response to physical aggression across all types of in-patient settings. Incidences of restrictive practices have been shown to relate to a specific number of patients who experience multiple occurrences, in particular young people with a diagnosis of autism spectrum disorder who also have a background of trauma. We recognised that further work and improvement is needed and we will continue to work with commissioners and our own teams. In January 2025, we appointed an EPUT consultant psychologist as the Trust's Autism Specialist Consultant to support colleagues in working with autistic patients of all ages. Neurodivergence will continue as a quality priority for 2025-26.

Over the past year, our Employee Safety Programme Lead has led work to reduce incidences of violence and aggression and improve safety, taking learning from incidences of restraint. A Tackling Discrimination and Violence Pilot ran from July 2024 to February 2025 across five wards in our secure services, adult and adolescent mental health services (Fuji, Poplar, Grangewaters, Hadleigh and Finchingfield wards). The pilot aimed to test interventions to reduce incidences of discrimination and violence and to enhance support for staff following such incidents. Key outcomes were:

- Staff confidence in management support increased from **52% to 95%.**
- Fewer staff, reported being subjected to discrimination and violence - **83% to 46%**, and there was a **29% reduction** of such incidents recorded on Datix.
- Overall levels of Datix reporting rose from **58% to 68%.**
- 28% of staff rated the police response as good or higher, prompting strategic engagement with the Police and the Crown Prosecution Service and the creation of Racial Abuse Scrutiny Panels to improve police investigations and provide clarity to staff on roles and responsibilities of all stakeholders.
- Links were identified between preventing discriminative and violent incidents and reductions of restrictive practice.

- While incidents were sometimes predictable, preventative actions were not always taken.

The pilot demonstrated the potential for scaling interventions across the Trust, with further considerations for ownership, governance and refinement of the approach. This work aligns closely with the Safewards principles and will be adopted into the year two Safewards focus.

We have improved our approach of wider multi-disciplinary involvement by including senior nursing and allied health professionals in patient care planning and delivery. Our year one ambition to implement Safewards to support restrictive practice reduction has been monitored at our Reducing Restrictive Practices Steering Group, which established a baseline of the current position to agree future improvement trajectories. We have utilised interventions such as mutual expectations, soft words, calm down methods, talk down, getting to know you and bad news mitigation. We continue to work with the compliance team to map implementation across all wards to identify which interventions are in place where. Two Safewards learning events have been held during the past 12 months, focused on Safewards implementation, and there are plans are in place to hold quarterly events throughout year two.

In line with our year one priority, we continued to introduce change ideas such as MDT handovers, safety huddles, ward activities, safety crosses, debriefs and sensory strategies for de-escalation, Positive Support Behaviour Plans (PBS) and DBT strategies.

Four EPUT wards are engaged in the National Culture of Care Programme, part of NHS England's Quality Transformation Programme to improve patient experience, reduce restrictive practice and improve staff experience. This programme includes a suite of measures such as patient feedback, staff feelings of burnout and proxy measures that are indicators of culture on a ward. Feedback against these measures has not yet been received.

We have seen an overall **reduction of 12%** in restraints in the last calendar year:

- From 1 January 2023 to – 31 December 2023, we saw **2,893** restraints
- From 1 January 2024 to – 31 December 2024, we saw **2,545** restraints.

Figure 1: Restraints over time Jan-Dec 2023

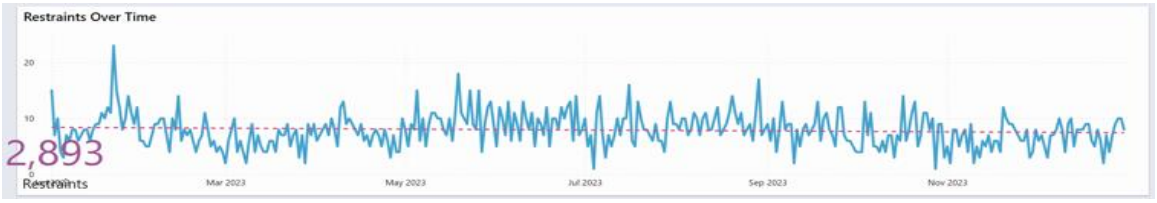
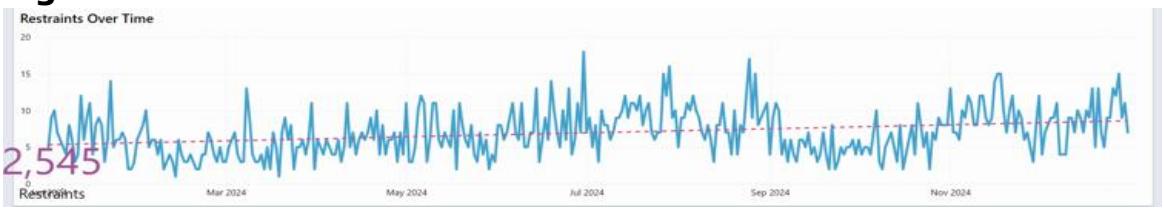


Figure 2: Restraints over time Jan-Dec 2024



We also commenced a review of oversight reporting for the use of rapid tranquilisation, including:

- Potential use of our new Electronic Prescribing System (EPMA) which was been rolled out to all mental health wards in 2024/25.
- A focus on physical health observations following episodes of rapid tranquilisation.

For year two, a Datix dashboard is being developed to enable escalation of any episode of rapid tranquilisation where physical health observations have not been completed, which will ensure there is clinical oversight and recommendations for practice - for example, the use of the non-contact physical observations tool where required physical observations are not obtainable.

Summary assurance statement

Partial completion

Work has continued for our year one priority with good progress, and we continue to drive forward to build on this for year two, where we will focus on our Safewards programme and our work with the National Collaborative.

Our Therapeutic and Safe Interventions De-escalation (TASID) training provides clinical teams with the necessary skills and competencies to de-escalate and ensure safe interventions are used during restraints.

TASID training continues to be certified by the Restraint Reduction Network under the British Institute of Learning Disability (BILD) Association of Certified Training scheme, and had its yearly review in the reporting period. We also hosted a Collaborative partner quality visit for our TASID training in September 2024 and will hold a similar event in the coming year.

We have introduced patient safety partner walkabouts, with four carried out in 2024/25. Specific learning points were raised in our secure wards around internet access and personal mobile phones, with patients reporting insufficient activity and leave. These issues have been taken forward by the clinical teams to improve in practice. There was also positive feedback around wards feeling calm and safe, staff being present, patients being interacted with, staff said to be excellent and trustworthy and patients feeling listened to. For Wood Lea Clinic, feedback from patients was overwhelmingly positive, giving the unit either a 4 or 5 star rating for care received.

For the acute adult mental health wards visited, evidence highlighted that improvements were still needed around ensuring a person centred approach to care is in place, handling of incidents and reducing restrictive practices. These issues will be tackled in the coming year through a quality improvement approach and the implementation of Safewards.

From a national perspective, benchmarking data exists through the mental health data set (MHSDS) submissions, but it has been difficult to compare using standardised denominators due to differing organisational sizes and demographics.

We will continue to explore this as part of our work with the national Culture of Care Programme, as restrictive practice data is one of the metrics being used to measure impact for the wards involved. We will also look at opportunities for using Tendable documentation audits, specifically for seclusion and long term segregation, in order to present findings in accordance with the Mental Health Act Code of Practice.

Safety - Priority 2

Infection Prevention and Control (IPC)

Why was this a priority?

This priority is based on the statutory requirements of the Health and Social Care Act (2010) Regulation 12, as detailed in the Code of Practice for the Prevention and Control of Infections with compliance assessed against the NHS England IPC Board Assurance Framework. The priority also underlines our ongoing commitment to:

- Promote best practice in IPC.
- Sustain a low number of Health Care Acquired Infections (HCAIs) across our services.
- Use expert knowledge and guidance and develop strong collaborative relationships internally and externally to provide safe environments for our patients.

What did we say we would do?

Our expected outcome aim was a 10% improvement in IPC standards in care and environments by 31 March 2025, achieved through:

- Review of practices in community settings through standardisation of practice across the Trust.
- Including training in aseptic non-touch technique, update and adherence to clinical guidelines.
- Undertaking environmental checks.
- Increasing the number of IPC champions in clinical services.

We said we would measure the improvement through:

- Monitoring performance data against IPC standards compliance.
- Peer review visits.
- Appreciative inquiry with patients and staff.

Did we achieve this?

EPUT has continued to make sustained progress in achieving the key IPC priority of reviewing practice in community settings. For the year ending in March 2025, we declared compliance of **83%** in IPC standards in care and environments, an **improvement of 18%** from the previous year.

Reviews of practice in community settings continue on an ongoing basis.

We have recruited an IPC nurse to work closely with teams in Mid and South Essex (MSE) to replace a colleague who left the organisation in Quarter 3, and review work will continue into the coming year.

A large-scale quality improvement project in relation to Aseptic Non-Touch Technique (ANTT) will now start as part of the Mid and South Essex (MSE) Community Collaborative. The Collaborative brings together the community health services delivered by different providers across the MSE area. To date, a review of community practices in relation to ANTT and discussions with colleagues have identified the need for increased education and competency assessment in wound management and other invasive procedures. The IPC Community Collaborative Group, led by EPUT, is in the early stages of formulating a shared proposal. This piece of work will roll over into 2025/26 and will involve colleagues from across the Collaborative.

Our IPC Link Practitioner forums have had variable attendance rates and so are under review for the coming year to make the sessions more meaningful and to encourage greater engagement. However, through the introduction of IPC link champions in community services, we were able to safely identify increased incidence of Group G Strep cases, with learning supported by system partner reviews which has been presented locally, regionally and nationally.

Summary Assurance Statement

Partial completion

As the year has progressed, the IPC team have been involved in peer review visits between EPUT and Norfolk and Suffolk NHS Foundation Trust (NSFT) to share best practice and identify elements for improvement in some of our sites. This has proved to be beneficial to both organisations, with further peer reviews planned for the coming year.

Internal quality assurance visits are undertaken by colleagues led by the compliance team, supported with audit and action planning information supplied by the IPC team. These visits have assisted in further escalation of previously identified environmental concerns and have also highlighted examples of good clinical practices seen.

The approved IPC programme of work will continue into years two and three, reporting bi-annually to the Quality Committee. A specific IPC quality priority is therefore not being set for 2025/26.

Safety - Priority 3

Safeguarding

Why was this a priority?

Under Section 75 of the Care Act (2014), EPUT has delegated responsibility to undertake/lead Section 42 Adult Safeguarding Enquiries for service users open to its mental health services in Essex.

Since the COVID-19 pandemic, there has been a 30 per cent year on year increase in safeguarding concerns raised. This has proved challenging for operational teams to undertake enquiries within the recommended time frames within Southend, Essex and Thurrock (SET) guidance, compounded by the increase in complexity reported for some concerns.

The Trust also had a considerable number of safeguarding enquiries that were open outside of the identified SET guidelines. This is an issue across the wider health and care system and has been placed on both the EPUT and Essex County Council Section 75 risk register.

In April 2024, 1,022 safeguarding enquiries were reported as open, and a further 1,032 enquiries were received. 76% of all enquiries were closed by 31 March 2025. Of the remaining 521 open enquiries, 355 were opened since January 2025.

What did we say we would do?

The safeguarding Team have been working to improve the responsiveness and quality of Section 42 enquiries through a quantitative analysis of cases in each care unit, with achievement measured through performance data monitored against SET adult guidelines, service user experience and compliance with the Care Act 2014.

This work has also included a review of the Datix reporting mechanism undertaken by our clinical safeguarding specialists.

Our expected outcome aims were:

- 70% of Section 42 enquiries completed by year end.
- 100% of Datix risk management entries completed for all Section 42 enquiries by year end.
- Demonstration of the Making Safeguarding Personal approach in all enquiries completed by year end.

Did we achieve this?

At year end, 76% of all enquiries had been closed - **this exceeds our target of 70%.**

This was achieved through increasing the capacity within the EPUT Safeguarding service to support operational teams with closures, using experienced practitioners with oversight from the Named Professional for Adults to provide assurance that all enquiries had undergone a robust review. In addition:

- The EPUT Safeguarding team had meetings with Essex County Council adult services colleagues to gain a clearer shared understanding of the contractual requirements identified under the Section75 agreement and greater awareness of the thresholds for enquiry.
- The duties of the Clinical Specialists for Safeguarding were also reviewed and prioritised, with a key focus given to open safeguarding cases and providing specialist support to clinical teams.

Lessons identified during the caseload review were discussed and evaluated by the Safeguarding Team using a reflective practice approach, to improve the decision making process that informs thresholds for enquiry. The review also identified areas of gaps in knowledge and skills, leading to the delivery of targeted learning and professional development for clinical teams on undertaking a safeguarding enquiry.

The following actions were also taken to provide on-going assurance and compliance with SET key timeframes, and to ensure service managers have access to reports that support oversight and management of safeguarding caseloads within their service:

- Introducing Care Unit level safeguarding caseload progress reports for to Quality and Safety Meetings to given local leadership oversight.
- Producing bi-monthly caseload reports for service managers to support their management of cases.
- Providing safeguarding skills training for around 200 managers on running reports directly from the EPUT Datix incident management system.
- Developing a safeguarding dashboard in the EPUT Power BI data system.
- Introducing a justifiable delay reporting process through Datix.
- Providing assurance to the Essex Safeguarding Adults Board on the delivery of Section 75 delegated responsibilities.

Summary Assurance Statement

Partial completion

To support our assurance, we have:

- Held face to face discussions with Care Unit directors on safeguarding caseloads.
- Reported the management of caseloads and improvement trajectory through bi-monthly reports to the Safety of Care Group and the Mental Health Act and Safeguarding Subcommittee, chaired by our Executive Chief Nurse.
- Made the Datix manager training available via the staff intranet.
- Held regular meetings between clinical safeguarding specialists and team leaders to provide local assurance and give the opportunity to provide expertise safeguarding support.

Actions taken forward into 2025/26 include:

- Reviewing Adult Safeguarding Level 3 training, with learning gained through the process of supporting practitioners in safeguarding practice and the undertaking of enquiries.
- Developing a safeguarding performance dashboard.
- Continuing to deliver a programme of safeguarding compliance checks within clinical areas.
- Implementing joint audit processes with Essex County Council.

Our Deputy Director of Nursing for Safeguarding and Mental Health Act and the Associate Director for Adult Social Care for the Essex Safeguarding Adults Board will continue to work in partnership on the key deliverables under Section 75 and governance processes.

Experience - Priority 1

Reducing health inequalities

Why was this a priority?

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' clinical areas of requiring accelerated improvement. One of these areas relates to chronic respiratory disease, with a requirement for a clear focus on Chronic Obstructive Pulmonary Disease (COPD) and driving uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and resulting emergency hospital admissions.

People with severe mental illness (SMI) have been shown to have high rates of respiratory disease. People with schizophrenia have higher rates of COPD than the general population and are more likely to die of infections such as pneumonia and influenza, common precipitants for COPD.

What did we say we would do?

We said we would create baseline data insights to set improvement into 2025/26, by:

- Identifying cases of chronic respiratory disease by completing health checks for people with severe mental illness.
- Develop care pathways within EPUT and acute trust services, including smoking cessation and access to vaccinations.
- Review clinical guidelines for COPD.
- Review uptake of Covid, flu and pneumonia vaccines, monitor cases of infective exacerbations and emergency hospital admissions due to COPD exacerbation.

Did we achieve this?

We focused on our initial development of baseline data insights on health checks for people with severe mental illness (SMI) so that this would support the identification of patients with chronic respiratory disease.

Health checks

Planned outcomes:

- Increase the number of inpatients who have had a physical health check in the last year to 95% on inpatient mental health wards.

- Understand the provision of physical health checks to ensure equality of access across services.
- Have a robust reporting system across community and inpatient services.
- Increase the number of patients with SMI who have had the 6 parameters taken in the last year.

To escalate patients who had not had a health check, breach lists were created for teams to identifying patients, enable staff to focus on specific patients and ensure checks were completed.

Over the 2024/25 year, each clinical area has focusing on improvement activities. The most successful teams have:

- Dedicated resource.
- Administration staff to book patients in.
- Nearby space to allow patients to move around as part of the physical health check.
- Working equipment.

Initiatives in teams have included:

- Sending all patients with a care coordinator a letter with the SMI health check leaflet enclosed.
- Setting up dedicated email addresses for patients to book themselves in.
- Providing staff with dedicated kit bags prepared for them to take out to visits in the patient's own home.
- Access to SystmOne to allow wider access to previous test information
- Focus on other opportunities to carry out health checks, including at depot clinics and outpatient clinics.

Although further improvement is needed to achieve all the key performance indicators, changes in the last year have seen an increase in compliance in physical health checks across all areas. This position will now support the identification of patients with a serious mental health illness who have abnormal results reported following health checks – in particular, results which indicate chronic respiratory illness and other key co-morbidities that can lead to poor health outcomes resultant from health inequalities.

Smoking cessation

In England alone, almost 75,000 people die from smoking related diseases each year. EPUT signed up to the NHS Smoke Free Pledge to support the delivery of a smoke free NHS by 2030. There are several associated commitments to work on.

Outcomes delivered in 2024/25:

- Developing a dedicated resource for an inpatient tobacco dependency advice service.
- Appointing a smoking cessation coordinator.
- Distributing referral pathway posters to wards and clinical areas, with a new QR code referral process and dedicated branding/logo.
- Drafting a smoking cessation pathway standard operating procedure
- Progressing the rollout of smoking cessation training - level 2 smoking advisor training for ward staff is now available.
- Developing an advanced smoking cessation workshop presentation for medical staff.
- Training over 60 volunteers to be physical health link practitioners, with face to face workshops supporting these volunteers.

Review clinical guidelines for Chronic Obstructive Pulmonary Disease (COPD).

This review has not yet been completed

Our clinical guidelines are being reviewed as part of the Quality Senate, to ensure that all guidelines are evidenced based, aligned to NICE publications where appropriate and have a prioritised approach for review and ratification. The COPD clinical guideline is included in this approach.

During 2024/25, we also launched the SOPHIA electronic platform, making access to clinical guidelines, standard operating procedures, and policies easier for clinical teams. Using SOPHIA also ensures that only the most up to date versions are available to staff.

Monitor cases of infective exacerbations and emergency hospital admissions due to COPD exacerbation.

Our data systems do not currently allow us to pull the data of patients suffering from acute exacerbation of COPD who are transferred from mental health to physical health services or an acute hospital.

As we develop our clinical pathways for the new Electronic Patient Record System (planned to be operational during 2027) we will design data

capture to specifically target patients with serious mental health and respiratory disorders. In the meantime we will use the shared care record system to identify patients on the SMI register. Once we can access full data, we will gain a greater understanding of the prevalence and priority of focus for this indicator.

An increase in the uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions

All EPUT wards were visited within two weeks to offer and administer seasonal vaccinations to current inpatients, people who would not be able to access the national primary care vaccination programme. At the end of this reporting period, we have delivered **577 vaccinations**.

Summary assurance statement

Partial completion

Although not all our priorities have been achieved, we have seen an improvement in our achievement of physical health standards and our smoking cessation services have continued to expand.

The Reducing Health Inequalities (RHI) group shifted focus during the year and reduced the scope to be included in this quality priority. During the year, it was identified that there was a need to refocus the core priority on race equity; our creation of a Patient and Carer Race equality framework (PCREF) being the main driver. As a result, the group have been focusing efforts on this, and monitoring progress against an annual plan. To date the group have:

- Identified data requirements.
- Recruited two lived experience leads for both the RHI group and the PCREF.
- Worked with system partners to address race equity as a priority.
- Drafted the year two RHI annual plan which has been reviewed by the experience of care group.

As this is a newly formed group there have been challenges in year one in terms of setup and data, but these issues have been worked through and now the group is progressing well.

Race equity for patients and carers is being built into a wide range of change initiatives across the organisation as we continue to embed the PCREF. With the incoming quality dashboard, the group will be better placed to baseline, benchmark and monitor improvement as we continue to drive change. Finally, next year's plan is well developed with clearly defined deliverable objectives and is now on track.

Experience - Priority 2

Promoting neurodiversity

Why was this a priority?

Neurodiversity describes different thinking styles that affect how people communicate with the world around them. It is an umbrella term that includes conditions like autism, Attention Deficit Hyperactivity Disorder (ADHD), dyslexia, dyspraxia, dyscalculia and Tourette's. Approximately 1 in 7 people in the UK have some kind of neuro difference. Being neurodiverse does not correlate with low intelligence. Evidence suggests that Neurodiverse people are less likely to access healthcare, leading to premature mortality and risk to their health and wellbeing. Many people who do access care can face interventions which result in restriction and may be disproportionate, ultimately leading to compulsory treatment with poor outcomes.

Neurodiverse people can also be subject to misdiagnosis or late diagnosis driven by a lack of understanding of their condition(s). There is a need to reduce stigma and discrimination towards neurodiverse people and ensure health and care services are accessible, improving care and support and reducing untimely deaths.

What did we say we would do?

We said we would:

- Reduce the number of patients waiting for assessments for conditions such as ADHD and ASD.
- Introduce improvement standards for patients with learning disabilities.
- Create clear care pathways for neurodiverse patients.
- Hold a neurodiversity awareness launch event.
- Increase the number of Patient Safety Partners working in our service.

Our expected outcome aim was to achieve a 7.5% reduction in the numbers of patients waiting for assessments by the end of December 2025.

Did we achieve this?

We established an improving neurodiversity steering group which has then worked collectively and collaboratively with two established forums of people with neurodivergent conditions and people with learning disabilities. This created opportunities within our new quality priority for challenge and positive scrutiny. By using this feedback, we are working towards moving our approach from *promoting neurodiversity* to *working with neurodivergence*.

We have not fully created our baseline performance data for wider conditions beyond autism at the time of writing this Quality Account, but have robust plans to ensure this is delivered in line with our plans for year two.

We have also:

- Held a range of activities during Neurodiversity Celebration Week in March 2025.
- Launched a neuro-inclusive cafe for staff in April 2025.
- Welcomed over 20 experts by experience who are autistic, have a learning disability or both, to support in training our workforce.
- Created an advisory role autism specialist consultant psychiatrist to help ensure autistic patients receive the best care. The post holder is a Child and Adolescent (CAMHS) psychiatrist and performs the advisory role alongside their existing role.

Summary assurance statement

Partial completion

The promoting neurodivergence steering group has been formed and includes a wide range of external partners, but specific circumstances have so far limited its achievements. Although data is still limited, we can reasonably state that staff awareness of neurodivergence is much higher than in 2023/24, thanks to with increased uptake of the Oliver McGowan training.

We have now introduced the National Autism Trainer Programme (NATP) as a supplementary and more advanced training offer in areas where it is most needed, such as inpatient services.

This is embedded into our culture of care programme, which has 'autism-informed' as one of its core tenants. A focused session of the clinical senate on neurodivergence resulted in recommendations to take forward with system partners, with some quick wins already adopted. Once our quality dashboard is launched in 2025/26 it will be much easier to benchmark and monitor progress to evaluate impact. Next year's plan is developing well, with clearly defined and deliverable objectives.

Experience - Priority 3

End of life care

Why was this a priority?

'How we care for the dying is an indicator of how we care for all sick and vulnerable people' (National End of Life Care Strategy 2008).

End of life care incorporates the last year of a person's life, whatever the cause or condition they are living with. They and their families, carers and loved ones should expect good end of life care with services to meet their individual needs. There were 581,363 deaths registered in England and Wales in 2023 (national data for 2024 is not yet available). Dementia and Alzheimer's disease continue to be the leading causes of death, accounting for almost 12% of all deaths in 2023.

At EPUT, our primary aim is to ensure quality of care for patients at the end of their lives across all our services. Our End of Life Care Subcommittee monitors quality in all services via the End of Life Care work plan and the Trust's Quality of Care strategy.

What did we say we would do?

We said that we would ensure that everyone receiving end of life care in our services would:

- Have fair access to palliative and end of life care, irrespective of the care setting.
- Be cared for by staff who can provide a personalised approach.

We said we would do this through:

- A standard Trust-wide approach through partnership working.
- Ensuring multiagency services work collaboratively.
- Increasing the number of end of life champions in our services.
- Reviewing deaths where the patient was not able to die in their preferred place of death.

By measuring performance data against the number of people registered as being in the last year of their life, our expected outcome aim a 7.5% improvement in personalised preferred place of death documented by the end of March 2025.

Did we achieve this?

Data recorded for people who died in their Preferred Place of Death (PPD) in both South East Essex (SEE) and West Essex (WE) community services is shown in the following tables. The national average figure is 76%.

Table 1: Percentage of South-East Essex residents dying in their Preferred Place of Death (PPD)

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
85.6%	80.0%	81.7%	80.0%	90.5%	95.3%	90.1%	87.1%	80.0%	84.9%	84.5%

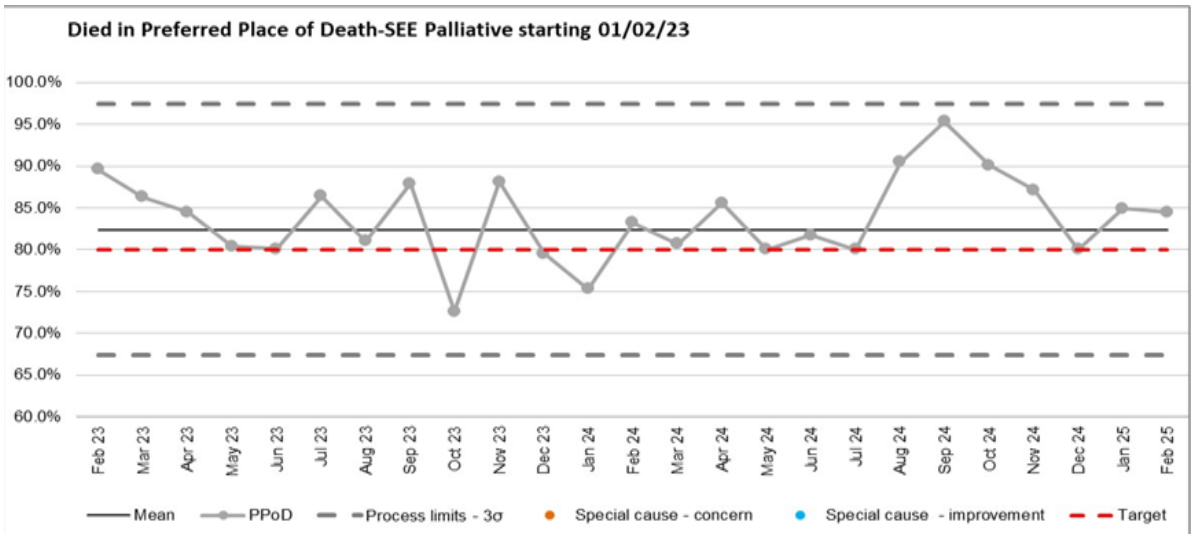
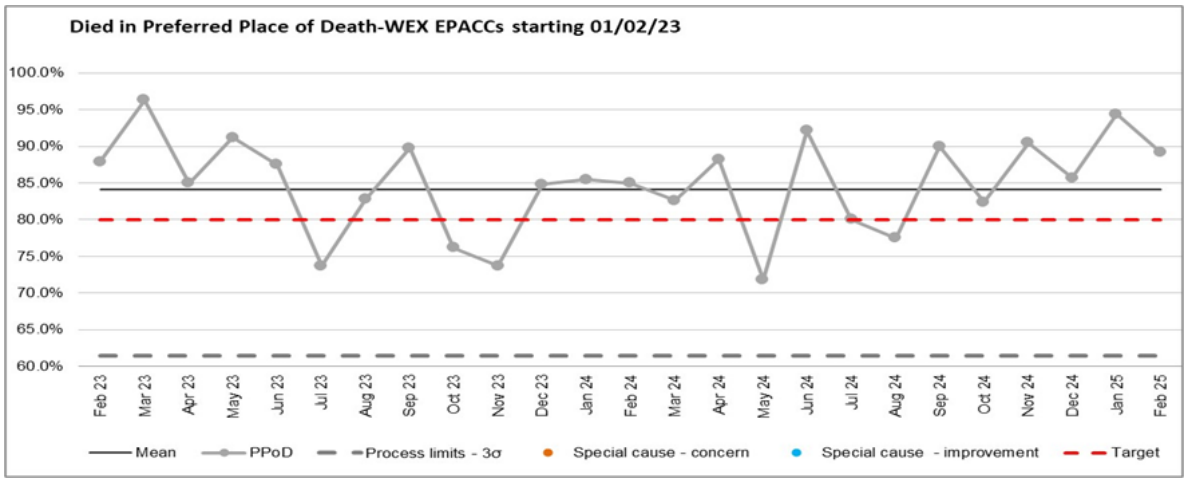


Table 2: Percentage of West Essex (WEX) residents dying in their Preferred Place of Death (PPD)

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
88.2%	71.8%	92.1%	80.0%	77.5%	90.0%	82.4%	90.5%	85.7%	94.4%	89.2%



There has been a fluctuation and decrease at times in the number of people dying in line with their PPD, but these are within common cause variation limits. Clinical insight has identified issues with timely Continuing Health Care (CHC) funding across Essex (also recognised nationally), which have been discussed at integrated care board (ICB) level. In such cases, there has been an increase in admissions because of lack of funding to support care at home. Reviewing the PPD data shows families call paramedics for falls, bleeds, heart failure and respiratory issues. Access to continuing health care (CHC) funding delays has therefore been added to the end of life care risk register along with identified mitigations due to the impact on admissions and discharges.

The tables below show referral trends into EPUT community services, monitored through the end of life care dashboard. The growth of frailty and dementia diagnosis is evident for patients in both south east and west Essex. The use of the FREDA template has increased our recording of data. This template supports a human rights-based approach in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy (FREDA).

These principles are the basics of good clinical care and underpin what clinicians already do on a daily basis. Monitoring also supports staff training needs.

Table 3: Palliative care referral data

South East Essex - Palliative care referral data	Apr 24 - Jan 25
Reason for Referral	2402
Cancer Sub-total	569
All other non-cancer diagnosis	46
Believed to be in the Last 12 Months of Life	86
Bereavement	0
Chronic renal failure (N18)	20
Chronic respiratory disease (J40-70)	77
Dementia including Alzheimer's Disease (G30 and other F00-03)	257
Frailty	524
Heart Failure	144
HIV Disease / Aids (B20-24)	0
Liver Disease	7
Motor Neurone Disease (G12)	10
Neurological conditions including MS and Parkinson's	33
Other heart and circulatory conditions (I00-I99 excluding I50)	9
Stroke	17
Blank	602
West Essex - Palliative care referral data	Apr 24 - Jan 25
Reason for Referral	1807
Cancer total	417
All other non-cancer diagnosis	88
Chronic renal failure (N18)	0
Chronic respiratory disease (J40-70)	97
Dementia including Alzheimer's Disease (G30 and other F00-03)	279
Frailty	777
Heart Failure	90
HIV Disease / Aids (B20-24)	0
Liver Disease	20
Motor Neurone Disease (G12)	6
Neurological conditions including MS and Parkinson's	11
Other heart and circulatory conditions (I00-I99 excluding I50)	15
Stroke	4
Blanks	3

Electronic palliative care coordination registers

Within our community services, there has been a growth in the number of people identified as palliative and registering for end of life care.

This has impacted on the capacity of teams caring for end of life care patients, both in terms of early identification of patients and the personalisation agenda to support patient choice.

These tables show the numbers of people identified as needing end of life care on the Electronic Palliative Care Coordination systems (EPaCCs).

Table 4: South-East Essex EPaCCs

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
2486	2535	2619	2657	2685	2730	2716	2730	2769	2747	2802

Table 5: West Essex EPaCCs

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
1007	1032	1039	1096	1109	1171	1202	1232	1262	1277	1318

Note: The register only shows people are currently alive and not those who have accessed services and died within the month reported.

The community End of Life Care and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) audits are complete, approved and have been shared across EPUT. The final quarter of the National Audit for Care at the End of Life (NACEL) was submitted in December 2024 - findings will not be available until collated and reviewed by the national team. From 1 January 2025, the Trust signed up to participate in a new NACEL mental health audit alongside the community adult NACEL audit, covering all expected inpatient deaths. We have submitted four patient records so far for the NACEL audit, one in mental health and three in community services.

2024 - Audit findings from Community audit

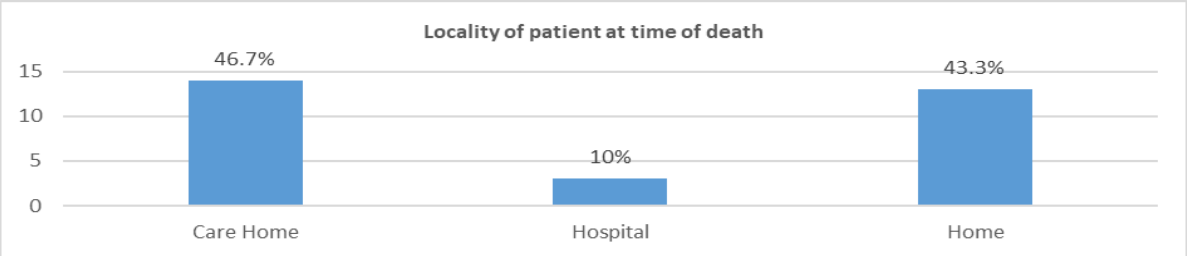
The audit for 2024 is now published. It reviewed 30 records of expected deaths of people who received end of life care in EPUT community teams and care homes. The rise in care home deaths also covers other residential care homes which our community nursing teams support.

The reduction in hospital deaths supports the PPD request of patients wanting to die at home or their usual place of residence.

This is a positive outcome and supported by care closer to home, in line with national guidance.

Locality of patient at time of death

Figure 2: Percentage of recorded locality in to review against a patient's preferred place of death



End of Life Care Champions

There are currently 69 end of life care champions across EPUT, covering different clinical disciplines in our specialist, community and inpatient/care home services. There has been an increase of **15%** in this reporting period.

Policy, clinical guidelines and standard operating procedures

The following have been updated in the year to support staff in preparing to care for people at the end of their lives with a personalised approach:

- End Of Life Framework 2025-27
- CG84 – Clinical Guideline for Care of Deceased Patient
- CG88 – Clinical Guideline for End of life
- Subcutaneous Drug Administration in Community Health Services by Patients, Carers and Relatives in Essex 2025
- DNACPR Standard Operating Procedure 2025.

Summary assurance statement

Partial completion

The aim of the end of life care dashboard has been to provide quantitative data to evidence end of life care service provision. The current dashboard has been developed to include data from community services for both adult physical and mental health services.

There is ongoing development to broaden the scope of the dashboard as the data is currently taken from the Electronic Palliative Care Coordination portals (EPaCCs) in both south east and west Essex. The current measurements reviewed all recordings of where people have died and if their preferred place of death (PPD) with care supporting their individual needs was met. This has included monitoring and reviewing all those deaths not in line with PPD, looking for trends or service-related issues. The end of life care dashboard for community services has been reviewed monthly by the end of life care steering group with discussion on trends and data collected.

The End of Life Care Steering Group has two lived experience ambassadors as core members. They both bring a different perspective of experience, expertise and enhance the meetings by sharing, questioning and supporting a grounded view of end of life services.

The community teams have used the iWantGreatCare platform to collect feedback from families of service users. It has proved difficult to extract end of life care evaluations and work is currently under way to help identify relevant feedback.

The palliative care, community inpatient wards and care home teams have sent out an evaluation of service questionnaires to bereaved relatives throughout the year - 24 responses were returned. Services also received many compliment cards and letters. Some of the comments themes received for staff who have been personally thanked include:

- They gave me time and support and couldn’t have done more.
- Staff were always sympathetic and listened to me, supporting me.
- I was supported and was happy with my mother’s care.
- They always gave us time which meant everything.

There are a number of national documents which support recommendations for high quality end of life care, and EPUT’s End of Life Care Framework (2025-27) has been written in line with these recommendations. Documents include:

- Ambitions for Palliative and End of Life Care (2021-2026).
- NICE guidance for end of life care (2019).
- Strategy for End of Life Care (2008).

The documents identify six ambitions and the actions required to achieve each one:

- Each person is seen as an individual.
- Each person gets fair access to care.
- Maximising comfort and wellbeing.
- Care is coordinated.
- All staff prepared to care.
- Each community is prepared to help.

Effectiveness - Priority 1

Improving physical health

Why was this a priority?

There is a significant gap in life expectancy between people with mental illness compared to the general population, and this is largely due to preventable or treatable physical health conditions. New data from the Office for Health Improvement and Disparities shows 120,273 adults in England with severe mental illness (SMI), including psychosis, post-traumatic stress disorder and schizophrenia, died before the age of 75 between 2018 and 2020. Of these, the Royal College of Psychiatrists estimated in 2023 that 80,182 deaths (two in three) were potentially preventable, an average of 26,727 people each year. Adults with SMI were between 2.5 to 7.2 times more likely to die before the age of 75 than adults without SMI. (Office for Health Improvement and Disparities 2023).

This difference may be partially due to health services not recognising physical illness in people with mental illness due to a range of factors, including:

- Service organisation.
- Skills and attitudes.
- Factors related to illness behaviours.
- Stigma.

Diagnostic overshadowing can also cause significant delays in detecting and managing conditions appropriately.

What did we say we would do?

We said we would improve recognition of early warning of acute health deterioration by increasing the numbers of staff who have:

- Completed NEWS2 training in the use of the National Early Warning Score 2 principles, achieving 85% compliance.
- Completed Intermediate Life Support (ILS) training, achieving 85% compliance.
- Been involved in post incident debrief and learning and working collaboratively with multiagency providers.

We also said we would improve the thematic analysis of deterioration and diagnostic overshadowing and the monitoring of numbers of patients who required emergency transfer.

Our expected outcome aim was to create baseline of cases of acute health deterioration to set improvement into 2025/26.

Did we achieve this?

Improved recognition of early warning of acute health deterioration

The following actions have been completed:

- Approved an adult inpatient 'non-contact physical observation' tool, and commencing work on adult, children and young people community versions.
- Delivered bespoke training sessions in CAMHS, inpatient and community teams on deterioration and resuscitation.
- Developed a Competency framework specifically for nursing staff working within mental health settings. The framework is a self-assessment tool which staff undertake, with signposting to education/experience to address any shortfall.
- Updated the DNA/CPR following system led changes.
- Embedded resus link practitioners within inpatient wards.
- Over 70 staff volunteered to become physical health link nurses; each inpatient ward now has a link nurse.
- Undertook a pilot on two wards for better management of secondary physical diagnosis, including workshops and introducing physical link

health practitioners on each ward with support from practice nurse educators.
- Formed a physical health priority task and finish group.
- Begun physical health competency framework and bite sized teaching pilots.
- Updated and shared resuscitation, deteriorating patient and NEWS2 clinical guidelines, including the addition of revised UK Sepsis Trust screening tools.
- Engaged with the University College London health innovation partnership to:
    - Support the mission to help five million people from North London to the Essex coast live longer, healthier lives.
    - Support ongoing Martha's Rule pilots in acute trusts, preparing to l link in with national developments in 2025/26 which may involve mental health trusts.

Completion of NEWS2/ILS training

During the reporting period, NEWS2 training was not included in the Trust's mandatory training tracker, so it has not been possible to reliably report on compliance. We have therefore recommended that NEWS2 training becomes an 'essential' element of staff training and work has begun to produce an EPUT specific online training module. With a target of 85% compliance for substantive staff, at February 2025 we had achieved:

- **89%** for Basic Life Support and Automated External Defibrillator (AED)
- **72%** for Intermediate Life Support.

Immediate life support figures remain below the expected compliance level whilst we remain dependent on external training resources. Our plan to develop an internal ILS faculty in this reporting period remains on hold, but a task and finish group has been created to address the funding issues and explore potential alternatives, which will continue into 2025/26. An additional phase of ILS external ILS training will provide continuity of training delivery until June 2025, with a trajectory to achieve compliance by June 2025.

Table 6: Resus Training compliance

	Overall Compliance		
	Total	Trained	
	Target	No	%
Basic Life Support and AED	3,942	3,496	89%
Immediate Life Support	1,020	739	72%

There is additional face to face training for bank staff for Basic Life Support and AED and Immediate Life Support, currently running at **70%** and **46%** respectively.

Completion of post incident debrief

Face to face support has been provided to clinical teams following five inpatient deaths, including teams participating in structure debriefs facilitated by the Resuscitation Council UK.

Multiagency provider services working collaboratively with EPUT

Whilst this approach was initially pursued, it could not be achieved because of constraints on all parties involved. Instead, we have sought feedback from colleagues at the East of England Ambulance Service NHS Trust following episodes of patient deterioration. Feedback has included:

- *A patient deteriorated, and ambulance crew were called for. The patient was stabilized but as the paramedic arrived, the health care assistant (HCA) and paramedic witnessed them crash and implemented CPR together. The HCA had only ever done this before in training. The paramedic and ambulance crew fed back how equipped and trained staff were. There was quick action and a well stocked Resus bag, with plenty of Oxygen. Staff were a credit to the service.*

Create baseline of cases of acute health deterioration to set improvement into 2025/26

We have started work on identifying the number of emergency transfers to acute hospital.

Thematic analysis of deterioration and diagnostic overshadowing

We carried out a thematic review of eight non-patient safety incident deaths amongst EPUT inpatients/those who had died within 30 days of discharge where their death was due to physical health causes. Dates of death ranged from June 2022 to February 2024. There were no deaths where concerns about care or patient safety incidents had been identified as part of the review.

There were areas of good practice identified for every patient reviewed, including:

- Staff recognising deterioration and arranging transfer to acute care.
- Evidence of good communication with next of kin throughout the case notes.
- Appropriate assessment and management of the patient's physical health during their admission.
- Evidence of an EPUT clinician challenging to an acute trust when they felt a patient was not medically fit for discharge.
- Effective management of a choking incident.

The eight patients within this review were all long-term in-patients with significant lengths of stay prior to their deaths. All had a wide range of physical health comorbidities, some of which were complex. Six deaths occurred in an acute trust within 24 hours of transfer. Two occurred in EPUT wards, were sudden and unexpected and were managed effectively.

Key areas for development identified in multiple reviews are:

- Full and accurate completion of fluid balance charts.
- Full and accurate completion of NEWS 2 charts, coupled with the use of the non-contact physical health observation tool whenever a patient is asleep or declines their physical observations being taken.
- Undertaking dedicated MDT physical health reviews and escalation/treatment plans within 72 hours of admission.

Other areas for development are:

- Raising awareness swallowing problems, nutrition, hydration and continence.

- Ensuring record are kept of local training given on identification of an issue, with processes to ensure that all staff, including those not present at the time of any local training session are also briefed.
- Ensuring that communication around the patient's deteriorating physical health condition is clear and concise and understood by family.
- Availability of on-site doctors to certify deaths in a timely manner, avoiding need to call ambulances, if possible, where DNACPRs are in place.
- Continue to raise awareness of and minimise risk of sepsis and COVID-19 infection and to manage these illnesses appropriately on identification.

This work will be continued via our care units and physical health work stream, and much of it is already ongoing or is planned.

Summary assurance statement

Partial completion

Although not all priorities were achieved, we have seen sustained improvements and significant work has been undertaken to drive forward our improving physical health agenda.

This remains a priority for 2025/2026, where there will be specific focus on our use of early warning scores, the introduction of structured clinical assessment, escalation and communication algorithms and the use of immediate clinical measures.

Effectiveness - Priority 2

Suicide prevention

Why was this a priority?

The Five Year Forward View for Mental Health (2016) set out an ambition to reduce the number of suicides in England by 10% by 2020/2021. This remains a national ambition and is reaffirmed through the NHS Long Term Plan. The NHS Long Term Plan highlights particular issues which also align with our own strategic objectives related to suicided and self-harm:

- Transitions between child and adult services.
- Crisis care, including post crisis support.

- Support for those who self-harm.
- Reduce inpatient suicide to zero and the overall suicide rate by 10% year on year.

The approach also mirrors EPUT's aims to promote recovery through inclusivity, least restrictive practice and trauma-informed care.

Guidance, research, and modelling that underpin this priority includes:

- NICE Suicide Prevention (QS189) and Self-Harm (CG71) Quality Standards and Clinical Guidance.
- The Zero Suicide Alliance objectives.
- The Safewards approach.
- CQC standards for mental health.
- The Mental Health Act.
- World Health Organisation objectives.
- Towards Safer Services (2022) recommendations.
- CQC quality statements (2023).
- CQC Reducing Harm from Ligature in Mental Health Wards (2023).
- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (2024).
- Self-harm is a related priority given the link between self-harm and suicide (Aggarwal, 2025; Chan 2016; Hawton, 2015).

What did we say we would do?

We will provide psychological support for people who repeatedly self-harm, improve trauma aware care planning and an aim to achieve a 10% reduction of non-fixed ligature incidents in inpatient areas.

Did we achieve this?

We built on our previous suicide prevention work and relaunched our suicide prevention steering group, setting aims to support the delivery of trauma-informed care and a psychological response to self-harm to support reduction of self-harm incidents by non-fixed ligature in inpatient settings.

We agreed to measure:

- Number of non-fixed ligature incidents in inpatient areas.
- Number of completed personalised care plans.
- Documented offer of psychological support following an incident of self-harm.

The table provides more detail.

Table 7: 2024 Suicide prevention plan

2024	Summary of plan
Quarter 1	• Establish the TOR and ensure that the right people are attending the steering group. • To review the intelligence to establish the key priorities linking in with the wider picture • To secure regular streams of data. Including STORM training figures.
Quarter 2	• Explore neurodiversity, LGBTQ, to see if there is any data to support if there are higher prevalence's of suicide within these particular groups. • Purposeful admission, linking with high intensity service users with increased self harm and suicide attempt. Is admission helpful for these people. How do we manage risk at that stage and how does risk present itself. Purposeful admission.
Quarter 3	• Quality of interventions when discharged/follow up, peer support, psychological intervention. • To review risk assessments and assess their validity.
Quarter 4	Review the impact of the year To set year 2 priorities To set our parameters to be able to evaluate year 2.

Psychological support for people who repeatedly self-harm and trauma-informed care planning

We performed a deep dive review to establish where we are currently. We completed a self-harm audit to establish what training is currently available for supporting a psychological response to incidents of self-harm, which identified training needs in a range of settings, including inpatient wards. We then developed a baseline for current activity, which now requires input from our suicide prevention steering group to finalise the defined target group.

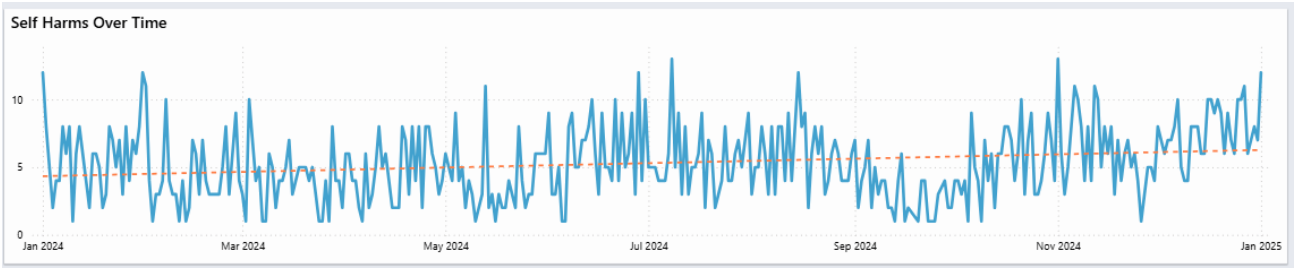
We developed a trauma-informed project plan to deliver trauma-informed care and care planning across all our services, recruiting a dedicated consultant psychologist via a secondment to support the plan.

Example of patient artwork as part of ward therapeutic activity

10% reduction of non-fixed ligature incidents in inpatient areas

In the reporting period, data shows that the method of ligature risk presentation is changing; there has been a **significant reduction for fixed ligatures** in Datix reporting, but an **increase in non-fixed ligature** incidents. However, the levels of harm indicated in these incident reports has reduced, despite the increase in the number of non-fixed ligatures reported in the last 12 months. We have also seen that by implementing individualised care interventions, there is an increase in no/low harm outcomes for attempted ligature in inpatient settings.

Figure 3: Self-harm incidents over time 2024



Over the last year, **99% of self-harm incidents** were reported as **no/low harm** across all ligature incidents (fixed/non-fixed). Of the ligature incidents reported in 2024, only **0.52%** were reported as fixed ligature incidents. During the reporting period, the highest reporting wards were consistently our three CAMHS tier 4 wards.

Work has been undertaken within the Specialist Services Care Unit to understand what interventions are in place, as well as to consider the support required for improvement.

In 2025/26, we will be working as part of a national QI collaborative, led through the National Patient Safety Forum. Ligature risk reduction and reduction in wider self-harm activity across our services requires the continued focus of different strategic groups. This approach will help fully realise the improvement and culture change we are seeking. This will be overseen by our suicide prevention steering group, which will continue to monitor reduction in self-harm non-fixed ligature activity.

Summary assurance statement

Partial completion

In the reporting period, we have developed a well-established steering group co-chaired and co-delivered with our lived experience ambassadors. We have successfully gained wider attendance from system partners to enable joined up working that supports alignment with local and national activities.

We have worked to develop a more detailed data set reflecting the demographics of EPUT populations relative to incidents of suicide and self-harm, which will be included the Quality Dashboard during 2025/26.

Our steering group prioritised a series of 'deep dive' areas where we sought assurance regarding the progress of actions intended to deliver improvement. These included presentations from:

- Our NHS Talking Therapies team on the higher number of reported deaths registering in these services, as well as themes identified and actions taken.
- Colleagues at National Rail on a thematic analysis that identified areas of concern across Essex regarding completed or attempted suicide at railway stations. This enabled triangulation with EPUT safety alert calls and improved working across sectors to reduce risk.

We achieved our target of training 60% of registered staff in STORM suicide risk and management skills across our urgent care services. We have worked to develop a risk assessment plan and safety planning approaches for 2025/26, which includes an options appraisal for future Trust-wide training of staff.

We also co-produced our case for change for the Trust's move from risk stratification to a more personalised approach to risk and safety planning, which will be taken forward into 2025/26.

Effectiveness - Priority 3

Medicines optimisation

Why was this a priority?

Medicines continue to be the most common therapeutic intervention in healthcare and play a critical role in maintaining health, preventing illness, managing chronic conditions and curing disease. It is estimated that over 2 million doses of medication are scheduled for administration each year within EPUT inpatient wards alone. The total cost of medicines to the NHS in England in 2022/23 was £19.2 billion, an increase of 8% on the previous year. Approximately 49% of that expenditure relates to prescribing in hospitals. Annual expenditure on medicines within EPUT is around £5.9 million each year.

Pharmacy staff are involved in reviewing individual patients' medication regimens to ensure that they are safe, appropriate and clinically effective; liaising with and providing advice to prescribers; supporting patients to get the most from their medicines, as well as ensuring timely and consistent supply of medicines. Many of our pharmacists are non-medical prescribers and can prescribe medicines directly.

Wider duties of our ward- and community-based staff extend to ensuring that medicines handling processes within the Trust meet the consistently high standards expected, providing training and supporting problem-solving on a regular basis. Every year, our Pharmacy team makes over 10,000 clinical interventions to ensure the best possible results for our patients, advising on dosing, allergies, side effects and potential interactions with other medications.

The NHS Mental Health Implementation Plan identified the need for additional mental health pharmacist posts working in the community to support patients with severe mental illness. Over the last three years, new pharmacist posts have been created as part of the transformation. Demand for pharmacy services is recognised to be growing, with a resulting shortage of pharmacists and pharmacy technicians. This makes it difficult to fill vacancies and retain staff, making it important that we do everything possible to make EPUT an employer of choice for pharmacy professionals.

To meet the growing need, the NHS Long Term Workforce Plan proposes expanding numbers of training places for pharmacists by around 50%, with increases also in pharmacy technician training places. This provides

the opportunity for the pharmacy department to host trainees as part of a 'grow your own' approach to recruiting staff in the future.

What did we say we would do?

We said we would enable pharmacy team members to spend time counselling patients about their medicines, by:

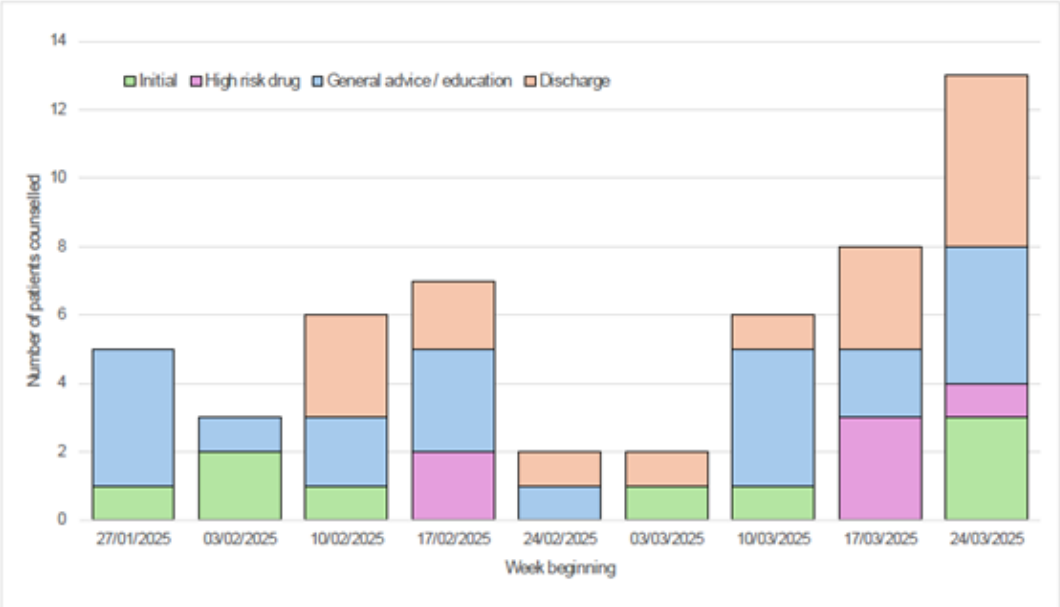
- Improved pharmacy technician availability through time released as our electronic prescribing and medicines management system (ePMA) was rolled out across mental health inpatient wards.
- Increasing pharmacy technician time through implementation and recruitment of Year 1 posts within the Time to Care programme.
- Measuring activity data showing the number of medicines counselling sessions offered and taken up.

Our expected outcome aim was to create a baseline of improved medicines adherence through better patient understanding of medicines, and to set improvement into 2025/26.

Did we achieve this?

The roll-out of ePMA to inpatient mental health wards took place across the reporting period and was complete at the end of February 2025. This has resulted in more pharmacy technician time being freed up to undertake patient counselling.

Figure 4: Medication counselling rates from January to March 2025

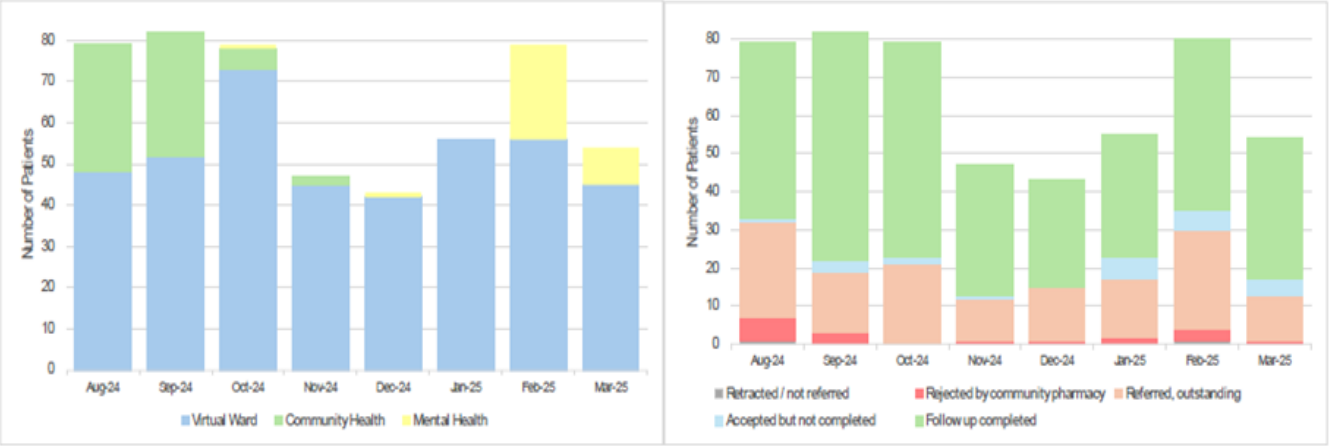


A pharmacy standard operating procedure has been developed for patient medication counselling and staff training and competency assessment is underway with a deadline of the end of March 2025 for completion.

During February 2025, 18 patients were counselled about their medication, covering topics such as monitoring requirements, side effects and patients' beliefs and views about taking medication. Emphasis has been placed so far on high-risk medication such as lithium and valproate. Numbers are expected to increase over the coming months.

Referrals by pharmacy staff to the national Discharge Medicines Service provided by community pharmacies have also started for suitable patients leaving mental health wards. During February 2025, 23 such patients were referred, and numbers are expected to increase over coming months.

Figure 5: Patient referrals April-24 to March 25.



We also recruited to the following pharmacy posts through the Time to Care programme:

- 3 WTE advanced clinical pharmacists at band 8A – all in post at October 2024.
- 2 WTE pharmacy technician band 4/5 – one in post at February 2025 and one offered a start date in April 2025.
- 4 WTE pharmacy support workers at band 3 – all in post at November 2024.

Summary assurance statement

Complete

During the reporting period, the Pharmacy and Medicines Optimisation Strategic Plan 2024-2028 gained board approval and launched in Quarter 3, providing the Trust with a framework of key priorities and measures to continue to deliver over the next four years. The Medicines Management Group has provided monthly assurance to the effectiveness of care executive group to highlight achievement and provide assurance. The approved Pharmacy and Medicines Optimisation programme of work will continue reporting bi-annually to Quality committee - there will not be a specific quality priority set for 2025/26.

Quality of Care Strategy - Year 1 Programme Evaluation

In April 2024, we EPUT launched our Quality of Care Strategy with a programme plan for delivery over three years to April 2027. The Quality of Care programme provides a clear focus on developing the golden thread of keeping quality at the heart of all our services. Three pillars of *Experience, Effectiveness* and *Safety* drive the quality approach and contribute to Trust wide empowerment, learning and improvement.

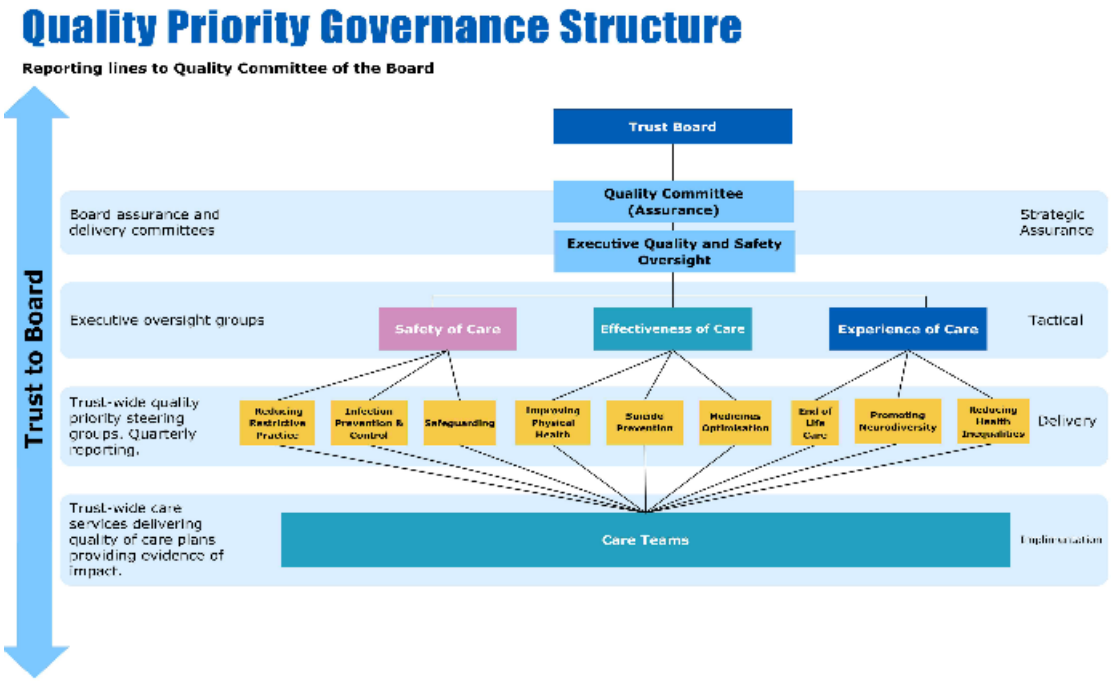
The strategy was co-produced, taking a "start with people" approach with extensive engagement with the people we care for, their loved ones and supporters, our local communities and our staff and systems partners. During its development, we identified first year quality improvement priorities and have implemented them using a quality assurance framework approach:

- Developing annual plans.
- Using quality improvement methodologies.
- Identifying measurement controls.
- Agreeing expected outcomes.
- Triangulating evidence assurance methods to review impact.

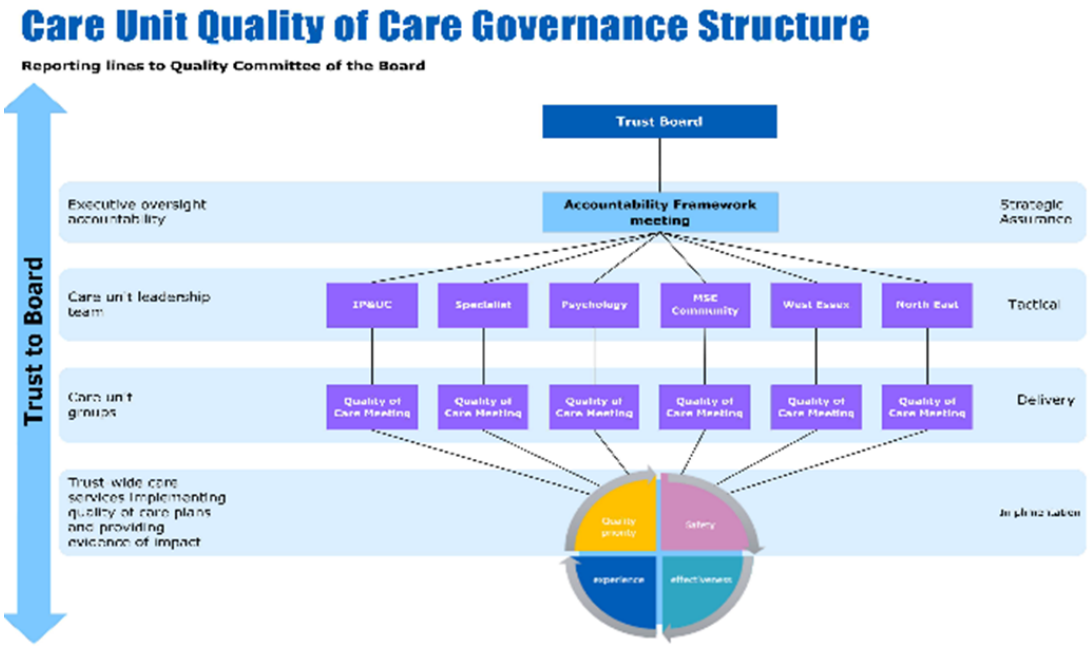
Each quality improvement priority has been managed by a Trust-wide steering group, which is co-led with lived experience ambassadors and clinical leads to ensure the continued importance of co-production principles. We have aimed to develop a "figure of 8" communication approach of quality insight, quality improvement and evidence which is reported through local care unit quality of care meetings, quality steering groups, executive oversight groups and Board assurance committees, aiming to promote bi-directional feedback mechanisms. Each Quality Improvement priority steering group has set areas of focus with our Council of Governors for this Quality Accounts. We have also developed driver diagrams with agreed primary and secondary drivers and change

ideas to monitor impact. The following structures show how our plans are designed to achieve lasting improvements.

Figure 6: Governance structures



The Quality of Care Strategy has had a strong focus in its first year on



ensuring that structures and processes to support quality and clinical governance are embedded. This recognises that governance structures are essential for escalating information in ways that are sufficiently timely, useful and clear.

By continuing to develop accountability frameworks for each care unit with executive oversight, we have seen more of our teams adopting data insight to better understand the quality of services. There is more work to be done to ensure greater focus on the validation and triangulation of information, so that quality issues can be resolved quickly and learning can take place, along with the monitoring of quality outcomes and the impact of the quality improvements being made by teams delivering care.

The creation of a quality governance framework supports quality assurance into the Board's Quality Committee, and provides executive oversight for experience, effectiveness and safety.

The Quality of Care Strategy also provides a quality foundation for the Trust's Operating Model based around six clinical operational delivery units, led by multi-disciplinary and multi-professional leadership teams. Investment in this approach ensures the leadership model supports a strong clinical voice, with clinical quality at the centre of every decision made.

Safety of Care

There were five key areas of focus in year one of the delivery plan. Delivery against each is described below:

- An **updated Trust policy for the Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP) for the next two years** was published at the end April 2025 and made available on our website – 100% achieved.
- An **electronic platform to support our culture of learning plan** is being tested with our urgent care and in-patient care unit, with the aim of rolling it out Trust wide. The platform helps staff to undertake thematic analysis and support shared learning in practice – 100% achieved.
- Whilst we have previously held **annual safety conferences** with partner organisations, we are now moving towards **quarterly learning events** which triangulate the pillars of quality with examples from practice to enhance Trust wide learning. The first of these was held in April 2025.

- **Safety of Care Group meetings** have run successfully each month from May 2024 – 100% achieved.
- The **work plan for the Safety of Care Group has been developed**, and our safety team are undertaking thematic reviews of patient safety incidents to finalise our 2025-27 PSRIP – 100% achieved.

Effectiveness of Care

There were nine key areas of focus in year 1 of the delivery plan. Delivery against each is described below:

- **Eight topics that were proposed following Quality of care development workshops gained Quality Committee agreement** for the Clinical Senate to review – 100% achieved
- Eight **Clinical Senates** were planned and five were held in 2024/25 – 75% achieved
- **Our Quality Impact Assessment process and document has been reviewed and updated** and has been in use since September 2024. This has now been shared with and adopted for across the Mid and South Essex Community Collaborative, driving consistency of approach with our system partners – 100% achieved.
- **Establish a process to review all existing clinical guidelines and clinical policies** – a group has been established to review and ratify new and updated clinical guidelines and ensure alignment with NICE guidelines and the use of the EPUT Clinical Senate – 25% achieved.
- **Our Quality Assurance Framework was established** and our nine quality priority leads have adopted the elements in their annual work plans. This provides clear planning, quality control, quality assurance and the utilisation of quality improvement methodologies – 100% achieved.
- **Design an effectiveness element in our Quality Power BI monitoring dashboards** - requirements are being scoped and tested to be launched in 2025/26 – 20% achieved.
- **Effectiveness of Care meetings** have run successfully each month from May 2024, as part of our **new governance meeting structure** – 100% achieved.
- Our **work plan for the Effectiveness of Care Group** has been developed ad socialised - 100% achieved.

- We have yet to hold **an Effectiveness Grand Round** - this will now be held at the end of the 8-topic senate completion in year two – not achieved.

Experience of Care

There were five key areas of focus in year one of the delivery plan. Delivery against each is described below:

- **Launch a new governance meeting structure** - the Experience of Care Group held seven meetings during the year – 100% achieved
- **Socialise the experience of care work plan** – some work was delayed – 75% achieved.
- **Hold co-production events** – a successful co-production conference was held in October 2024 – 100% achieved.
- **Launch the national 10 point dignity challenge** – we piloted the challenge in our two dementia care homes, with evaluation planned in the coming year to inform a wider rollout – 25% achieved.
- **Update the iWantGreatCare questionnaire to include "feels like" questions** – this is now planned for the coming year, following a pilot in our dementia care homes – not achieved.

Quality of Care programme year one evaluation and next steps

Our approach to adopt quality management principles in the first year of the programme was to focus on:

- **Design** of our quality governance structures.
- **Build** our quality capabilities.
- **Deploy** plans and change ideas to measure impact.

We said we would establish baseline data to demonstrate future impact of the strategy, and that year one would focus on a quality reset with a socialisation programme to drive a movement of change, creating the evidence base and methodologies to measure quality outcomes.

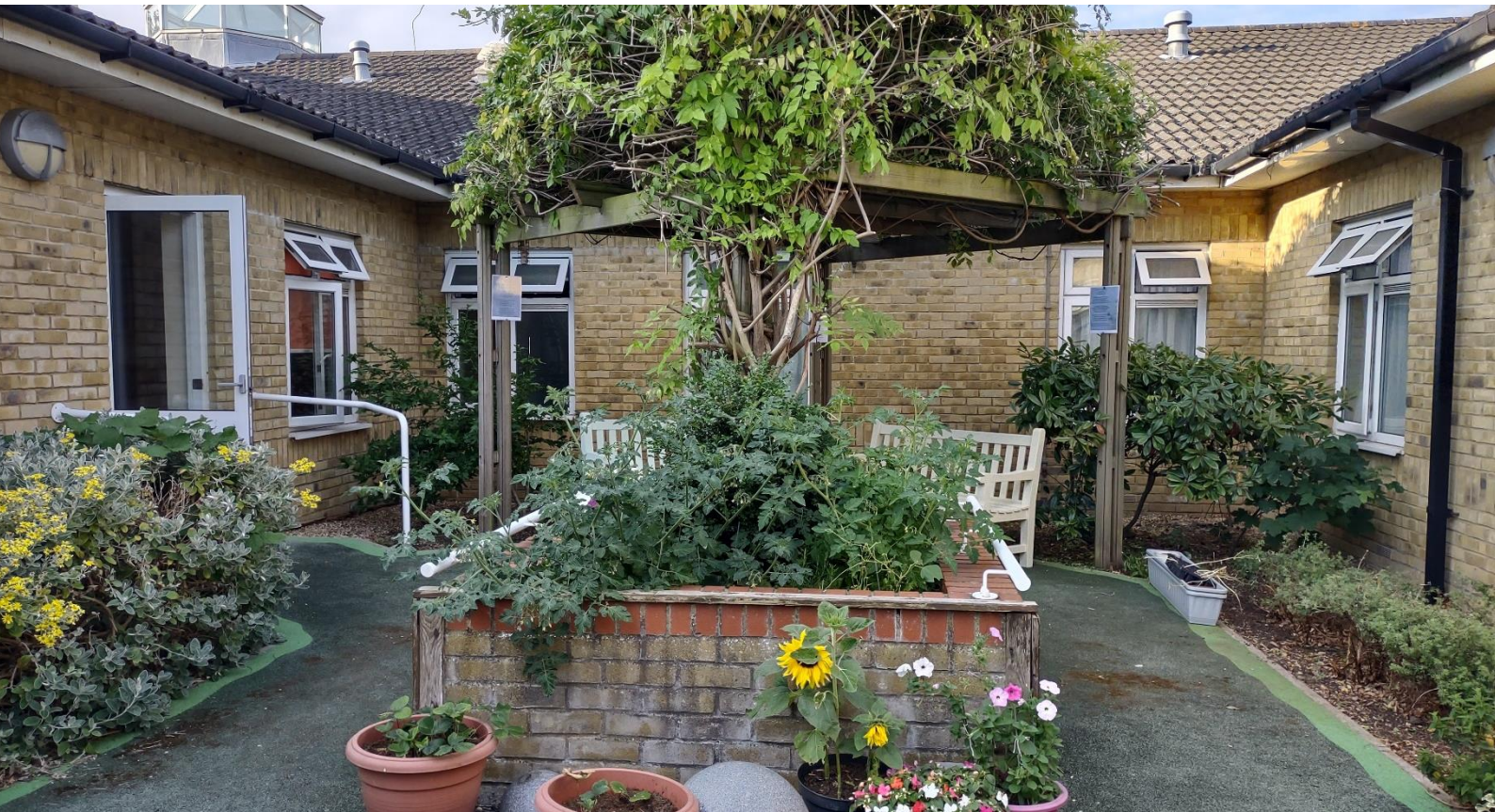
We have made some progress against these aims. However, it is important to recognise that there are areas where progress has been limited, in particular, the readiness of a quality dashboard to support our establishment of baseline data.

Where data has been available, it has required a significant amount of manual triangulation, finding data from a variety of sources to support clinical insight and decision making.

The majority of data currently available supports performance monitoring rather than quality outcomes, and does not enable us to thematically review care using population protected characteristics. We have made progress which enables us to launch a first level quality dashboard early in 2025/26, which will be supported by collaboration with NHS England as part of its mental health, learning disability and autism transformation programme. We are also participating in a national pilot to develop early warning signs in mental health services. Both pieces of work will enable us to benchmark locally and regionally against nationally agreed quality indicators in future.

During 2025/26, we will utilise the NHS Improving Patient Care Together (IMPACT) self-assessment baseline data to evidence where we are as a Trust in terms of people partnerships, competence, leadership and evidence base. This gives importance to an approach that is inclusive and representative of all those who deliver care. The results will guide our continuous improvement. We will also take learning from the national Mental Health Intensive Support Teams' work with mental health services in Manchester.

Also in 2025/26, our quality governance arrangements will change to bring together the three executive led groups into one executive led Quality of Care oversight delivery group. This will build on considering the three pillars of quality together, to provide greater triangulation of experience, effectiveness and safety of care.



2.2 Quality improvement priorities for 2025/26

To help set out our quality priorities for the coming year, we held a Quality Conversation workshop in February 2025 with staff, patients, experts by experience and key partners, to ensure we continue with our commitment of a co-produced approach.

Throughout the coming year, we will continue to follow our Quality Assurance Framework (QAF), , providing a structure and measures for success to understand what works best to make our services better for our service users and staff.

To evaluate our success, we will be using appropriate QI tools identified through each step of the QAF to enable a structured QI approach and monitoring of sustainability and the impact of changes. This will be shared widely throughout EPUT.

Figure 7: Quality Planning

What is Quality Planning?

- Uses existing data to define quality priorities
- Builds on issues that are important to people we care for their loved ones and supporters, our staff, Board and system partners.
- Aligns with the Trust strategic objectives, legal frameworks, national, regulatory and best practice
- Uses recommendations and learning from quality improvement to date.

What is Quality Control?

- A set of tools, processes and checks to monitor impact against agreed standards
- A marker for following best practices and indictors of quality from a day to day perspective.
- Are conducted by those who are doing the work

What is Quality Assurance?

- Are processes used to ensure and provide confidence through various evidence sources
- Quality Assurance includes assessment, triangulated evidence and reflection on quality.
- Informs quality improvement areas across the Trust.

What is Quality Improvement (QI)?

- Is the systematic use of tools to continuously improve quality of care and outcomes for patients.
- Includes key principles such as training staff in QI approach, using data to understand areas for improvement and empowering staff to act on ideas for improvement.
- QI methods can work in discrete projects, as well as organisation-wide to ensure continuous quality improvement at scale.

Trust conditions for success

Quality Priority Overarching: Culture and Competence

Why is this a priority?

To create the conditions for what we need to achieve, we will set out a culture and competence Quality Priority that crosscuts all our proposed priorities. This will align with the Quality of Care strategic delivery plan which details a key focus of creating cultural readiness, bringing people together to develop a movement of change over the three year life of the strategy. The national Mental Health Improvement Support Team (MHIST) have identified consistent conditions for success, drawn from four years of working with mental health trusts. Below summarises the conditions and will provide the template for EPUT to first benchmark against and then set trajectories for implementation and adoption. This priority will be led by our executive team, who remain committed to ensuring that quality of care drives everything we do.

Figure 8: Conditions for success

End of assignment report: Greater Manchester MHNHSFT (March 2025 MHIST)

Experience

Quality Priority 1: Reducing health inequalities

Why is this a priority?

The NHS Long Term Plan articulated a need to take a more systematic approach to reducing health inequalities. Our Working in Partnership with People and Communities Strategy was developed and agreed in 2023. It aims to address health inequalities across our services and work with our system partners to reduce health inequalities and improve population health - developing population health management and recognising our role as an anchor institution in Essex. This quality priority builds on the progress made to date to embed the Trust's approach to health inequalities.

What will we do	How will we evaluate success

Improve access, experience and outcomes for:
• Black women within mental health perinatal services across Essex:
  ○ Pathway development
  ○ Access routes
  ○ Co-production
• Men from global majority backgrounds within mental health community services in Mid and South Essex: 'COMPASS' pilot
	• Improvement trajectory monitored through Quality Dashboard
	• Focus groups feedback (Q1, Q4)
	• Measure using agreed perinatal outcome tools
	• Peer review
	• Measure Dialog Plus outcomes – delivering a reduction in crisis presentations and admission to hospital

Improve data collection across the Trust so that we can: • Perform meaningful thematic analysis • Establish our areas of focus to inform further projects to increase access to our services	• Through thematic review of ethnicity data to understand groups who may be underserved

Promote smoking cessation – focusing on inpatient mental health wards: • Ensure that all patients have access to trained smoking cessation advisers • Ensure patients can access smoking cessation support following discharge from inpatients to community settings • Explore the Use of peer support partners to evaluate success of interventions on smoking cessation habits in inpatients patients • Explore recording mechanism for smoking activity • Ensure our new unified electronic patient record (UEPR) captures data	• Audit documented and displayed ward smoking cessation leads • Training compliance for those identified to provide advice • Spot check audit on patients admitted as using nicotine who are discharged at six weeks to assess smoking status • Evidence that feedback and involvement from patients and peer support partners has supported evaluation and improvement • UEPR pathways complete

Quality Priority 2: Patient experience with PSIRF

Why is this a priority?

We will develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in a high-level patient safety learning response. This will be based on the NHS England/Health Services Safety Investigations Bodu *Learn Together* document, outlining the nine principles of engaging and involving patients, families and staff following a patient safety incident. We will co-produce with our Patient Safety Partners suitable tools to capture patient experience and improve our understanding of this part of the patient's journey.

What will we do	How will we evaluate success
Develop an improvement plan for compassionate engagement of patients, families and carers who have been involved in patient safety incidents where there has been harm	Evaluate the impact of the improvement plan, specifically: • Duty of Candour data captured in the Datix incident management system

• Trust-wide communication about the role of engaging and involving patients following a patient safety incident, and the importance of this commitment • Support Patient Safety Partners (PSPs) to contribute to this work through the development of the improvement plan and tools to capture patient experience • Ensure PSPs with relevant interest and skills are allocated to each care unit in line with the Level 4 Patient Safety Partner framework, with a specific remit to contribute to this Quality Priority • Co-develop tools with PSPs tools, reviewing available tools to gather feedback from patients and families following involvement in a patient safety incident • Develop a standard operating procedure (SOP) highlighting how to request feedback on the involvement experience • Scope other sources of information that can provide insight into patient and family experiences following investigations, for example through online forums or legal claims following an investigation	• Compliance with Duty of Candour training • Training provision for engagement leads • Alignment of PSPs to each care unit. • Evaluating survey results using the Health Services Safety Investigations Body (HSSIB) Principles of Effective Engagement (adapted version) and face to face meetings • Evaluate staff feedback to review confidence and competence through gaining feedback • Thematic review of feedback forums and how data can be used to improve engagement

Quality Priority 3: Experiences of neurodivergent people, families and carers in inpatient care

Why is this a priority?

Neurodiversity describes different thinking styles that affect how people communicate with the world around them. It is an umbrella term that includes conditions like autism, Attention Deficit Hyperactivity Disorder (ADHD), dyslexia, dyspraxia, dyscalculia and Tourette's. Approximately 1 in 7 people in the UK have some kind of neuro difference. Being neurodiverse does not correlate with low intelligence. Evidence suggests that Neurodiverse people are less likely to access healthcare, leading to premature mortality and risk to their health and wellbeing. Many people who do access care can face interventions which result in restriction and may be disproportionate, ultimately leading to compulsory treatment with poor outcomes.

The Trust's Quality Senate has reviewed current publications, best practice documents and presentations from subject experts to make recommendations for the Trust to take forward into 2025/26 to improve care – in particular trauma informed care, neurodivergence and personalised care.

What will we do	How will we evaluate success
Use trauma-informed and least restrictive clinical and environmental approaches • Trauma informed development implementation through the feasibility and adoption of recommendations from the Quality Senate and trauma informed transformation plan	• Use the Roots assessment tool in Q1 and Q4 for baseline and trajectory setting and achievement • Observational study of staff demonstrating trauma-informed, neurodivergent-affirming approaches in practice as part of quality visits • Patient and carer evaluation, led by lived experience ambassadors
Train staff in neurodivergent-led practices to support needs-based care, including: • National autism training program • Oliver McGowan training (levels 1 and 2)	Evaluate staff training and culture change by: • Monitoring staff training compliance • Evaluating staff, patient and carer appreciative enquiry

• Practitioner skills training	• Tracking incidents where lack of knowledge/skills are included in the learning
Develop an improvement plan for neurodivergent young people using inpatient CAMHS services, their families and carers to reduce restrictive practices by promoting collaborative care and family involvement. Draft an improvement plan with contributions from young people and families, to include: • The involvement of the young person and their family/carers in personalised care and safety plans that discuss de-escalation techniques for distressing behaviour • Development of standardised high quality behaviour support plans to provide families and staff with strategies to help reduce risks when challenging behaviours occur, along with other strategies to help people behave in non-challenging ways and reduce the need to use restrictive practices • The employment of a peer support worker • The use of advanced care and safety plans, including sensory profiles and communication passports • The offer of flexible visiting policies that allow parents/families to be active participants in their young person's care • Assessing the experiences of young people and families	• Patient reported outcomes • Surveys, interviews or visual rating scales to measure feelings of safety, autonomy and well-being. • Audit of behaviour support and individualise care plans to demonstrate improved involvement to meet care needs • Family/carer satisfaction surveys on involvement in care and perceived impact of changes • Hold regular family forums or focus groups to understand concerns and areas for improvement • Track family complaints, compliments and formal feedback related to restrictive practices

Effectiveness

Quality Priority 4: Suicide prevention

Why is this a priority?

The Trust will move away from the current risk assessment that uses RAG ratings to demonstrate acuity to personalised safety planning. This is in response to the Health Services Safety Investigation Body (HSSIB) Interim Report (2024) on Learning from Deaths and Near Misses in Mental Health Services, which recommends the implementation of suicide risk and safety planning by March 2026. We have identified by thematic analysis of incidents and from coroners' reports that outcomes of individuals who died due to suicide had been risk assessed as green in the lead up to the event, or were deemed not clinically appropriate for admission. The Trust has mandatory risk assessment training in place with Skills Training in Suicide Prevention and Self-Harm Mitigation (STORM) offered in addition. STORM is an evidence-based course, which enhances the skills necessary for staff to effectively support individuals who self-harm and who may also present with suicidal ideation in a more personalised way. The Trust is now working with colleagues at North East London NHS Foundation Trust (NELFT) and East London NHST Foundation Trust (ELFT) who have already implemented safety planning to learn lessons from their experience before full implementation and to assist it plans with this change.

What will we do	How will we evaluate success
Finalise and submit our case for change to move towards personalised risk assessments and safety planning. This will include: • Reviewing Trust risk assessment policy and creating best practice clinical guidelines • Reviewing Trust training programme • Developing impact measures in relation to Trust-wide changes	• Confirm completed submission by the end of April 2025 • Monitor achievement of in year key milestones against a developed project plan • Agree impact measures that will be included within our assurance reports to monitor impact and the progress of this particular work stream
STORM training • Increase training compliance to 75% for all registered clinicians	• Confirm finalised process for compliance information and monthly compliance figures

within community, urgent care and inpatient services • Increase training capacity across the Trust by developing a sustainable training plan to deliver our target • Develop compliance and heat map for training uptake	with a heat map/trajectory across the Trust • Complete delivery of the training plan
Self-harm reduction • A reduction in fixed and non-fixed ligatures across our inpatient wards by 10%.	• Monthly monitoring of related incidents • Deliver the reduction by April 2026 • Develop a trajectory to monitor progress throughout year 2

Quality Priority 5: Reducing inpatient falls

Why is this a priority?

People who fall in inpatient settings can experience significant and potentially preventable causes of morbidity and mortality, especially if falls for elderly patients result in femoral fractures and intracranial haemorrhage. Key to reducing the risk of falls in hospital is a multifactorial risk assessment followed by action to address each falls risk factor identified. Early assessment of a person with a suspected severe injury is also important following a fall, to ensure timely and appropriate analgesia, investigations and management. This quality priority focusses on strengthening training on and implementation of the multifactorial falls risk assessment, addressing key areas for improvement identified in the National Audit of Inpatient Falls and local Trust audit findings by strengthening assessments and information sharing following a patient falling.

What will we do	How will we evaluate success
Falls prevention: • Review clinical guidance and education in accordance with national best practice • Review and develop the falls prevention e-learning training	• Confirm current guidance and eSOPs in place • Complete NICE quality standard audit and action findings • Monitor compliance with the current falls training through

for all staff. Ensure patient stories are included for shared learning
• Provide accessible versions of falls and bedrails leaflets
• Offer dedicated strength and deconditioning training to core staff groups
• Falls Review Group to evaluate and determine if the current package is to be maintained or a new version created, including patient stories for learning
• Review falls assessment tool and care plans for adults and ensure alignment to UEPR development
• Employ QI approaches to increase the number of risk assessments pre and post falls across mental health and physical health inpatient wards
• Robust review of recent national and local audits of inpatient falls and compliance with actions
• Strengthen the use of falls data at local level
• Care unit falls lead to provide expert support to areas under a 90% audit compliance trajectory
• Optimise the use of assistive technologies to support falls prevention
	the Harm Free Care Group and Physical Health Steering Group
	• Evaluate patient and carers survey results relating to ease of access to information
	• Focus groups and patient stories
	• Audit assessment and care plan audits through Tendable against improvement trajectory
	• Baseline data in line with falls per 1000 bed days, with trajectory for agreed reduction set in year 3
	• Reduction in falls severity with trajectory agreed
	• Thematic review to support the Trust's falls safety improvement plan and its adoption across ward areas
	• Review utilisation in falls prevention of:
	  • Oxevision
	  • Mat sensors
	  • New profiling beds

Post falls care: • Strengthen early assessment following a fall with moderate and severe harm by ensuring a Decision-Making Tool (DMT) is completed, and immediate safety actions identified and actioned	• Implement revised Decision-Making Tool (DMT) specifically for falls • Audit of completed DMT for every fall with moderate and severe harm • Thematic review of post falls care provided for patients with moderate or severe harm to

• Completed DMT comes to the Falls Review Group for multidisciplinary team review and identification of learning	identify any learning to include in the Trust's safety improvement plan

Quality Priority 6: The Management of the Deteriorating Patient

Why is this a priority?

The deteriorating patient is a quality priority as early identification and timely intervention can significantly reduce harm, prevent avoidable deaths, and improve patient outcomes. Recognising and responding to deterioration is critical across all care settings, including hospitals, primary care, and community services. This priority will focus on inpatient settings across both physical and mental health wards.

What will we do	How will we evaluate success
Increase Early Recognition of Deteriorating Patient Use Early Warning Scores: • Implement the National Early Warning Score (NEWS2) to routinely monitor vital signs (e.g., respiratory rate, oxygen saturations, temperature, blood pressure, heart rate, and level of consciousness). • Rollout staff training and competences Introduce Structured Clinical Assessment algorithm across all inpatient wards: • Implement the use the ABCDE approach (Airway, Breathing, Circulation, Disability, and Exposure) to systematically assess the	• Monitor Patient safety data - Datix, ward huddles • Report on training compliance of 'Recognising and Managing Deterioration' e-LFH Training • Use Tendable platform to undertake spot check audits. (Early detection using NEWS2 and PEWS Observation and escalation chart) • Use Tendable platform to undertake audits of patient records • Thematic review of case where patient deterioration occurred • Staff feedback evaluation post debrief

patient's condition and documentation of identification of underlying Causes and document in patient record Introduce Structured Escalation algorithm across all inpatient wards Use Structured Communication Tools: • Employ SBAR (Situation, Background, Assessment and Recommendation) Framework to clearly and quickly communicate the patient's status to the clinical team. • Embed deteriorating patient escalate algorithm Clear escalation protocols ensure that expertise is mobilized without delay. Initiate Timely Interventions Stabilisation measures: • Assessment initiated, promptly start interventions—such as oxygen therapy, intravenous fluids, or medication adjustments to address the patient's needs. • Tailor Interventions to the Cause e.g. sepsis, respiratory, cardiac. • Ongoing Monitoring and continuous reassessment and escalation if required	

Safety

Quality Priority 7: The development of a patient safety culture

Why is this a priority?

The National Patient Safety Incident Response Framework (PSIRF) sets out how we develop effective systems and processes to respond to patient safety incidents in a meaningful way, Safety culture has been a reoccurring theme in recent reports where poor care was identified, such as the Francis Report, Morecombe Bay, East Kent and Ockenden reviews. The importance is further highlighted in responses from the Berwick and Winterbourne Review (NHS England, 2023). Following a review of health and safety, we have agreed to introduce the use of the safety culture toolkit to strengthen our current safety culture profile. We want to create a culture which enables staff to speak openly about and raise patient safety concerns, without fear of blame, reprimand or intimidation, creating the required space to learn from such events to make care safe.

What will we do	How will we evaluate success
Leadership • Develop a care unit leadership commitment and model a culture of transparency and accountability • Promote active leadership participation in safety initiatives to set clear expectations for safety standards	• Evaluate leadership involvement in patient safety walkarounds and discussions via monthly updates as accountability framework
Staff groups • Ensure every staff member understands what constitutes a patient safety concern and knows how to raise a concern on Datix • Provide ongoing patient safety training for all staff, including human factors, risk management and communication skills	• Review Datix training compliance via accountability framework meetings • Use results from the NHS Staff Survey and EPUT's Speak up Guardian Surveys to gauge perceptions of safety, teamwork, and reporting culture • Evaluate ability across all care units for staff to access restorative supervision

• Promote a "just culture" where staff are not punished for honest mistakes but held accountable for reckless behaviour • Encourage inter-professional teamwork training (e.g. simulation exercises)	• Conduct focus groups and interviews with staff to understand their experiences
Incident reporting and learning • Ensure that Datix provides a robust patient incident reporting system aligned to services within each care unit, with defined categories in place reviewed by local leadership in a timely manner • Implement robust governance processes led by empowered care unit teams to monitor, manage, gain insight and learn	• Use safety huddles and debriefings to review and learn from real-time issues • Monitor trends in incident reporting rates via Datix for each service • Assess whether lessons learned from incidents lead to safety improvements • Track the number of near misses reported - an increase may indicate a more open reporting culture

Patient and staff engagement
• Involve patients in their own safety by encouraging them to ask questions and raise concerns
• Support staff well-being, recognising that burnout and stress can impact patient safety
	• Monitor impact using patient and staff feedback triangulating data:
	  ○ Staff sickness
	  ○ Vacancies rates
	  ○ iWantGreatCare
	  ○ Patient complaints related to safety concerns
	  ○ Incidences relating to staff safety concerns

Continuous improvement and innovation • Use data and feedback to drive improvement (e.g. Patient Safety Incident Response Framework - PSIRF). • Adopt new technologies and best practices that enhance safety such as Oxehealth and MaST	• Measure how many safety recommendations are implemented following incidents • Improvement trajectory in staff safety training completion rates • Track the effectiveness of safety interventions
Regulatory and policy compliance	• Completion of CQC safety domain action plans

• Align with NHS policies and frameworks such as the NHS Patient Safety Strategy • Engage with the Care Quality Commission (CQC) and NHS England to ensure compliance and improvement	• Comparison of Trust performance against NHS England's Patient Safety Strategy and local Integrated Care Board targets

Quality Priority 8: Transformation of community mental health teams

Why is this a priority?

Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. The NHS Long Term Plan and NHS Mental Health Implementation Plan (2019/20 to 2023/24) set out how the NHS will develop new and integrated models of primary and community mental health care. A new community-based offer will include access to psychological therapies, improved frailty and physical health care, employment support, personalised and trauma informed care, medicines management and support for self-harm and coexisting substance use. The Trust's Quality Senate has reviewed current publications, best practice documents and presentations from subject experts to make recommendations for the Trust to take forward into 2025/26 to improve care; the following with relevance to this priority - trauma informed care, a move away from the Care Programme Approach (CPA), dementia and mild cognitive impairment and personalised care.

What will we do	How will we evaluate success
• Support all clinicians to embed the use of MAST (management and supervision tool) in everyday practice, especially for those people presenting with an escalation of need	• Monitor trajectory of reduction of patients experiencing crisis (need baselines to measure this)
• Move ownership of flow and capacity to ICB locality model, supported by the community	• Reduce out of area placements by 25%

mental health team who know the person/family/carers best	• Achieve inpatient operating model purposeful admission and effective discharge benefits realisation metrics
• Capacity and caseloads will be reviewed as part of the transformation programme	• Productivity gain of at least 4% on 2024-25 activity for all community mental health teams
• Needs based care approaches and adoption of evidenced based care implementation through the feasibility and adoption of recommendations from the Quality Senate	• Complete feasibility analysis against recommendations made • Evaluation adoption of recommendations into transformation programme

Quality Priority 9: Reducing restrictive practices

Why is this a priority?

The use of restrictive practices can have a significant impact on a person's mental health, physical health and emotional wellbeing. The use of restrictive interventions should reduce over time with effective positive behaviour support, leading to a better quality of life. This priority is part of a three-year programme of work that has so far focused on listening to patients, families and staff, testing different strategies with clear governance in place and linking to regional and national forums to discuss and agree best practice. This year, the Trust will focus on the implementation and evaluation of Safewards. This is an evidence-based model designed to improve safety in mental health wards and reduce the need for restrictive practices, such as seclusion, restraint, and rapid tranquilisation. By fostering a calmer, more therapeutic environment, the Safewards approach helps de-escalate tensions and manage conflict proactively.

What will we do	How will we evaluate success
Reduce triggers and preventing conflict • **Identifying and managing flashpoints**: Safewards helps staff anticipate potential conflict triggers, such as admissions, ward rules or interpersonal tensions, and address them before they escalate • **Calm ward environment**: Structured de-escalation strategies, such as soft lighting, quiet areas and sensory rooms, reduce agitation and distress • **Reducing power struggles**: By shifting focus from control to collaboration, staff interactions become more patient-centred, minimising resistance	• Measure the number of recorded patient-on-patient or patient-on-staff incidents • Monitor instances of self-injury or suicide attempts on wards • Assess whether incidents have decreased in severity (e.g. fewer injuries, reduced police interventions)
Enhancing staff-patient relationships • **Positive approach**: Staff are encouraged to frame interactions in a supportive, hopeful manner, reducing the likelihood of confrontation • **Mutual expectations**: Clear, collaboratively developed ward expectations help ensure consistency and fairness in care delivery • **Increased trust and engagement**: When patients feel heard and respected, they are less likely to respond with aggression or distress, reducing the need for restrictive interventions	• Evaluate patient surveys and feedback • Conduct regular Patient Reported Experience Measures (PREMs) on ward safety, relationships, and care quality • Use iWantGreatCare to assess whether patients feel the ward is safe and therapeutic • Monitor staff surveys and wellbeing metrics • Gather data from staff on confidence in de-escalation techniques, morale, and stress levels. • Measure perceived safety and effectiveness of interventions. • Evaluate focus groups and interviews

	• Conduct qualitative assessments with patients and staff on their experiences of Safewards and ward culture changes
Providing alternative coping strategies • **Distraction and de-escalation tools**: Wards using Safewards introduce activities such as comfort boxes, de-escalation techniques, and self-soothing tools, reducing distress • **Reassurance and peer support**: Trained peer workers or designated 'talk down' staff help defuse tense situations before they escalate • **Clear information sharing**: Patients are more likely to cooperate when they understand their care plans, reducing uncertainty and anxiety	• Monitor uptake and usage of key Safewards elements: ○ Engagement with interventions ○ Patient participation in de-escalation techniques ○ De-escalation spaces, and alternative coping strategies • Staff compliance with Safewards principles: • Audit the implementation and fidelity of Safewards interventions across wards
Promoting positive culture and learning • **Reducing staff reliance on restriction**: Safewards supports a cultural shift towards relational security rather than physical control • **Staff training in de-escalation**: Regular training in trauma-informed care and conflict resolution reduces unnecessary restrictive practices • **Post-incident reflection**: Learning from incidents helps staff refine their approach,	• Monitor trajectory of reduction in inpatient length of stay • Evaluate whether patients recover faster due to a more therapeutic environment • Monitor staff sickness and retention rates • Evaluate whether reduced conflict improves staff wellbeing and retention

further reducing the need for restrictive interventions	
Aligning with NHS and policy goals • Support the NHS England Restrictive Practice Reduction Programme and aligns with the Mental Health Units (Use of Force) Act 2018 ('Seni's Law'), which mandates transparency in the use of force • Improved (CQC) ratings - a reduction in restraint and seclusion enhances compliance with safety and patient dignity standards • Encouraging least restrictive practice approach as outlined in NICE guidelines and the Mental Health Act Code of Practice	• Review adherence to best practice guidelines on least restrictive approaches • Audit alignment with Mental Health Units (Use of Force) Act 2018 (Seni's Law) • Monitor feedback from CQC inspections on ward safety, patient dignity, and restrictive practices • Evaluate adoption of the NHS England Restrictive Practice Reduction Programme • Audit alignment with NICE and Mental Health Act Code of Practice

2.3 Statements of Assurance from the Board

During 2024/25, EPUT provided and/or subcontracted 180 relevant health services. EPUT has reviewed all the data available to them on the quality of care in 180 of these relevant health services. The income generated by the relevant health services reviewed in 2024/25 represents 99% of the total income generated from the provision of relevant health services by EPUT for 2024/25.

Participation in clinical audit

Clinical audit is a quality improvement process undertaken by doctors, nurses, therapists and support staff to systematically review the care provided to patients against best practice standards. Based upon findings, the organisation will take actions to improve the care provided.

During 2024/2025, there were 13 national clinical audits and one national confidential enquiry that covered relevant health services that EPUT provides. During that period, EPUT participated in 100% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EPUT was eligible to participate in during 2024/2025 are as follows:

- National Audit of Care at the End of Life (NACEL) - Mental Health Spotlight Audit.
- National Audit of Care at the End of Life (NACEL) - Acute & Community Hospital.
- Sentinel Stroke National Audit Programme (SSNAP).
- National Audit of Cardiac Rehabilitation (NACR).
- National Respiratory Audit Programme (NRAP) - Pulmonary Rehabilitation.
- National Paediatric Diabetes Audit (NPDA).
- National Clinical Audit of Psychosis (NCAP) – Early Intervention in Psychosis.
- National Audit of Inpatient Falls (NAIF) (part of the Falls and Fragility Fracture Audit Programme).
- National Diabetes Foot Care Audit (NDFA).

- Psychotropic Medication in Children and Young People's Mental Health In-Patient Services.
- Prescribing Observatory for Mental Health (POMH) –
    - Topic 24a Opioid Medications in Mental Health Services
    - Topic 21b: The Use of Melatonin
    - Topic 18c: Use of Clozapine
- National Confidential Enquiries in Patient Outcomes (NCEPOD): Rehabilitation following Critical Illness.

The national clinical audits and national confidential enquiries that EPUT participated in, and for which data collection was completed during 2024/2025, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry:

Audit/Enquiry Name	Number of cases submitted (as % of cases required by terms of audit/enquiry)
National Audit of Care at the End of Life (NACEL 5)	100% of required cases
POMH - Topic 16c: Rapid Tranquilisation	100% of required cases
National Clinical Audit of Psychosis - Early Intervention in Psychosis 2024	100% of required cases
POMH - Topic 21b: The Use of Melatonin	100% of required cases
POMH - Topic 24a: Opioid Medications in Mental Health Services	100% of required cases
Psychotropic Medication in Children and Young People's Mental Health In-Patient Services	100% of required cases
National Confidential Enquiries in Patient Outcomes (NCEPOD): Rehabilitation following Critical Illness	100% of required cases

The following national clinical audits that EPUT is participating and for which data collection is ongoing are as follows:

- National Audit of Care at the End of Life (NACEL) - Mental Health Spotlight Audit
- National Audit of Care at the End of Life (NACEL) - Acute & Community Hospital
- Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Cardiac Rehabilitation (NACR)
- National Respiratory Audit Programme (NRAP) - Pulmonary Rehabilitation
- National Paediatric Diabetes Audit (NPDA)
- National Clinical Audit of Psychosis (NCAP) – Early Intervention in Psychosis 2025
- National Audit of Inpatient Falls (NAIF) (part of the Falls and Fragility Fracture Audit Programme)
- National Diabetes Foot Care Audit (NDFA)
- POMH – Topic 18c: Use of Clozapine.

The reports of 10 national clinical audits were reviewed by EPUT in 2024/2025 and we intend to take the following actions to improve the quality of healthcare provided.

National Audit of Inpatient Falls (NAIF)

In line with national recommendations, the following actions are intended to ensure that EPUT continues to meet national expectations in falls management.

- To continue to take part in the national audit and to continue to monitor falls numbers
- To carry out a corporate audit to assess documentation and to check that falls prevention and management aligns with national standards. It should also include a review of the multi-factorial assessment. The audit tool should include questions relating to how the patient was moved from the floor to indicate use of lifting equipment
- To consider the use of "Tendable" to enable contemporaneous collection of audit data relating to falls
- Explore the use of the vision assessment tool "Look Out" to support vision care planning
- To consider the use of 4AT delirium assessment tool to help identify when delirium may be a factor in patient's presentation

- Clinical Falls lead to work with operational staff and to offer adhoc training and advice/support as required
- Ensure that analgesia is offered if required and encourage staff to inform ambulance services if there are signs of deterioration in patients waiting for transfer to acute care services
- Encourage Datix handlers to consider using the "severe" degree of harm category to reflect the potential life changing impact of sustaining neck of femur fractures.

National Diabetes Foot Care Audit Round 8 (2022 - 2023)

- To ensure that healthcare professionals arrange an early expert assessment of all new foot ulcer episodes. Better links with hospital services are needed to ensure that those patients who present with foot ulcer complications receive the expert assessment and treatment that is required
- To maintain staff competency to assess, recognise and to act on new or deteriorating wounds and refer onwards as necessary
- To target referrals from external services to ensure that the service receives them in a more timely manner.

National Paediatric Diabetes Audit (2022-2023)

- Several areas of good practice were identified along with some improvements; however, all those identified improvements relate to the partner organisation that we completed this national clinical audit with
- There were no improvements for EPUT to take forward on this occasion, as a result of this national clinical audit.

Sentinel Stroke National Audit Programme (SSNAP) - Round 11

- Increased physiotherapy minutes with patients - a trained senior physiotherapist and a junior physiotherapist have since been recruited
- To provide patients with a joint care plan on discharge
- To provide patients with a named person to contact following discharge
- To improve the Compliance Score – an electronic form has been introduced which will aid communication and speed up processes so that results for SSNAP can be recorded within 2 weeks
- Training on the new SSNAP data set to be provided to the team
- To explore ways of increasing frequency and intensity of therapy across a 7-day service for all disciplines

- Upskill ward staff to ensure continuity of therapy goals outside of therapy sessions.

National Audit of Cardiac Rehabilitation (NACR)

- To explore substantive funding for an administrator and clinical staff. Team expansion will assist with work started in 2024 to improve the Cardiac Rehabilitation service
- Implementation of an earlier initial assessment is vital to pick up patients with complications to avoid readmission and is requested consistently by patients
- Additional training of staff to support the completion of Functional Assessments (pre and post Cardiac Rehabilitation Programme).

POMH - Topic 22a: Use of Anticholinergic (antimuscarinic) Medicines in Old Age Mental Health Services

- Implementation of alerts in the EPMA system when patients are prescribed medications with high anticholinergic side effects
- To raise awareness among prescribing doctors of the need to review for anticholinergic side effects and document them appropriately
- The presence and active participation of pharmacists in MDT ward reviews to improve medication management.

POMH - Topic 23a: Sharing Best Practice Initiatives

- This project did not produce any recommendations as its main focus was to share brief examples of local activity that had been undertaken to address an aspect of prescribing practice that had been identified as an area for improvement in a POMH audit report
- The project did highlight that quality improvement initiatives were more likely to fully achieve the desired improvement if they had strong support from senior managers/clinicians as well as having a focussed, single aim. It also highlighted that the most common barriers to conducting quality improvement activities were lack of time and/or resources and the limitations of the current electronic patient record.

National Clinical Audit of Psychosis (NCAP) – Early Intervention in Psychosis (EIP) 2024

- Teams across EPUT continue to deliver evidence based high quality care. Teams are actively continuing to develop services, most notably with the development of further Service User Involvement groups across all Essex EIP teams.

- All teams continue to ensure that team members are reminded of NCAP standards that are in place to ensure excellent access to evidence based care for people experiencing a first episode of psychosis. It was evident that all teams engage in regular training to support the development of knowledge and skills required to meet these standards and that this should be maintained.
- Across all areas, teams are striving to find ways of engaging service users and their families in evidence-based care and treatment and ensuring that they are articulating the variety of resources and interventions on offer including in group and 1:1 setting, online and face to face. The development of these resources should continue to be shared amongst the EIP teams in EPUT.

National Audit of Dementia - Spotlight Audit in Memory Assessment Services 2023

- To develop a checklist that is attached to the referral, ensuring that all information is provided.
- Consider using Accurx - an automated messaging service for appointments - which could help reduce incidents of patients not attending appointments.
- Staff to ensure they record evidence that discussions around sight, hearing, falls, alcohol consumption and smoking have taken place
- Ongoing communication and collaboration between the service and the neuroimaging department to provide a smoother pathway, better communication and timelier reporting.
- Staff to be formally trained to complete ECGs, which will allow for a more personalised and timely response.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Planning for the End

- A number of recommendations were put forward from a national viewpoint, including normalising conversations about palliative/end of life care, to ensure patients have a named coordinator and that palliative and end of life care should be a core competency for all healthcare staff.
- Following this national clinical audit, EPUT conducted two clinical audits in relation to end of life care and DNACPR - as a result, recommendations that reflected the national recommendations and that were applicable to EPUT were proposed.

The reports of five Trust-wide clinical audits were reviewed in 2024/2025, and EPUT intends to take the following actions to improve the quality of healthcare provided:

Audit of Resuscitation Equipment

- To raise awareness of the importance of maintaining immediate access to resuscitation equipment in all areas.

Physical Health & NEWS Audit in Inpatient wards

- To review the use of Tendable to support more contemporaneous data collection/analysis for future audits.

Re-audit of Post-Fall Neurological Observations

- To undertake bone health checks
- To explore the feasibility of including bone health and vision assessment in the core assessment process
- Record the written information that has been provided to the patient and/or in the EPR.

Audit of End of life Care in Community Health Services

- To seek further feedback from other stakeholders who support partnerships and MDT working.
- For clinical staff to have the opportunity to attend training for extended roles and obtain competencies for DNACPR and verification
- Continue to support partnership training as a system approach to enhance all areas within primary and secondary care.
- Ensure that end of life care online training is available to all staff and the competency framework is updated to support this. Continue to utilise bespoke training opportunities for teams from lessons learned and complex care.
- To work alongside lived experience ambassadors to support the patient experience and end of life subcommittee. This will support co-production and lived experience as part of the quality framework during 2024.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit

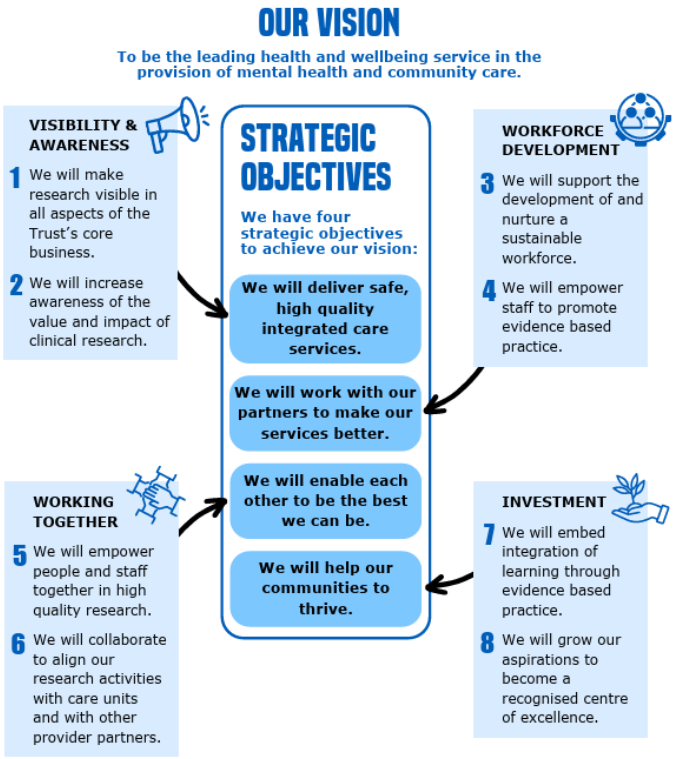
- To work within system partnerships to ensure electronic data sharing across services, including end of life care templates and the Electronic Palliative Care Co-ordination system (EPaCCs) in west and south east Essex.

- Ongoing training opportunities for all staff to ensure DNACPR is included in end of life training, so staff feel confident to have conversations and an understanding of the Mental Capacity Act and best interest decisions.
- To work with system partners to deliver training, guidance and the competency framework for senior clinical staff so they can authorise DNACPR and reduce delays in awaiting a GP signature.
- To ensure DNACPR document completion training is available to all medical staff and senior clinical staff with competencies. Continue to audit a variety of teams to ensure best practice is being followed.

Participation in clinical research

We launched our research strategy – Best Research Together – in January 2024. Since then, we have seen a significant improvement in the profile and organisational awareness of the research agenda throughout 2024/25. The strategy was designed to directly support the delivery of the Trust's Strategic Plan for 2023/24 to 2027/28.

Figure 9: EPUT's vision and strategic objectives



In the last year, we have delivered a higher volume of clinical research and a higher proportion of more complex, interventional research. We now have more clinicians from different professions trained to lead studies and we are making participation in trials accessible to more patients.

The number of patients receiving NHS services provided or sub-contracted by Essex Partnership University NHS Foundation Trust in 2024/25 that were recruited during that period to participate in research approved for adoption to the NIHR portfolio was 4,925 - nearly 1,000 more than the year before (2023/24 total 3,956). This includes the 4,506 patients recruited this year into a commercial trial EPUT is conducting with Limbic – an evaluation of a conversational information collection tool to access talk therapy – which opened in June 2023.

This level of participation puts the Trust as the joint fourth highest recruiting NHS Mental Health Trust against 44 other equivalent trusts within the UK[1]. The number of recruits arose from participation in 21 research studies opened to participation at EPUT in 2024/25, down from 24 studies in 2023/24 but with a greater proportion of more complex, interventional studies this year which give high accrual weightings.

Weighted recruitment[2] has improved significantly during 2024/25 from an average of 35 per week over the first five months of the financial year up to over 100 per week since that time, with a total of 2,984 patients recruited.

We introduced seven newly trained principal investigators this year - four doctors, two psychologists and one service lead. The Research team has also been promoting research activity through involvement and engagement of junior staff and trainees in service evaluation, service improvement and case studies. Research team members have actively engaged and supported staff to open 28 new service evaluations in 2024/25. Research has become a feature of Trust induction for all new joiners since September 2024.

[1] National Institute of Health & Care Research

[2] Weighted recruitment can be used as a high level indicator of productivity in research delivery and is calculated by multiplying the raw number of patients recruited to studies by the complexity multiplier attributed to each study

Relationship with National Institute of Health Research (NIHR)

In October 2024, partners in the Mid and South Essex Integrated Care System – including EPUT – transitioned from NIHR's North Thames Clinical Research Network to the East of England Regional Research Delivery Network, which supports our delivery of high-quality research and support development of research capacity, capability and infrastructure.

Patient and public involvement in clinical research

We have a valuable resource in our Lived Experience Ambassadors who have been helping us to design and improve our services.

We have been a committed contributor to the yearly NIHR National Patient Research Experience Survey (PRES), using this feedback to inform processes and build on our engagement with research participants. Within the cohort of all mental health trusts, EPUT is the 4th highest recipient of PRES feedback. PRES responses are very positive, with 95% of respondents saying that they would take part in research at EPUT again. Following feedback that a participant was not informed of the results of the study, we amended our end of study process to systematise sending out the results of a study to participants where the protocol allows.

High performing studies

In line with our Research Strategy, we are a research active organisation and ensure our patients have access to the latest treatments and technologies. Evidence shows that clinical research active providers have better patient care outcomes. Alongside our partnership study with Limbic, our top recruiting studies with over 100 weighted recruitment participants include:

- Pharmacogenetics in Mental Health – opened April 2024 - an interventional study investigating the use of pharmacogenetics tools in guiding the prescription of psychotropic drugs
- CARERS trial – opened September 2024 - an interventional feasibility trial of a skills enhancing programme for carers of people presenting with complex emotional needs and/or chronic emotional dysregulation

- COBALT – opened May 2024 - an interventional drug trial for patients with diagnosis or clinical features of Dementia with Lewy bodies or Parkinson's Disease Dementia
- Routine screening for gambling-related harm – opened October 2024 - observational feasibility study for screening for gambling or gambling-related harm in mental health and drug and alcohol services
- RECOLLECT 2 – opened September 2022 - interventional study exploring the impact of Recovery Colleges on Student Outcomes and factors which affect these.

Commercial research

This year, EPUT has invested in developing commercial research plans. We are developing relationships with a range of life sciences industry partners with the objective of opening a small number of treatment trials in 2025/26. We have benefited from internal and external capital investment in equipment during 2024/25 to enable these plans.

Academic partnerships

A key part of our Research Strategy is to continue to build academic partnerships. This has been made possible through a series of joint clinical academic appointments with the University of Cambridge, University College London (UCL) and strategic partnership working with the University of Essex and Anglia Ruskin University (ARU). The partnership with ARU was celebrated with our third annual joint research conference held in Cambridge in September 2024. The partnership aim is to work directly with academics from ARU campuses to collaborate on developing new studies in the field of mental health. EPUT's partnership with UCL resulted in a successful capital grant application in 2024/25 which enabled the acquisition of new equipment for research and development for joint studies.

Our research partnerships with other local higher education institutions have continued to flourish, in particular with ongoing academic training provision in our psychology services provided through BSc, MSc, PhD and Dclinpsych from the University of Hertfordshire, University of Essex and University of East Anglia.

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

NHS England paused the nationally mandated CQUIN quality incentive scheme during 2024/25.

Registration with the Care Quality Commission (CQC)

Essex Partnership University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with conditions.

These conditions relate to EPUT's two dementia care homes, Clifton Lodge and Rawreth Court:

- A requirement to have a registered manager for each site
- A maximum of 35 beds provided at each site

The Care Quality Commission has not taken any enforcement action against Essex Partnership University NHS Foundation Trust during 2024/25.

EPUT has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust is rated as *Requires Improvement* by the CQC, with the rating for the caring domain being *Good* (from the inspection in November 2022).

In the reporting period, the CQC published one report pertaining to inspection activity carried out in 2024/25:

- 6 February 2025 – Clifton Lodge Care Home (inspection: January 2025).

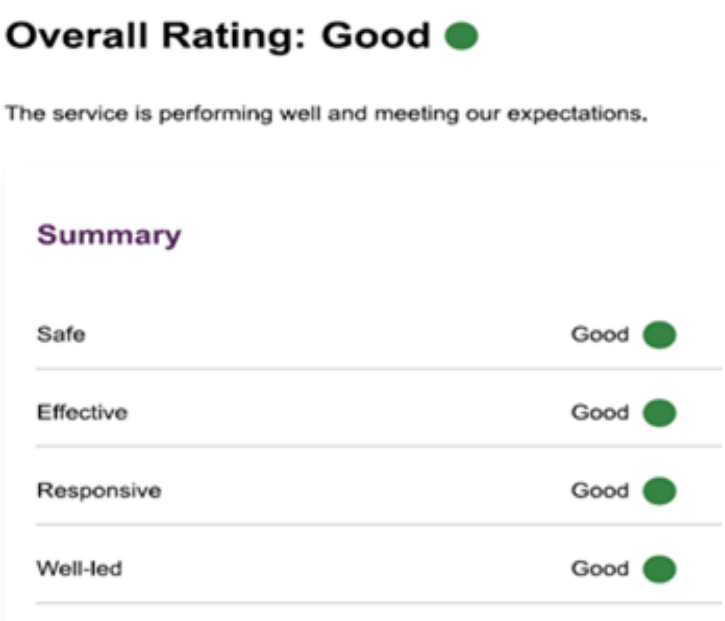
The inspection found that Clifton Lodge delivers person-centred, high-quality care and that staff actively engaged with people and their families to create detailed care plans, incorporating their preferences and support needs.

Inspectors also found that the service tailored activities to meet people's needs and interests. Staff arranged structured activities for people to join to keep them stimulated and engaged throughout the day.

They also made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

The CQC published its report in February 2025. The service has an improved rating of *Good*. The full report for the inspection can be viewed on the CQC website at https://www.cqc.org.uk/location/R1LJ3/reports.

Figure 10: Clifton Lodge Care Home QC Rating



In April 2025, the CQC published its report following an unannounced inspection in March 2024 of forensic and secure services at Brockfield House, giving the service a rating of *Good*. The full report is available from the CQC website at https://www.cqc.org.uk/provider/R1L/reports/AP1626/forensic-inpatient-or-secure-wards.

A CQC report is still awaited following the unannounced focussed inspection for the Safe and Well Led domains on EPUT's adult acute and PICU services in November/December 2024.

We continue to focus on our CQC quality improvement plan. 95% of actions are now reported as complete and 53% have been agreed for closure through our Evidence Assurance Process.

Data quality

Essex Partnership University NHS Foundation Trust recognises that it is essential for an organisation to have good quality information to facilitate effective delivery of patient care, and that this is essential if improvements in the quality of care are to be made.

Essex Partnership University NHS Foundation Trust adheres to a number of nationally mandated dataset submissions in the form of the Mental Health minimum dataset, Talking Therapies dataset (IAPT) and Community Services dataset, which create our Data Quality Maturity Index (DQMI) score.

The latest published national data at February 2025 shows the Trust is maintaining high scores in both standard and experimental datasets, reporting higher data quality performance than the national scores.

Table 8: Data Quality EPUT performance with national standards

Data Quality Maturity Index	EPUT Standard Dataset Score	EPUT Experimental Dataset Score	National Standard Dataset Score	National Experimental Dataset Score
CSDS	86.9%	82.7%	72.6%	68.0%
IAPT	99.4%	92.9%	96.2%	87.0%
MHSDS	95.3%	88.4%	47.8%	43.2%
Overall DQMI	93.9%	88.5%	71.1%	65.6%

	>= National Dataset Score

The National Dataset Scores is the overview of all providers across England.

Information Governance Data Security and Protection Toolkit attainment levels

The Data Security and Protection Toolkit (DSPT) is an annual self-assessment for organisations handling NHS patient data in England. It ensures compliance with UK GDPR, the Data Protection Act 2018 and cybersecurity standards, safeguarding patient confidentiality and protecting against data breaches.

Essex Partnership University NHS Foundation Trust's Data Security and Protection Toolkit Report overall score for 2023/24 was graded as 'standard met'. The DSPT submission for 2024/25 will be made on 30 June 2025.

Standards of clinical coding

Essex Partnership University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Note: The clinical coding functions noted above and previously undertaken by the Audit Commission are now under the guidance of NHS England.

ICD-10 clinical coding is completed on all inpatient episodes and spells each month with a 100% completion rate.

Essex Partnership University NHS Foundation Trust will be taking the following actions to improve data quality.

We are committed to improving data quality across all systems over the coming years, with several initiatives and changes to practices being implemented, including:

- A new Data Quality Assurance Framework - Building upon the existing data quality maturity index, the new framework will establish improved intelligence for gaps in data quality, providing proactive advice and guidance on the importance of good quality data, how it is used and offering practical advice for making improvements. The framework will introduce a new assurance report to track common issues and their level of maturity over time.
- A new data platform - The Trust has implemented a new data platform that will mature over the course of the next 12 months. This new platform will bring together the source data from our clinical and non-clinical systems as a single source of truth for data intelligence. The new platform will make data quality reporting more insightful and actionable to support the new Data Quality and Assurance Framework.
- Business Intelligence dashboards - Building upon the success from the integrated performance report and safety dashboards, the Trust is committed to better data insight to support decision making. Our focus for the next period will be on workforce data intelligence, bringing together the data from our people systems to provide our managers and leaders with better insight, where previously manual

data analysis has proven difficult and issues with data quality have been hard to identify.

Learning from deaths

Learning from the deaths of people using our services is a fundamental part of strengthening our safety culture and ensuring the quality of our services continually improves.

The aim of reviewing the care provided is to help improve care for all our service users by identifying whether there were any problems, understanding how and why these occurred and taking meaningful action to implement any learning. Due to the nature of the services we provide, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss, and we are continuing to strengthen our processes to support those people.

Our processes strengthen the focus on learning outcomes, ownership closer to the service and align with the Patient Safety Incident Response Framework and the *National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March* 2017).

The 2024/25 Quality Account, in line with national guidance reference 27.7 to 27.9, will report on the following mandated information:

- The number of case note reviews or investigations finished in 2024/25 which related to deaths during 2023/24 but were not included in the Quality Account for that previous reporting period (Quarter 4 information).
- An estimate of the number of deaths included above which EPUT judges, as a result of the review or investigation, were more likely than not to have been due to problems in the care provided, with an explanation of the methods used to assess this (Quarter 4 information).
- A revised estimate of the number of deaths during the previous reporting period, taking account of the deaths referred to in the point above (Quarter 4 information).

We seek to identify learning from all reviews undertaken under the learning from deaths arrangements and agree improvement actions,

irrespective of whether the death is more likely than not to have been due to problems in care provided.

The process includes:

Learning from deaths process	Review Stage
An initial review by the local clinical service lead from the clinical notes (undertaken for every death reported) with the aim of identifying any immediate learning and whether escalation is required for a more detailed review under Stage 2 or Stage 3	1
A more detailed clinical case note review using a Trust pro forma (based on Structured Judgement Review methodology) by a senior clinician not involved in the care of the service user	2
A review undertaken under the Trust's Patient Safety Incident Response Plan (PSIRP) using one of the national investigation methodologies under the Patient Safety Incident Response Framework (PSIRF)	3

The following section provides further information, examples of learning and improvement actions we have taken.

Explanatory note: Within national guidance, trusts determine local approaches to mortality review and define which deaths should be in scope for review. Therefore, mortality data is not comparable between trusts.

Figures in this report reflect information as at 4 February 2025 for Quarters 1 to 3 in 2024/25 and for Quarter 4 in 2023/24. Information relating to Quarter 4 is not available until June each year and is thus always reported in the Quality Account for the following year.

During the reporting period (Q4 2023/24 to Q3 2024/25), as of 4 February 2025, 165 deaths of our service users were in scope of the Learning from Deaths arrangements.

The number of service user deaths 'in scope' for mortality review (Q4 2023/24 to Q3 2024/25) (National Guidance reference 27.1)	
Reporting Period	**Number**
Q4 2023/24	59
Q1 2024/25	40
Q2 2024/25	42
Q3 2024/25	24
Total	**165**

All deaths in scope are subject to a minimum of a Stage 1 review (see table on previous page for details of stages of review). In addition, by 4 February 2025, zero Stage 2 case record reviews (individual or as part of thematic reviews) and 10 Stage 3 PSIRF investigations have been carried out in relation to 10 of the deaths above.

In addition to those completed, 13 Stage 2 case record reviews (individual or as part of thematic reviews) and 31 Stage 3 Patient Safety Incident Response Framework investigations are in progress. In zero cases, a death was subjected to both a Stage 2 case record review and a Stage 3 investigation.

The number of deaths in each quarter for which a Stage 2 case record review or a Stage 3 investigation was carried out was:

The number of deaths 'in scope' for mortality review subject to case record review / investigation (PSIRF) (National Guidance reference 27.2)	
Reporting Period	**Number**
Q4 2023/24	23 (of which 15 in progress)
Q1 2024/25	9 (of which 7 in progress)
Q2 2024/25	14 (of which 14 in progress)
Q3 2024/25	8 (of which 8 in progress)

In addition to the Stage 2 and Stage 3 reviews detailed above:

- 35 of the deaths in scope for the period Q4 2023/24 - Q3 2024/25 have been subject to multi-agency review within the Essex Drug and Alcohol Partnership
- 22 of the deaths in scope for the period have been subject to review under the national "Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)" review programme

In addition to these reviews, our care units undertake local reviews using PSIRF methodologies for some deaths to identify and inform their learning actions. Data in relation to the number of these reviews is not currently collected centrally, but processes are being put in place to be able to collate and report on this data from Q1 2025/26.

Zero, representing 0% of the patient deaths during the reporting period, were judged to be more likely than not to have been due to problems in the care provided to the patients/service users.

The percentage of deaths judged more likely than not to have been due to problems in care **(National Guidance reference 27.3)**	
Reporting Period	**Number and % of deaths in each quarter**
Q4 2023/24	Zero (0%)
Q1 2024/25	Zero (0%)
Q2 2024/25	Zero (0%)
Q3 2024/25	Zero (0%)

Notes

The judgements on all deaths other than deaths reviewed under the PSIRF methodologies (see below) use a tool designed locally by the Trust, based on the structured judgement review tool/methodology published by the Royal College of Psychiatrists in November 2018.

The methodology of the Stage 3 Patient Safety Incident Response Framework (PSIRF) reviews focuses on quality learning outcomes and no determination in terms of likelihood of problems in care has therefore been assigned for these reviews to date.

Research is being undertaken with relevant colleagues nationally, regionally and locally with a view to agreeing an appropriate approach to

making a determination for these deaths. Once a definitive local process has been agreed, this will be applied to all deaths reviewed under PSIRF methodologies since 1 April 2022.

Examples of learning derived from the review / investigation of deaths judged more likely than not to have been due to problems in care **(National Guidance reference 27.4)**	
Derived from the review / investigation of deaths judged more likely than not to have been due to problems in care (National Guidance reference 27.4)	N/A
Action taken in consequence of the learning above (National Guidance reference 27.5)	N/A
Impact of the actions described above (National Guidance reference 27.6)	N/A
N/A as there were zero deaths judged more likely than not to have been due to problems in care during the reporting period.	

We seek to identify learning from all reviews undertaken under the learning from deaths arrangements and agree improvement actions, irrespective of whether the death is more likely than not to have been due to problems in care provided. Every quarter, a report is presented to the Trust Board providing an overview of key examples of learning from deaths and actions taken – these quarterly reports are available on our website. Some examples of learning themes identified and actions taken as a result in the period of this Quality Account include:

- Opportunities to strengthen the Trust's contribution to the **physical healthcare of patients in receipt of mental health services** - a Quality Improvement project has begun which will develop physical health skills of EPUT inpatient staff via a national competency framework and training, including enabling them to recognise and manage deterioration. The outcomes of thematic reviews of non-patient safety incident physical health cause deaths of community

patients with Severe Mental Illness and of EPUT inpatients were reported during this year – these reflected the importance of strong collaborative working across health sectors and of EPUT's contribution to the physical healthcare of patients.

The physical health work stream in the Trust is overseeing this work and the outcomes of the reviews have been, or are being, shared at multi-agency forums to strengthen collaboration.

- Opportunities to strengthen **communication within and across EPUT teams as well as with partner agencies** involved in a patient's care - a number of proactive steps have been taken to formally strengthen opportunities for communication and collaboration both locally and Trust wide. For example, a local service emphasised the necessity of holding group multi-disciplinary team (MDT) meetings on a regular basis - focusing on the importance of consistent communication and collaboration amongst the team to ensure comprehensive patient care with the aim of establishing routines that prioritise timely MDT meetings, minimising gaps in care and improving overall patient outcomes.

  Over the past year, multi-agency locality operational groups involving mental health services and agencies in the Essex Drug and Alcohol Partnership have been or are in the process of being established across all localities to provide a forum for discussion of the care of dual diagnosis patients. Similarly, operational groups have been or are in the process of being established involving acute Trust and EPUT colleagues to discuss and plan care for patients who are receiving services from a number of health providers.

- Opportunities to improve holistic care via **improved access to records of services provided by other healthcare providers** involved in a patient's care - the electronic Shared Care Record containing key patient information from a variety of electronic sources continues to be developed as a key source of information and awareness raised with staff about accessing this information.

  In the longer term, the Trust is involved in a transformational project to create a Unified Electronic Patient Record system for use by EPUT and other health providers.

- Opportunities to strengthen **care planning** - the Trust has a programme of work in place for implementing nationally approved Goal Attainment Score (GAS) care plan. This will include involving patients and carers in the development and review of care plans.

Opportunities to strengthen **risk assessment** - in response to specific learning, a service reviewed the way in which risk was stratified in terms of the service risk management policy. This was a service wide review involving input from all clinical staff and included updating the service policy.

- Opportunities to strengthen services to patients who are receiving **end of life care** - the Trust has undertaken much work, together with partner agencies, to strengthen the quality and timeliness of care provided to these patients by reviewing care provision, documentation, system templates, staff awareness and training across agencies.
- Opportunities to strengthen receipt of timely and confirmed **information on causes of death** which will assist in learning conclusions – in the absence of any national or local systems by which we are routinely notified of confirmed causes of death, we are taking forward exploration of ways to strengthen the processes by which we can receive this information. Medical examination officers have agreed to share information and appropriate information sharing agreements are being put in place. We have also started to explore the possibility of receiving this information from local authority Registration Services.

Learning identified often aligns with the themes of the Trust's Safety Improvement Plans (SIPs), detailed within this report, therefore ensuring that learning from deaths is utilised to inform the actions taken via these SIPs.

Over the past year, each of the Integrated Care Boards covering EPUT's services has embedded a multi-agency forum in which learning from deaths is shared and considered for system wide service improvement. Agencies represented at these meetings led by the Integrated Care Boards include acute hospital trusts, community health providers, mental health providers and local authorities.

EPUT is an active participant in these meetings, ensuring that learning particularly relevant to whole system working is shared at these meetings and joint solutions agreed.

Prevention of Future Death Reports (Paragraph 7 of Schedule 5, Coroners and Justice Act 2009)

In 2024/25, HM Coroner issued the Trust with six Prevention of Future Death (PFD) reports, drawing attention to areas where action should be taken to prevent harm to future service users. The Trust provides a response to HM Coroner on the actions it will take.

Our Learning Collaborative Partnership (LCP) receive details of the PFDs to facilitate Trust-wide learning and triangulation with other key work streams such as patient safety learning events, complaints and claims. Individual actions are monitored at care unit quality and safety meetings with oversight presented at care unit accountability framework meetings.

The themes identified in PFDs during 2024/25 were:

- Policy/SOP application.
- Discharge and transfer.
- Record keeping/access to records.
- Risk assessment and care planning.
- MDT communication.
- Care coordination.

Core quality indicators

The data given within the core quality indicators is taken from the Health and Social Care Information Centre indicator portal (HSCIC), unless otherwise indicated.

<table>
<tr><th colspan="3">Indicator: Percentage of patients followed up in 7 days</th></tr>
<tr><td colspan="3">This indicator measures the percentage of patients/service users followed up, either face to face or by telephone, within seven days of their discharge from a psychiatric inpatient unit.</td></tr>
<tr><td rowspan="4">The national collection of this measure was retired in April 2021. This performance continues to be monitored internally.

The percentage of patients who were followed-up within 7 days after discharge from psychiatric inpatient care during the reporting period</td><td>Reporting period</td><td>EPUT Year End Score</td></tr>
<tr><td>April 2022 to March 2023</td><td>99.2%</td></tr>
<tr><td>April 2023 to March 2024</td><td>91.3%</td></tr>
<tr><td>April 2024 to March 2025</td><td>92.7% (March)</td></tr>
<tr><td colspan="3">EPUT considers that this data is as described for the following reason:

The Performance team holds this information but also keeps a record once validated by the Trust Operational Productivity team. Once validation is complete, the compliance figures are generally much higher than initially produced, primarily due to system interoperability issues and specific agreed exclusion reasons.</td></tr>
<tr><td colspan="3">EPUT is taking the following actions to improve this score, and so the quality of its services, by:

The Performance team is continuously working with operational colleagues to improve this score and ensure accurate reporting. Operational leads maintain regular oversight of this performance and take forward any actions needed to address potential falls in compliance. A new hourly refreshed post inpatient discharge follow-up dashboard is available for to more actively monitor performance.

Data currently undergoes some manual validation to ensure data capture across multiple systems, as well as noting deaths within 72 hours of</td></tr>
</table>

discharge, the legal removal of a patient from the country, and those patients transferred or discharged to another mental health facility.

Indicator: Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment team acted as a gatekeeper during the reporting period

This indicator measures the percentage of adult admissions, which are gate-kept by Crisis Resolution Home Treatment team.

The national collection of this measure was retired in April 2021. This performance continues to be monitored internally.

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment team acted as a gatekeeper during the reporting period.

Reporting period	EPUT Year End Score
April 2022 to March 2023	100%
April 2023 to March 2024	100%
April 2024 to March 2025	100% (March)

EPUT considers that this data is as described for the following reason:

Operational services continue to assess all clients requiring admission. 100% of necessary cases were gate-kept in 2024-25.

EPUT is taking the following actions to improve this score, and so the quality of its services, by:

Operational staff are able to routinely monitor their compliance through self-serve published reports and raise any concerns through various escalation opportunity meetings.

Part 3

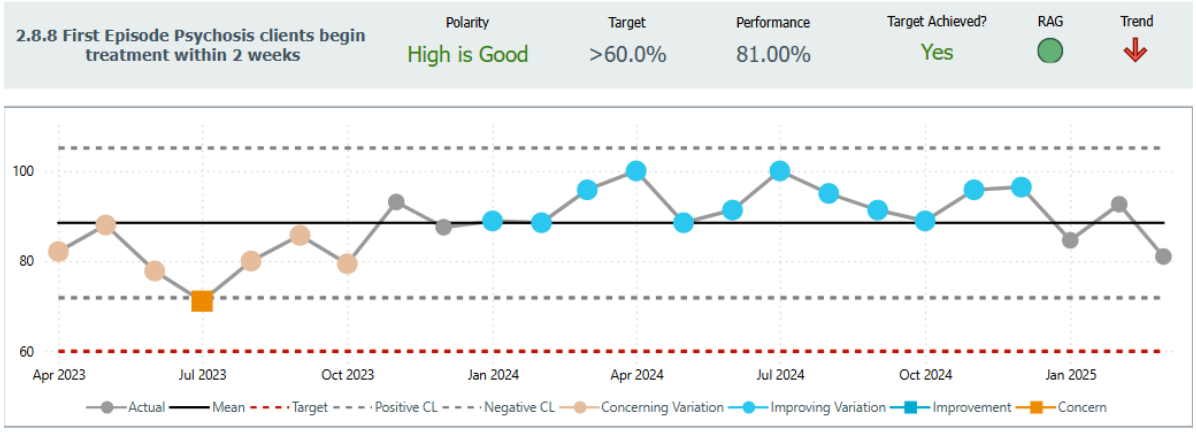
Review of Quality Performance

Performance against key national priorities 2024/25

In this section, we have provided an overview of performance in 2024/25 against key national targets relevant to Trust services contained in the NHS Oversight Framework.

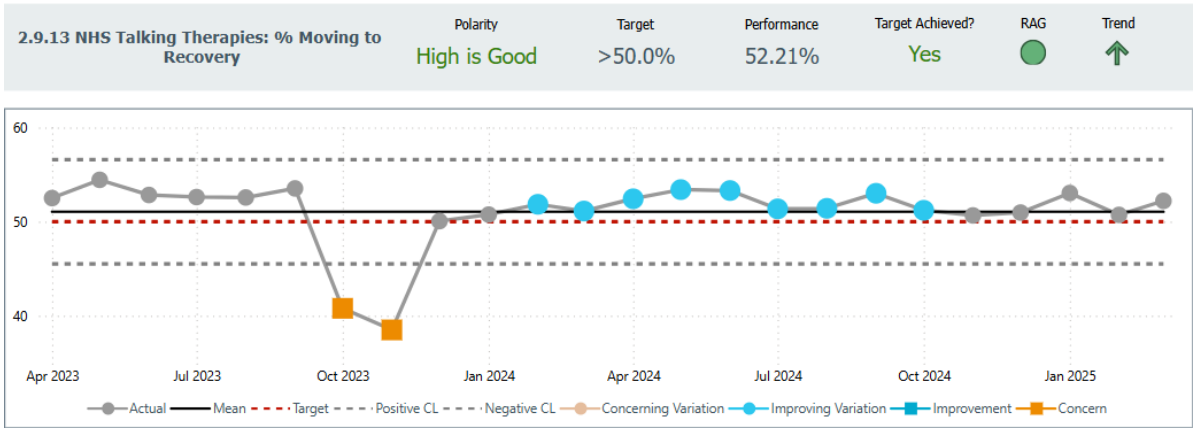
First episode psychosis: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

Figure 11: This indicator measures the percentage of referrals for people with a first episode of psychosis treated within two weeks. The performance indicator is set at 60%. Compliance with this target has been achieved consistently in 2024/25, improving on the 2023/24 performance which reported an average of 85% per/month, with 2024/25 averaging 95% per month.



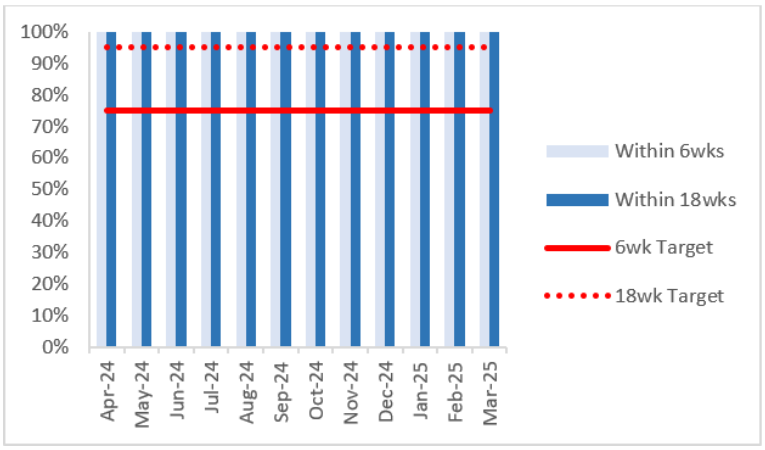
Improving access to psychological therapy services: recovery rates above 52% and waiting targets

Figure 12: This indicator measures the percentage of patients discharged from our Talking Therapies service (previously known as Improving Access to Psychological Therapies - IAPT) who have moved to recovery. Following the recovery focused audit in Quarter 3 of 2023/24, a near-miss model was developed to better capture those patients who are not achieving recovery, also supporting the national monitoring of reliable improvement which commenced in April 2024.



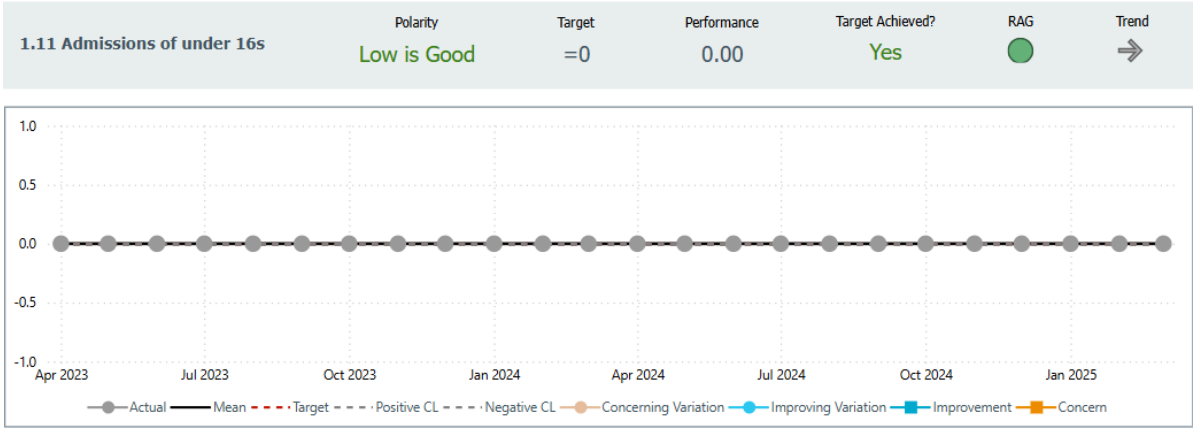
Waiting to begin treatment

Figure 13: This indicator measures the percentage of referrals to talking therapy services whose treatment commences within 6 weeks (target of 75%) and 18 weeks (target of 95%). Compliance with both targets has been consistently achieved throughout 2024/25, with 100% of service users being seen within the 18-week target.



Under 16 admissions to adult wards

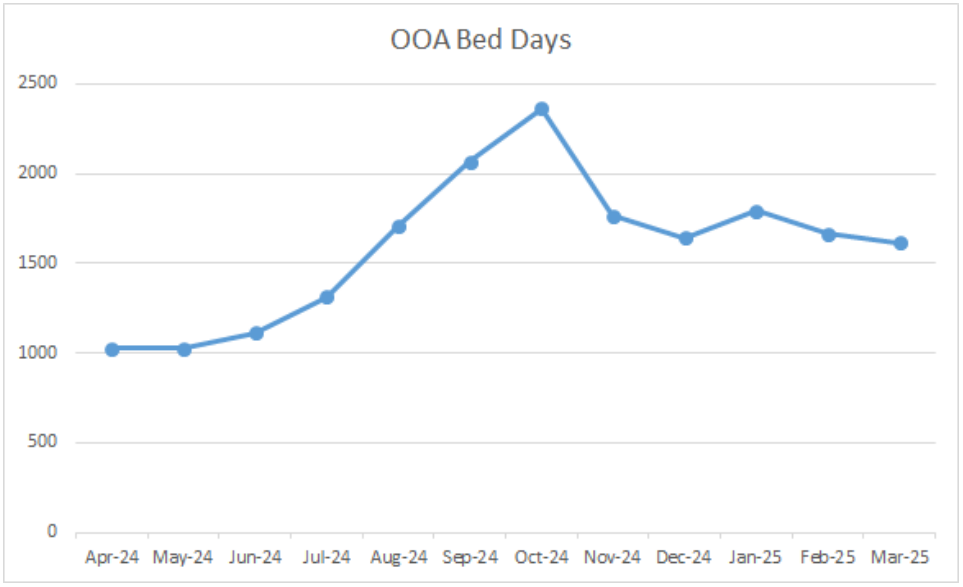
Figure 14: This indicator measures the number of admissions to adult mental health wards where the patient is under 16 years old. In 2024/25, there were no under 16 year olds admitted to adult wards within the Trust.



Out of area placements (OOA)

Out of area placements are measured by the number of days that patients have spent in inpatient facilities that are outside of the Trust's inpatient beds and are delivered by external providers. These exclude out of area placements that are deemed as appropriate.

Figure 15: Our performance over the last year: Out of area placements (inappropriate).



The table below shows the average number of days that patients have spent in an out of area bed each month for 2024/25.

Table 9: Monthly number of patients who have been placed in (inappropriate) out of area beds for 2024/25.

2024/25	Inappropriate placements	Repatriations	Remain OOA at month end
Apr-24	25	21	30
May-24	28	20	38
Jun-24	16	14	40
Jul-24	33	20	53
Aug-24	22	19	57
Sep-24	49	25	81
Oct-24	24	41	63
Nov-24	14	26	52
Dec-24	40	32	59
Jan-25	29	31	57
Feb-25	21	18	60
Mar-25	17	30	47

Infection Prevention and Control (IPC)

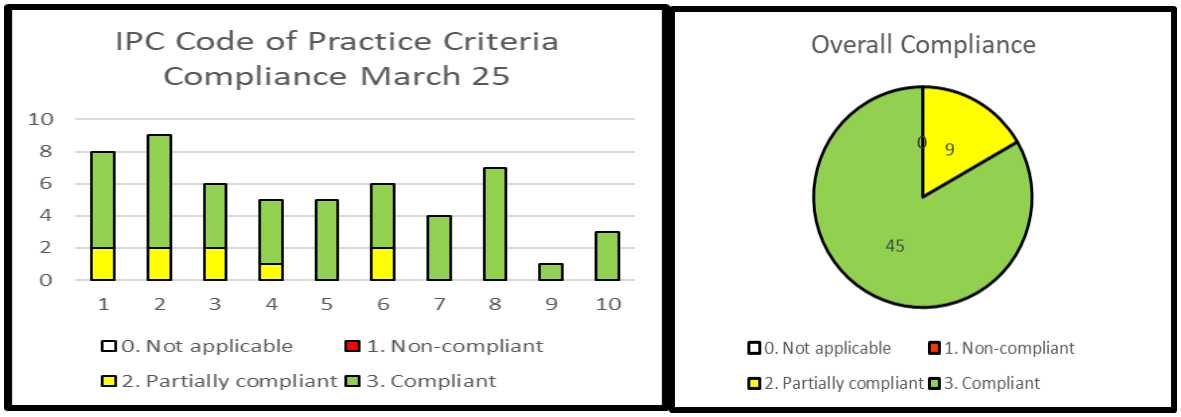
The Director of Infection Prevention and Control (DIPC) and Infection Prevention and Control (IPC) team have continued to provide specialist advice to all levels of the organisation and to the Mid and South Essex Community Collaborative. Assurance on policy is provided through regular self-assessment reporting against the Infection Prevention and Control Board Assurance Framework through our Quality Committee.

The team have continued to provide training for staff as part of the induction programme and ongoing mandatory training and provision of the national IPC training e-learning programme.

Overall compliance with IPC Board Assurance Framework (March 2025)

The Trust has an overall compliance of 45 out of 54 key lines of enquiry, which is an 18% improvement on last year.

Figure 16: IPC code of practice criteria compliance



Evidence of assurance and gap analysis against the criteria of the Infection Prevention and Control Code of Practice:

Criteria 1: Systems to manage and monitor the prevention and control of infection

Self-assessed as partially compliant with exceptions noted below

The Trust does not have a formal IPC surveillance system. This is mitigated by our collaborative arrangements and contracts with acute hospital pathology systems in our localities, as well as clinical teams having systems to alert the IPC team to individual cases of infection.

An overarching IPC audit tool for in-patient services was implemented during 2024 on the Tendable audit platform and is for self-audit by clinical teams. Once inpatient auditing is fully established, the Trust plans to move towards the inclusion of community-based settings. Commissioning colleagues have undertaken several assurance visits, giving very positive feedback, including:

"First impression of all areas visited was a minimalist environment which was clean, tidy, calm and well organised. In summary, the visit provided assurance with good IPC standards across the hospital. There was evidence that staff from the top down are invested in providing good, effective, clean and safe care for their patients. All staff engaged with

were able to discuss their IPC practices, demonstrating sound IPC knowledge. A very positive visit".

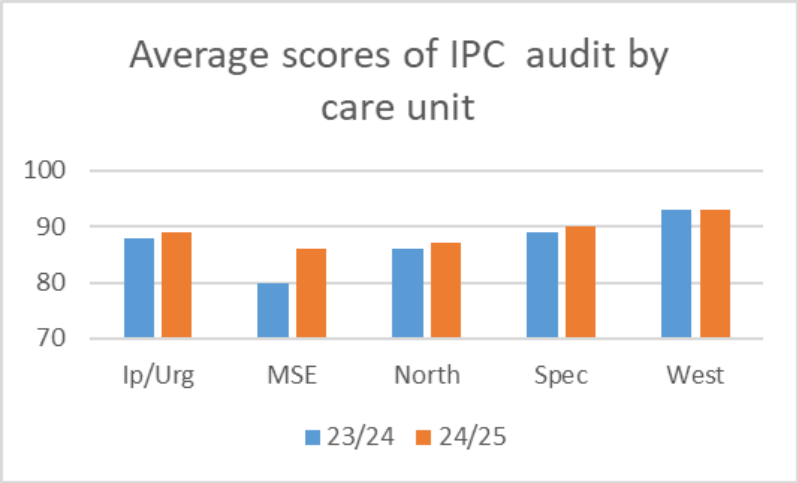
Themes highlighted include wards lacking storage space, which can IPC issues when materials are stored in inappropriate areas. Other issues highlighted included cleaning of fans, inappropriate or lack of use of "I am clean" stickers and insufficient evidence for replacing/cleaning curtains. Full reports have been sent to relevant services for teams to address.

Criteria 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Environmental audits are carried out by the IPC team on a yearly basis, with the aim of completing a full audit of all sites each year. Audits are fed back directly to teams and are followed up to monitor progress on action plans and provide expert advice and support to colleagues in relation to clinical practice or the patient environment.

A comparison between 23/24 and 24/25 can be seen below for each care unit. This shows a positive improvement in each care unit over the last year. Some individual departments have demonstrated significant improvement during this time. Overall, the target of over 85% compliance has been reached in each care unit.

Figure 17: Comparison between 2023/24 and 2024/5 IPC scores for each care unit



Inpatient teams complete an overarching self-audit of IPC practice on a quarterly basis; with ongoing assurance provided through ward manager and matron audits using the Tendable auditing tool.

Our estates and facilities team complete audits on environmental cleaning based on national cleaning standards, and reported an average score of 95% over the year across the whole Trust. This evidence is also reported to the IPC Steering group on a quarterly basis.

Over 10,000 estates tasks have been completed over the year in addition to planned preventative maintenance, all of which support improved patient environment. The ventilation systems in some parts of the Trust estate require an upgrade. This is being monitored and managed via the Ventilation Safety Group.

Food hygiene training compliance for relevant staff is undergoing review to ensure that all appropriate staff have the necessary training.

Criteria 3: Ensure appropriate antimicrobial stewardship

The Trust does not currently have an antimicrobial pharmacist in post, and a business case is required to secure necessary funding.

Criteria 4: Provide suitable and accurate information on infection to patients/service users, visitors/carers and any person concerned with providing further support

During the year, we have worked with patients and experts by experience to review relevant patient information leaflets

Criteria 5: Systems and processes are in place to ensure that patient placement decisions are in line with the National Infection Prevention and Control Manual (NIPCM)

Self-assessed as fully compliant.

Criteria 6: Systems are in place to ensure all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection

Training and education: The IPC team continue to provide expert training for staff as part of their induction as well as ad hoc training in the workplace based on learnings from managing or investigating outbreaks or cases of healthcare associated infections. Mandatory training is provided using the national E-learning platform.

We held a successful IPC conference during the year which was attended by around 60 colleagues from a variety of Trust services. The IPC team also produce a monthly IPC newsletter with information on relevant topics or infections, examples of best and areas for improvement noted during site visits.

Fit testing for FFP3 masks: Disposable FFP3 masks are used in the Trust and should be worn to protect staff when carrying out aerosol generating processes (AGPs), or when working with patients with certain respiratory infections and other infections that are transmitted via the respiratory route such as chicken pox and measles. At present, EPUT's guidelines also advise wearing FFP3 masks when performing CPR.

22 members of staff have been trained as fit testers in care units. The IPC team have recruited a fit tester who was due to join in April 2025 to support care unit fit testers and provide the service to staff who require it. A plan is also in place to identify new starters within four weeks of joining as part of the staff induction programme.

During the last two years, 26% of relevant staff have been seen for fit testing, 1,309 out of a total of 5,052 including bank staff. In the coming year the aim is to report on compliance via care units with the addition of a quarterly denominator to enable accurate data to be produced.
Hand hygiene monitoring: We monitor compliance with best practice for hand hygiene through quarterly audits completed by our inpatient teams – our overall compliance rate is **99.6%.**

Criteria 7: Provide or secure adequate isolation precautions and facilities

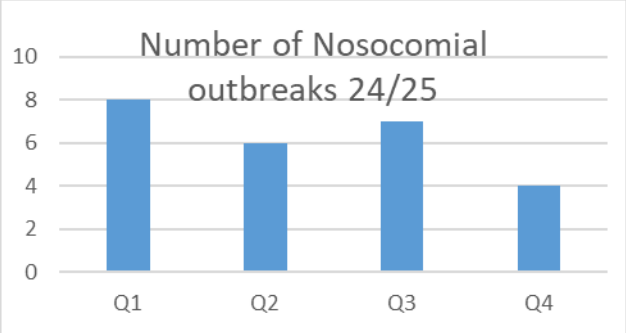
Self-assessed as fully compliant.

The IPC team has continued to work closely with clinical colleagues to identify patients with known, suspected or increased risk of infection. More staff engaged with this process as the year progressed.

We have also held discussions with system partners around appropriate alert organism surveillance systems for community and mental health services. It is acknowledged that many such services are in a similar situation to EPUT and are reliant upon contact from colleagues with timely information. Work continues to find a workable solution for the Trust, including via the new unified electronic patient record.

Nosocomial outbreaks of infection: The IPC team have supported clinical colleagues in the expert management of 25 outbreaks of infection during the reporting period. Learning from each outbreak is shared between teams and via the Trust's learning systems and the IPC Steering Group.

Figure 18: Number of Nosocomial outbreaks 2024/25



The number of outbreaks has reduced significantly on the previous two years and is attributable to the ending of the Covid-19 pandemic.

Table 10: Cases of healthcare associated infection

Clostridioides *difficile*: Clostridium difficile incidence is assessed as cases detected after 3 days of admission (these are considered attributable to an infection acquired in a healthcare setting). The system of reviewing cases determines whether cases were associated with or without breaches of local protocols, the latter being deemed unavoidable.	6 cases in total were detected after 3 days of admission. One of these also had several relapses.
MRSA bacteraemia: MRSA incidence is assessed as cases detected more than 48 hours after admission, which are considered to be attributable to an infection acquired in hospital, or cases where MRSA is considered to be a contaminant.	Achieved target to have zero cases of MRSA bacteraemia.
Gram-negative blood stream infections: E. coli bloodstream infections represented 55% of all gram-negative blood stream infections. Approximately three-quarters of these cases occur before patients are admitted to hospital, and the Trust continues to contribute to a system wide plan to support improvements across the health economy.	Zero cases reported.

Criteria 8: Provide secure and adequate access to laboratory/diagnostic support as appropriate

Self-assessed as fully compliant.

Criteria 9: Have and adhere to policies designed for the individual's care that will help to prevent and control infections.

Self- assessed as fully compliant.

Criteria 10: Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Self-assessed as fully compliant.

Performance against local strategic priorities

Because we deliver a wide range of services commissioned by different

ICS's and specialist commissioners, we have a great number and wide variety of mandated, contractual and locally identified key performance indicators (KPIs) which are used to monitor the performance and quality of services delivered.

In this section we have provided a summary of 2024/25 performance against the key operational metrics, quality of care metrics and organisational health metrics that NHS England previously set out in the NHS Oversight Framework.

We have included information of performance against a range of targets throughout this Quality Account to provide an overview of the performance of the Trust. We have also included some examples of quality innovations which have taken place throughout 2024/25 in the sections which follow below.

Full details of performance against all KPIs were provided to the Finance and Performance Committee each month during 2024/25 and any areas of significant under-achievement were advised to the Board of Directors as 'inadequate indicators' at each meeting.

Quality of care and outcomes	NHS Oversight Framework target	Year End (March 2025) position
CQC rating of Good or above	Good or above	Overall 'Requires Improvement'
Written complaint rate per 100 WTE	No target set	3.8 (March)
National Quarterly Pulse Survey	No target set	The results for 2024/2025 for the 9 core questions show an improvement in the motivation theme (I am enthusiastic about my job). The other 8 questions show a decline.
Never Events	0	0 (Apr-Mar)

There will be zero Safety Alerts Breaches	0	0 (Apr-Mar)
CQC Community Mental Health Patient Survey	No target set	Two questions scored in the highest 20% of trusts, 26 questions in the intermediate 20% and seven in the lowest 20% if truss
iWantGreatCare	No target set	89.5% positive score in March
People on Care Programme Approach (CPA) are followed up within 72 hours of discharge from hospital	80%	91.5%
Patients in settled accommodation	No target set	69% (LA target 70%)
Patients in employment	No target set	35.1% (LA target 7%)
Potential under-reporting of patient safety incidents	No target set	62.4 (MH benchmark >44.3)
Admissions to adult facilities of patients under 16 years old	0	0 (Apr-Mar)

Operational metrics	NHS Oversight Framework target	Year End Position
People with a first episode of psychosis (FEP) begin treatment with a NICE - recommended care package within two weeks of referral	60%	81.0%
Data Quality Maturity Index (DQMI) – MHSDS dataset	95%	91.8% (Latest published quarterly data at end December 2024)
Improving Access to Psychological Therapies (IAPT)/Talking therapies a) 50% of people completing treatment who move to recovery	52%	52.2%
Improving Access to Psychological Therapies (IAPT)/Talking therapies b) waiting time to begin treatment: ii) 75% within 6 weeks ii) 95% within 18 weeks	75% 95%	6 weeks 100% (March) 18 weeks 100% (March)
Continued reduction in inappropriate Out of Area Bed days to zero	Reduction	19,378 inappropriate out of area bed days
Leadership and Workforce		
Staff Sickness Rates	No target set	4.7% (March) (MH benchmark of <5%)
Staff Turnover	No target set	8.7% (March)

		(Local target based on national benchmarking <12%)
Proportion of Temporary Staff (Agency)	No target set	0.9% (March)
Staff Survey	No target set	The results for 2024 compared to the benchmarking average mostly show a decline in the People Promise scores. There was an area of improvement in the We are always learning theme. The three worse areas were: Staff Engagement, Morale and We are safe and healthy.

Patient safety

Patient Safety Incident Response Framework (PSIRF)

EPUT was an early adopter of the PSIRF in May 2021, with guidance from the National Patient Safety Incident team.

Following the early adopter phase, we have made significant changes and improvements to the PSIRF process and continue to refine processes to ensure that required improvements are incorporated. We established a PSIRF Oversight Project Board and local PSIRF oversight groups for each care unit. Care units participate in learning from reported patient safety events with the use of PSIRF learning response methods to improve patient safety.

PSIRF training and awareness sessions have been provided for learning response leads to lead and facilitate the interventions and develop safety actions.

The safety actions identified for learning are developed in collaboration with clinical teams and Patient Safety Incident Management (PSIM) team to ensure actions are completed and improvements implemented.

Table 11: Patient safety incident reviews commissioned in 2024/25

Type of Review	Description	Number commissioned 2024/25
After Action Review		33
Swarm Huddle		18
Multidisciplinary Team Review		7
Patient Safety Incident Investigation		14
Clinical Review	Phased out in 2023	3
Structured Judgement Review	Phased out in 2023 *	3
Total		78

* NHS England provided guidance on the type of learning responses used under PSIRF in August 2022. As a result, clinical reviews and structured judgement reviews have been phased out.

Learning from patient safety events

We identify safety improvement themes by analysing patient safety incident investigations and formulating safety improvement plans. Each themed area has been allocated to senior clinical and operational staff with sponsorship from our Executive Team to develop and progress the work. Current safety improvement plans include:

- Ligature risk reduction
- Physical health and the prevention of falls
- Multidisciplinary communication risk reduction
- Transitions for children and young people to adult mental health services
- Patient disengagement from services
- Medication incident risk reduction
- Discharge and transfer from in-patient services
- Record keeping
- Clinical handovers
- Policy and Standard Operating Procedure (SOP) application.

Each safety improvement plan has a working group with subject matter experts, professional groups and people with lived experience as patients of Trust services. These groups have carried out additional thematic analysis with recommendation to formulate safety actions with action owners to oversee and provide assurance for completion. The safety actions are evaluated using a system thinking and human factor approach through the application of PSIRF. Data can then be used to track and monitor the impact of the safety actions.

Monthly progress is overseen by the Patient Safety Incident Management Team, with assurance reporting formally through governance processes.

Patient Safety Partners

Our patient safety partners (PSPs) work with staff, patients, families and carers to help address issues raised and act as a critical friend to help the Trust understand what it does well and where it can do more.

A dedicated job description, person specification and induction process is used to recruit people with a background knowledge of EPUT services as a patient and/or carer or a member of public. People recruited as PSPs

work alongside our Patient Safety Incident Management Team to support learning, governance and the use of PSIRF.

In addition to participating in safety of care Governance meeting, oversight groups and safety improvement plans, our PSPs carry out site visits and provide safety walkabouts, meeting patients and capturing their story and experience of care. The feedback generated is reported directly to service team leads and managers and is used to help evaluate patient safety improvements.

Duty of Candour

We have reviewed our processes for engaging with families when harm has occurred to a family member. Family Liaison Officers (FLOs) are now integrated within our Patient Safety Team and we have implemented a new Duty of Candour policy. We have also taken the following actions:

- Reviewed training focused on the statutory duty of candour requirements and understanding, focusing on meaningful engagement and accurate record keeping with contact logs to support chronologies for the coronial process
- Reviewed training to promote understanding of statutory requirements, an emphasis on families and the importance of engagement throughout the patient safety review process from initial reporting to conclusion
- Revised template letters used to communicate with families, to ensure a family centred approach and support delivery of duty of candour
- Revised family engagement leaflets to provide information on the process, types of review, staff involved and the role of the FLO. The leaflets focus on how families can be involved in the review of their loved one's death, demonstrates how we value their contribution and want to ensure their voice is heard
- Updated information on the staff intranet to support colleagues acting in the role of a FLO
- Introduced a FLO forum to provide regular support and information along with regular updates
- Continued to provide FLO mentoring, including support and debriefing as required
- Worked closely with system partners to deliver family engagement sessions.

In the coming year, we will develop a survey to gain feedback and identify further improvements in our engagement with families.

Learning Response Forum

This forum has provided learning opportunities throughout the year, including:

- Embedding learning from case studies across our services
- Workshops on organisational changes to process
- Developing policies and a memorandum of understanding with system partners
- Delivering training in safety and human factors for key staff groups and developing patient safety introduction and awareness sessions which will be introduced in the year ahead
- Updating Datix to support improved reporting and oversight of patient safety incidents and Duty of Candour responses, which will continue into the coming year
- Work with our patient safety partners and lived experience ambassadors to review policies, develop information leaflets and conduct safety walkarounds.

Patient Safety Incident Response Plan (PSIRP)

Our PSIRP identifies local priorities for investigation and includes the following:

- Suicide/suspected suicide within 72 hours of discharge from a mental health inpatient ward
- Suspected/confirmed suicide of a patient with mental health problems alongside autism
- Suspected/confirmed suicide of a patient under the care of the eating disorder service
- Attempted suicide of a mental health inpatient (detained or informal) whilst on leave
- Absent without leave/abscond whilst detained under the Mental Health Act
- Life-threatening accident/injury to an inpatient where life-saving treatment is required
- Deliberate self-harm resulting in life threatening situation or life-saving treatment required
- Near miss ligature incident on mental health inpatient wards involving a fixed ligature point

- Infection Prevention and Control incident, for example the outbreak of a transmissible infection or hospital acquired infections with potential for severe consequence
- Physical health monitoring and surveillance, where either NEWS2 application and/or high-risk medications are a factor
- Delay in patient care/treatment resulting in moderate harm or above.

You can read more about our Patient Safety Incident Response Plan (PSIRP) on the EPUT website.

Embedding learning

We continue to use the following methods to share learning and findings from patient safety incident investigations and other learning response reviews conducted:

- **Sharing the report and learning with the patient/family:** The patient/ family are offered a copy of the approved report and the option of a meeting to discuss the report
- **Push and pull communications for staff:** safety alerts and team briefings
- **Five Key Messages and Lessons Identified Newsletter:** Key learning is shared in this format and published on the Trust Intranet for reference. Newsletters are shared at quality and safety meetings and placed in Culture of Learning folders in services areas which are available to staff and patients to read
- **Attendance and representation at meetings:** Care unit teams attend Learning Collaborative Partnership and Learning Oversight Sub-Committee meetings to share learning. Our Lessons Team attend at key governance meetings such as the Ligature Risk Reduction Group and Health Safety and Security Committee to share emerging themes
- **Themed learning events:** Held quarterly in care units
- **Live learning sessions:** Monthly sessions are recorded and made available on the Trust Intranet
- **Safety alert learning calls (SALC):** SALCs are put in place when there is significant opportunity for learning, based on the process for monitoring compliance with internal safety alerts
- **System-wide learning:** Developing learning forums to share learnings across services and teams, utilising existing forums where

appropriate, including Integrated Care Board monthly assurance meetings.

Table 12: Learning activities conducted in 2024/25

Session title	Number held	Staff attended	Views on Trust intranet
SEIPS	25	72	N/A
Human Factors	9	61	N/A
MAPSAF	5	53	N/A
Trust Induction (**ECOL)**	23	888	N/A
Lessons Newsletter (PDF)	12	N/A	2,519
5 Key Messages (PDF)	12	N/A	2,826
Newsletter and 5 Key Messages sent by email to all staff	12	N/A	14,788
Learning Matters Live	8	456	N/A

Clinical effectiveness

Quality assurance audits in our clinical areas provide assurance on a range of topic areas that are vital to improving care and monitoring effectiveness our care. During 2024/25, quality assurance audits have focused on our inpatient services and will be extended to cover community services in 2025/26. The Tendable audit system is also now linked with our Power BI data system to support quality insight and clinical governance reporting.

Quality assurance audits (Tendable)

At the beginning of October 2024, following a comprehensive review of the audits completed on the Tendable platform by our inpatient areas, a new suite of quality assurance audits was agreed and launched. The schedule for completion is shown in the following table. Services have gone live as follows:

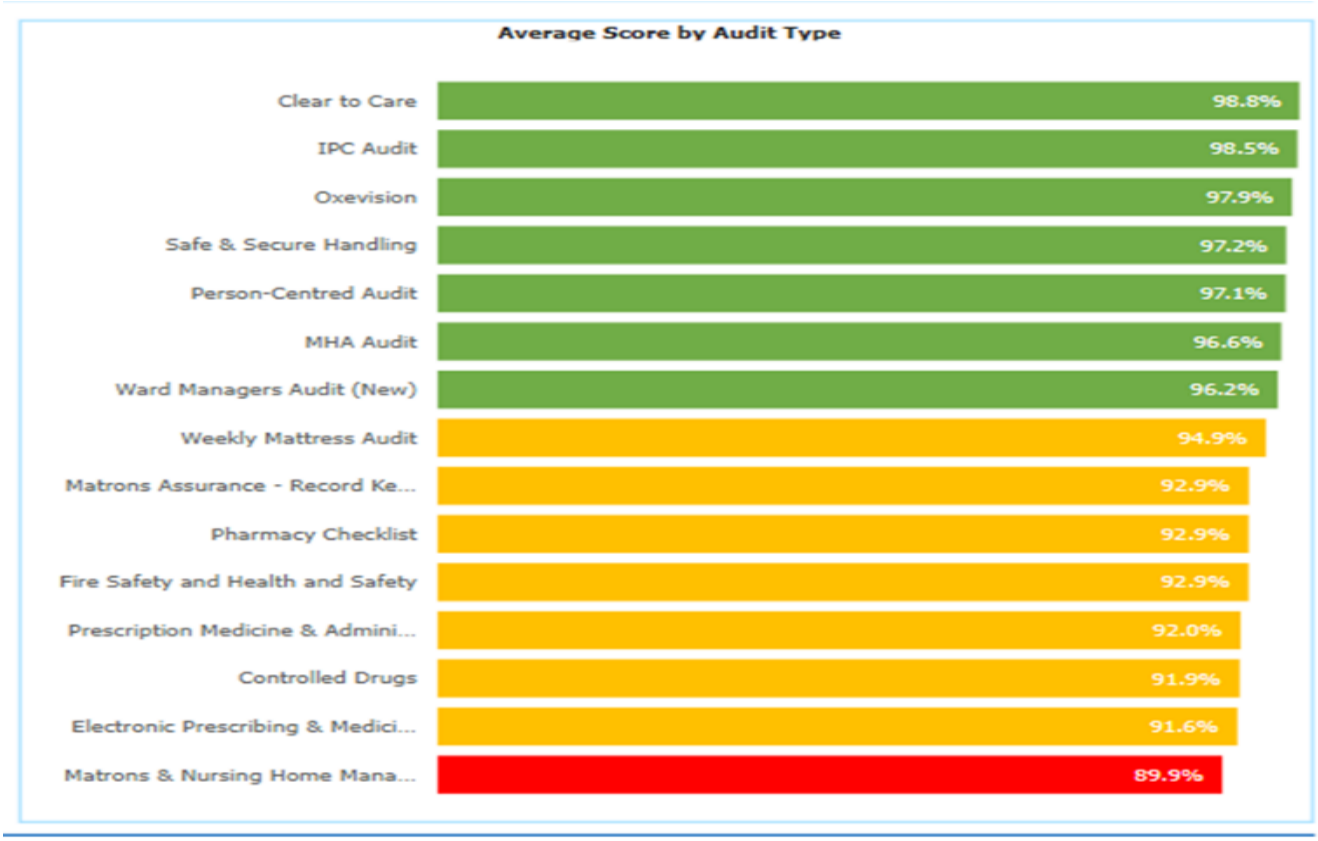
- Mental health inpatient wards - October 2024
- Specialist services - December 2024

- Perinatal mental inpatient care, dementia care homes and the Basildon Mental Health Urgent Care Dept - January and February 2025 and February 2025.

Table 13: Quality assurance audits

Audit	Frequency	Completed by
Clear to Care	Every shift (Day & Night)	Nurse in Charge/Qualified on Shift
Prescribing Medicine & Administration Chart (PMAC) Audit *(for those wards where ePMA is not yet in place)*	Weekly (x5 sets)	Qualified Staff Member
Electronic Prescribing & Medicines Administration (ePMA) *(for those wards where ePMA has been rolled-out)*	Weekly (x5 sets)	Qualified Staff Member
Mattress Audit	Weekly	Ward Nurse/HCA
Oxevision	Fortnightly	Qualified Staff Member/HCA
Ward Managers Audit	Monthly	Ward Manager
Person-Centred Audit	Monthly (x10 sets)	Named Nurse/Ward Manger/ Matron/Service manager
H&S/Fire Audit	Monthly	HCA/Security Nurse
MHA Audit	Monthly	Qualified Staff Member
Matrons Assurance - Record Keeping Audit	Monthly (minimum x1 set per ward)	Matron
IPC Audit	Quarterly	Qualified Staff Member
Controlled Drugs	Quarterly	Pharmacist
Pharmacy Checklist	Weekly	Pharmacist
Safe & Secure Handling of Medication	Six-Monthly	Pharmacist

Figure 19: Average compliance score by audit type for all mental health and specialist services for January and February 2025. (95% and above = green; 90%-95% = amber; below 90% = red).



In February 2025, the title of the Matrons' Assurance Record Keeping Audit was amended to the Matrons and Nursing Home Managers Assurance Record Keeping Audit to ensure that the audit was applicable and reflective of all services completing it.

When the compliance score for the Matrons and Nursing Home Managers Record Keeping Audit was reviewed in February 2025, one ward submitted an audit with "not applicable" responses, possibly as an error, which was scored by the Tendable system as zero. This may have skewed the overall results and may not be reflective of what is happening in practice. If compliance scores are recalculated without this audit, an overall total of 97.35% compliance would be obtained.

The five community physical health wards were due to go live with the new suite of quality assurance audits in April 2025, completing the roll-

out in inpatient services. Work will then follow to roll out a quality assurance audit programme across mental health and physical health community services.

Quality Senate

The aim of the Quality Senate is to create a space of professional curiosity, collaboration, shared ownership and psychological safety, where our care is professionally advised and agreed though the review of national, regional, local and research-based evidence on a chosen topic. We have agreed six priority areas for the first year:

- Trauma-informed care
- Move away from the Care Programme Approach (CPA)
- Dementia and mild cognitive impairment
- Neurodivergence
- Personalised care
- Population health

The Quality Senate forms part of the delivery of effectiveness of care by recommending how our services ensure care is evidenced based and effective, building towards greater consistency, reliability, equity and improved outcomes.

The guiding principles for the Senate are:

- Build on National Quality Board principles
- Foster the Trust's model of services being clinically led and corporately enabled
- Promote quality and equality impact
- Enable care based on best practice and evidence
- Ensure co-design and partnership with people with lived experience
- Be both advisory and accountable

Quality Senates completed by March 2025

Five Quality Senate sessions had been held by the end of March 2025, covering all the priorities set above, apart from population health. A part year review undertaken in September 2024 took feedback from senate members, summarised as follows:

Successes

- Increased representation of people with lived experience, including the appointment of a co-chair with lived experience

- Good attendance from professional and care unit membership
- Membership voice contributes to the discussion and understanding of organisational gaps, inequity of service and areas of good practice.
- Benefit of consensus agreement on recommendations, providing confidence when consideration of adoption is made
- Reviewed 103 evidenced based documents to date, with recommendations for change taken forward or informing business planning where investment is required

Improvement opportunities

- Need for consistent care unit and professional representation
- Process mapping of recommendations, tracking of adoption and impact monitoring
- Widen membership to support next steps, e.g. Director of Clinical Education, Director of Transformation
- Capturing the views of students on placements in EPUT services
- Better alignment of recommendations with both Trust and system strategic priorities
- Reflect on year one evaluation of the Quality of Care strategy to support new topic identification

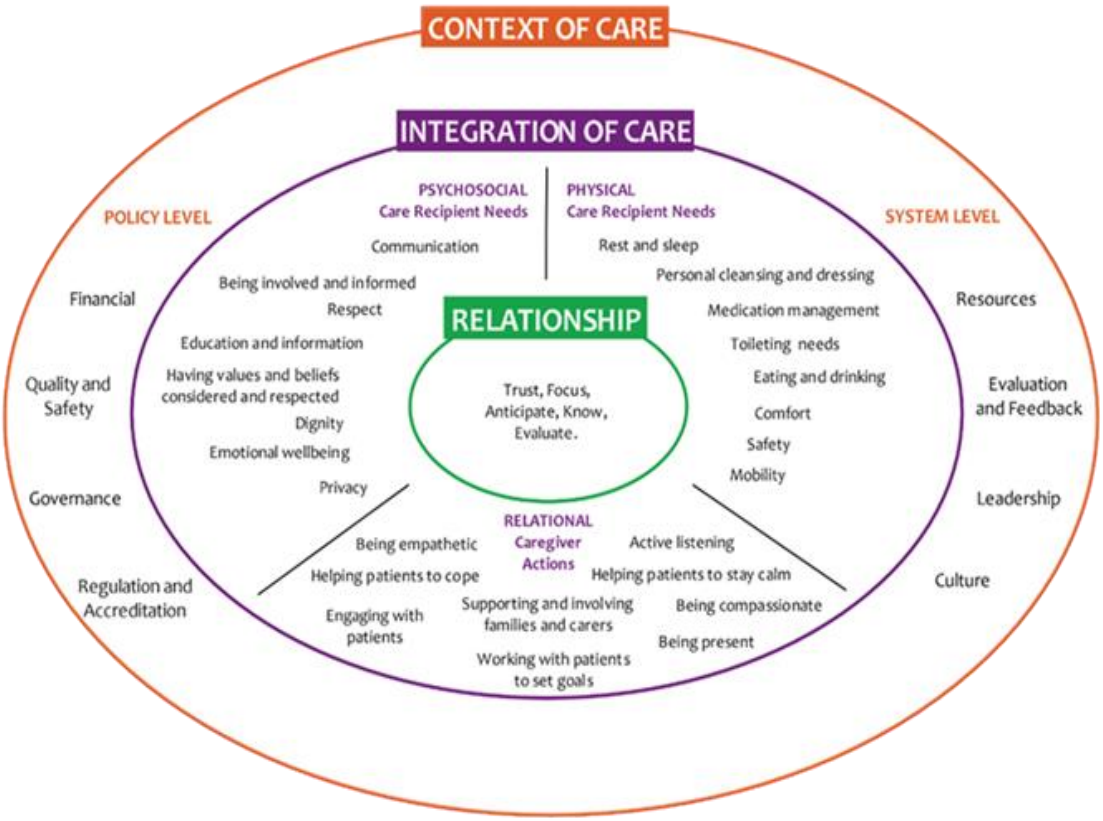
Next steps

- Introduce an empirical research review template to aid Senate members in analyzing information presented to them
- Move to bimonthly meetings to increase time between topics and ensure relevant information is available for topics to be agreed
- Continue to establish and embed the structure to drive professional, clinical and lived experience curiosity and collaborative recommendations
- Align recommendations with the Trust's year two quality priorities and eight key transformation programmes.

Fundamentals of Care

Over the past year, we have adopted the use of the Fundamentals of Care Framework to guide practice improvement that underpins the quality priorities shown below.

Figure 20: Fundamentals of Care Framework



The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with care recipients and their families, carers and loved ones. It also emphasises the need to integrate people's different fundamental needs:

- Physical – such as nutrition and mobility
- Psychosocial needs – such as communication, privacy and dignity
- Relational actions – such as care staff being empathetic and listening actively

The Framework was created from the expertise and experience of members of the International Learning Collaborative (ILC), a worldwide

group of distinguished professionals. EPUT is now a member of the ILC and we are therefore able to draw on an international body of evidence and mentoring as well as contributing to new evidence.

The framework was particularly attractive to us as it focuses first on the relationship, then the integration of care and the context of where that care is delivered. It is meaningful and relatable to individual care settings, whilst providing a framework we can all sign up to.

During 2024/25, we have piloted the Framework on our inpatient mental health wards, with a focus on reinstating the practice of giving each patient a named nurse and creating 'My care my recovery' care plans with each patient. In 2025/26, we plan to Framework across all care groups to support the delivery of our quality priorities, using evidenced based models to support the effectiveness of care.

Patient experience

Listening to the People we care for, their loved ones and supporters

Delivery against the strategic plan for working with people and communities in line with the national guidance

Our Working in Partnership with People and Communities Plan sets out our commitment to ensuring service users and their families and carers are at the heart of everything we do. The strategy was developed with our Lived Experience Ambassadors across four stages; analysis, hypothesis of core issues, testing and prioritisation. By delivering against this strategy, we have seen significant uplifts in all areas of participation, feedback, coproduction, and collaboration with the people and communities we serve. We continue to innovate and empower our growing lived experience workforce to think and act differently, resulting in changing organisational norms and culture towards a more open, transparent and inclusive one. For example, each of our tactical quarterly reporting groups for the Quality of Care Strategy has a lived experience lead, co-chairing each meeting. The strategy can be viewed in full on our website.

Strengthening our partnerships with people (patients, families and carers) and communities. This aim involves close working with voluntary, community and social enterprises across EPUT and all its services. The following examples show how we have continued to strengthen our partnerships:

Increased our involvement and attendance at networking and collaborative workshop events. This has included the North East Essex Mental Health collaborative event in which three of our Lived Experience Ambassadors shared their stories with colleagues from the Salvation Army, Essex County Council, RAMA (Refugee, Asylum seeker and Migrant Action) and Essex Police.

Supported the contributions of the lived experience ambassadors who contributed to the expressions of trauma exhibition at The Minories Gallery in Colchester, hosted by Healthwatch Essex. The exhibition, hosted in partnership with the Trauma Ambassador Group, featured artwork illustrating personal experiences of trauma through a range of multi-media pieces, with poetry and audio played throughout the exhibition, alongside interactive art pieces, paintings, textiles, photography and more.

Supported over 15 teams in EPUT to recruit **lived experience ambassadors to join interview panels** for positions both within the Trust and across the wider systems in which we operate.

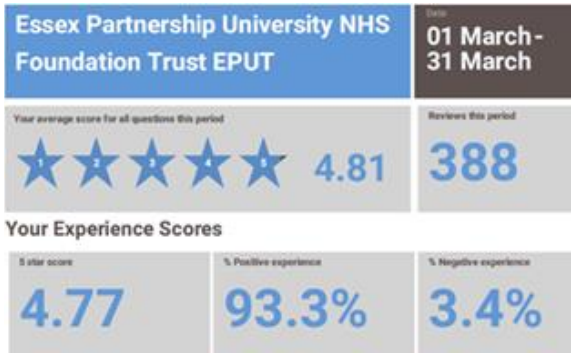
To ensure the effective delivery of the **Southend Essex and Thurrock (SET) All Age Mental Health Strategy for 2023 to 2028**, we have facilitated the System Implementation Group (SIG), utilising our reward and recognition policy and procedure. The strategy has an aim to ensure that people with lived/living experience of mental health and professionals working in mental health, work co-productively to improve services across Southend, Essex and Thurrock. As a pioneer of involving people in this way, EPUT has aided creating assurance that people with lived experience at the heart of the strategy, increasing likelihood of better outcomes in mental health services across the system. EPUT will help co-ordinate, support and (where appropriate) lead the implementation of the SET Strategy.

Developing the corporate volunteer function and team - introducing volunteers across all services, adding value to everything we do, as an extension of our workforce. We current have over 600 registered volunteers, including our Lived Experience Ambassadors, exceeding our original aim of a volunteer workforce of 500. This increase adds to our assurance of continuing people

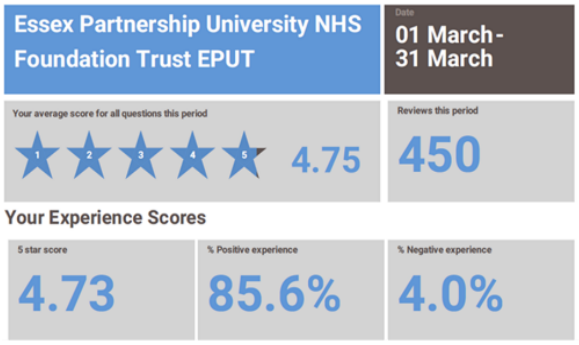
participation across all our services and care units. We are currently exploring a working agreement with the University of Essex to recruit student volunteers with a keen interest in health and social care as cultural advocacy volunteers. Our peer support worker pilot was so successful in demonstrating that lived experience is immeasurably valuable to both patient and staff groups in the pilot areas that we have progressed to moving our peer support workers to substantive posts.

Increasing the volume of feedback we receive through iWantGreatCare (IWGC), enabling our services to utilise experience data more effectively. IWantGreatCare feedback has continued to increase as detailed earlier in this report. We received 6,421 reviews in 2024/25, with a 5-star score rate of 4.75, 88.9% with a positive experience and 3.6% reporting a negative experience. A comparison with 2023/24 shows increase in reviews from 388 450 a month.

Figure 21: iWantGreatCare feedback



March 2024



March 2025

Developing our multi-faith service, ensuring patients and staff have their spiritual needs met

Key achievements are:

- **Chaplaincy team** – increasing the team from three Chaplains to six, with colleagues based in Chelmsford, Thurrock, Wickford, Epping, Harlow, Colchester, Clacton, Basildon and both CAMHS units.
- **Volunteer chaplaincy policy -** new policy in place, with standardised training and application processes in line with those for other volunteer roles.
- **Creating multi-faith rooms and boxes -** All inpatient units have a multi-faith space which is functional, respected and offers a reflective

sanctuary. Some rooms also have multi-faith boxes with bibles, Qurans, mindfulness reflections, prayer beads and prayer mats to supply patients with religious items whilst they are in hospital. These will be rolled out to all wards in the current year.

- **Memorials and funerals -** Our Chaplaincy team have provided pastoral care alongside memorial and funeral services for patients who have died and continued to provide pastoral and spiritual support after a patient safety incident. This year, our Head of Chaplaincy facilitated the funeral of our longstanding colleague, peer and friend Mark Dale.

Volunteers

It is vital that volunteers are recognised and valued as a workforce in their own right, independent of that of our Lived Experience Ambassadors. Volunteers at EPUT do not need to have lived experience of services. We are working with Anglia Ruskin University and the University of Essex to recruit volunteers, helping to deliver transferable skills to our local communities and potentially provide our future workforce with invaluable experience.

Improving the experience of care across all services

Following the successful pilot last year, IWGC volunteers are working across inpatient units to support and encourage patients, families and carers to leave reviews of their care. We have both digital and paper options to leave reviews, and introducing volunteers into the process shows that patients report greater feelings of confidence to give feedback and help patients to rephrase answers if required. This increased support has resulted in a 76% increase in feedback rates for those services with an IWGC volunteer. Having a physical presence on the wards associated with collecting feedback has also helped improved visibility and awareness of this function.

Volunteer, Maemi Writes:

"Volunteering has given me valuable insight into how the mental health care sector operates while providing a strong sense of purpose. As someone aspiring to become an assistant psychologist, this experience has been invaluable in helping me develop the interpersonal skills needed to engage with the types of individuals I hope to work with in the future.

Volunteers are great at gathering patient feedback because we come without preconceived notions or insider knowledge of the NHS. This "blank slate" approach allows us to ask open, unbiased questions and genuinely listen to patients' experiences, making their feedback more authentic and meaningful."

Volunteer, Ekaete writes:

"As a volunteer, I find immense fulfilment in being able to make a positive impact on people's lives. Volunteering has given me the opportunity to connect with others, learn new skills, improve my communication skills and gain valuable experience. It's incredibly rewarding to see the difference I can make, no matter how small it is.

I believe volunteers are invaluable in gathering feedback from patients. As an impartial and empathetic listener, volunteers can provide a safe space for patients to share their concerns and suggestions. Patients often feel better at ease sharing their honest opinions with someone who isn't directly involved in their care. This helps to ensure that their voices are heard, resulting in significant advances in patient care and services or the healthcare services."

Our Neurodivergent Network

Our Neurodivergent Network now has a lived experience lead in place and holds two regular meetings:

- One hosted with the Lived Experience Lead and Patient Experience team - "ask and listen"
- A "doing" group with our Patient Experience team, system partners and our Deputy Directors of Quality and Safety

The group ensures that the voices of individuals with lived experience inform the design, delivery, and improvement of services.

Image created by Mohsin Saeed, Co-production lead for the Neurodiversity network.

The Care Quality Commission (CQC) Community Mental Health Survey

The CQC's annual Community Mental Health Survey asks people who use NHS community mental health services in England about their experience of care. The survey results are used to build an understanding of the risk and quality of services. The survey involves 53 providers of such services. The 2023 survey (the survey with the most recently published results) received almost 15,000 responses, around 20% of people using services.

EPUT continues to participate in the survey. We used the 2023 results to identify and make changes to improve the experience of people using our services. This year, the methodology, eligibility, and questions used have been revised and so it is not possible to make comparisons with previous years.

Figure 22: People who took part in the EPUT survey

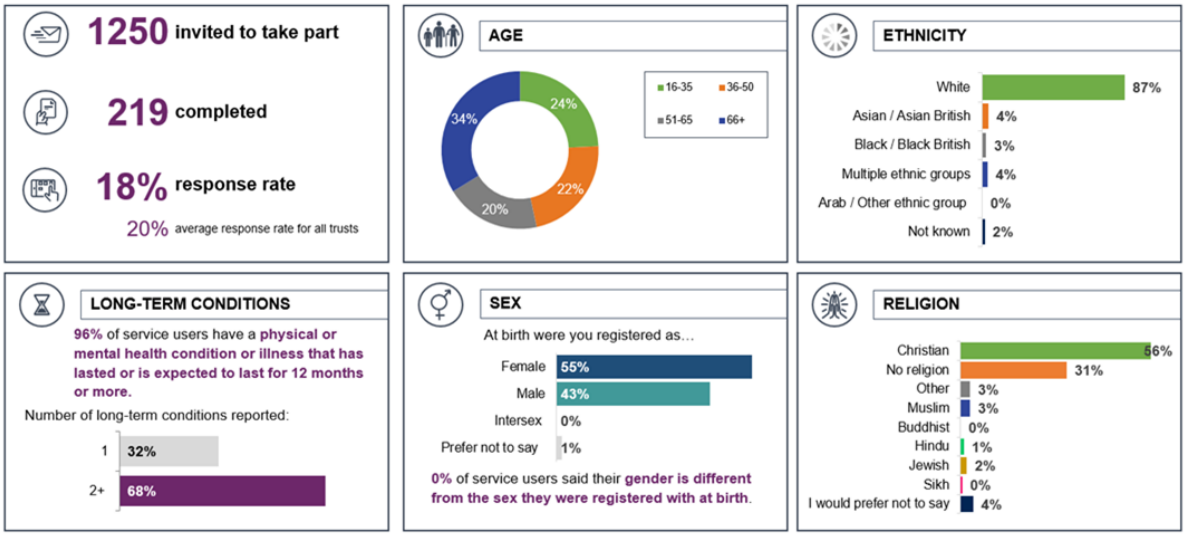


Figure 23: Comparison with other trusts (the number of questions where EPUT performed better, worse, or about the same compared with all other trusts)

Where our service user experience is best, (top 5 scores relative to national average):

- **Support while waiting**: service users offered support appropriate for their mental health needs while waiting (Q7)
- **Support in other areas of your life**: service users being given help or advise with finding support for finding or keeping work (Q32_2)
- **Planning care**: service users having a care plan (Q 13)
- **Support in other areas of your life**: service users being given support with physical health needs (Q31)
- **Support while waiting**: service user offered support with their mental health while waiting, between assessment with the NHS Mental Health team and first appointment for treatment (Q6).

Where our service user experience could improve (bottom 5 scores relative to national average):

- **Medication**: what will happen if they stop taking medication being discussed with the service user (Q21_4)
- **Medication**: side effects of medication being discussed with the service user (Q21_3)
- **Support in accessing care**: NHS Mental Health team asked if service users needed support to access their care and treatment (Q34)

- **Talking therapies**: service users having enough privacy to talk comfortably during taking therapies (Q25)
- **Support in other areas of your life**: service users being given help or advice with finding support for joining a group or taking part in an activity e.g. art, sport etc. (Q31_1).

The full report is available on the survey website.

Listening to concerns, complaints and compliments

The Trust acknowledges the value of feedback from patients, families and carers and continues to encourage the sharing of personal experiences. This type of feedback is invaluable in helping us ensure that the service provided meets the expectations and needs of our patients through a constructive review.

Complaints are expressions of dissatisfaction from patients and/or relatives who are unhappy about an aspect of their experience of our services. Complaints are invaluable for the identification of trends which enable us to improve service where necessary. We are committed to providing a complaints service that is fair, effective and accessible to anyone.

All complaints are treated confidentially and stored separately from the complainant's medical records. Making a complaint does not harm or prejudice the care provided to the complainant.

In 2024/25, the Trust received 194 formal complaints about its services:

	2023/24	2024/25
Formal complaints	275	249
PALS concerns	537	603
Concerns raised by Members of Parliament on behalf of constituents	69	73
Locally resolved complaints	60	59
Compliments	1,344	1,545

Within the year, 77 cases were referred to the Parliamentary and Health Services Ombudsman (PHSO) where the complainant was dissatisfied with the response received from the Trust, compared to 64 in 2023/24. One case was investigated by the PHSO but not upheld, and the other two referrals were awaiting initial assessment as at 31 March 2025.

268 formal complaints were reviewed and closed in 2024/25, with the following outcomes:

	Number	%
Upheld	31	12%
Partially upheld	116	43%
Not upheld	71	26%
Withdrawn	6	2%
Resolved locally *	2	1%
Not investigated **	42	16%

*Resolved Locally: these are complaints that were logged as formal complaints but were subsequently resolved informally by the Service, and therefore not investigated by the Complaints Team. This is only done in agreement with the person making the complaint and results in a faster resolution.

**Not investigated: these are complaints where it has not been possible/ appropriate to investigate for various reasons e.g. relates to care delivered by another provider complainant is signposted to the other provider), or where repeated attempts to contact the complainant has failed.

The 2009 NHS Complaint Regulations state that if a trust is not able to provide a response within six months, it must notify the complainant in writing to explain the reason why and provide a full response as soon as possible.

We aim to resolve formal complaints within 60 working days or three months. In 2024/25, we resolved 41% within 60 working days. We recognise that complex cases can take longer than 60 working days to

investigate, and if more time is required, we keep the complainant updated on the expected timeframe.

We are committed to keeping people updated and we aim to achieve 100% resolution of complaints within the timescale advised. In 2024/45, we achieved this for 98% of complaints, compared with 95% in 2023/24.

In 2024/25, 25 closed complaints were reopened. Reasons for reopening cases included where the complainant raised additional questions/concerns.

During the year, the main reasons to raise a formal complaint were in relation to:

	%
Clinical practice	58%
Communication	16%
Staff attitude	13%
Systems and procedures	9%
Other	5%

An important part of our complaints process is the independent review of a random selection of closed cases each quarter, carried out by our Non-Executive Directors. The reviewer rates the quality of the investigation and the response and considers whether the Trust has done all it can to resolve the complaint and if appropriate lessons were identified and taken forward.

Seven closed cases were reviewed in Quarters 1 to three, with the results shown below:

	2023/24	2024/25
Rated good or excellent for 'how the investigation was handled'	89%	100%
Rated good or excellent for the 'quality of the response'	100%	100%
Evidence of learning and /or improvement action (if applicable)	57%	86%

The following examples show changes which have been made in the last year as a result of complaints and concerns raised:

- In response to a complaint regarding the management of a patient's diabetes whilst on an assessment unit, several actions were taken including training sessions for staff by the specialist diabetic nurse, and all staff being advised to ensure advice is obtained from the diabetic team when an individual's blood sugars are repeatedly high.
- In response to a complaint raised by a family that their son took his own life three days after being assessed by a registered mental health nurse as being at 'no risk', several improvements to the assessment process were implemented. Clinicians now refer all patients, with their consent, to substance misuse services, and provide signposting and written information if they do not consent to a referral. Clinicians offer to speak with a family member/carer to gain further information and consider appropriate support, and it is now clearly documented if the patient declines this offer.
- In response to a complaint regarding a patient who had been inadvertently prescribed double the correct dose of medication when discharged from a ward for leave, all medication for discharge is now checked against the current prescription prior to handing to the patient or carer when they leave the ward. Any changes to prescriptions are reported to the pharmacy team urgently to be checked, and staff are required to explain medication to the patient/ carer before they leave the ward. This is then documented in the patient's clinical record.

In 2024/25, we received 1,185 compliment letters, emails and cards which we then shared with staff to highlight good practice and share learning. Examples include:

- The husband of a service user at the Crystal Centre praised the service, highlighting the good support and how easy it was to contact the service by phone, with staff even returning calls outside of normal office hours. He also thanked staff for ringing before they arrived, which gave them time to get ready for the visit and made his wife more comfortable with planning and coping with her day.
- A service user of the Home First Team at the Derwent Centre complimented the reception staff who made them feel valued and

heard, always taking the time to speak with them despite being busy. The service user said, *"I won't ever forget their kindness towards me".*

- The mother of a child under the Lighthouse Centre was visited by a physiotherapist for the last time before he transitioned to Adult Services and wanted to feedback how supported she had always felt by the service, saying that the support she had received had been amazing and that she did not know what she would have done without it.

Further information is available in the Complaints and Compliments Annual Report 2024/25 on our website.

Focus on Staff

Our People and Education Strategy

Since joining the Trust in May 2024, our Chief People officer has outlined a set of focused education and learning core objectives, based around developing an effective and aspirational education strategy that takes advantage of effective relationships with partners in education. Key objectives are:

Effective utilisation of apprenticeship levy and enhanced opportunities for work experience.

We have actively collaborated with the Mid and South Essex Healthcare Assistant Academy to develop a co-ordinated approach to recruitment, on-boarding and induction. The ambition is to ensure that new starters are supported to complete their care certificate in a timely way, have developing career conversations and developmental pathways followed by an early offer to start an appropriate apprenticeship.

More recently, we have revised our process for approving continuing professional development (CPD). The new process encourages staff to consider taking up apprenticeships, utilising our apprenticeship levy fund to support the costs of learning.

Review leadership development, demonstrating a clear link with areas of development across all leadership teams and for those who aspire to leadership roles.

Following a comprehensive review of our leadership and management programmes, we are seeking approval for a new set of programmes, alongside a review of the current outsourced programmes, including number of applications, cost, evaluation and timescale for attendance, alongside scoping apprenticeship and options from our local university and higher education partners.

Establish effective strategic and operational partnership arrangements with higher education partners.

We have established monthly catch-up meetings with the Deans of Health in both of our key partnership higher education providers - Anglia Ruskin University and the University of Essex.

We have recruited to a new joint appointment with Anglia Ruskin University, a role which focuses on innovation and assurance in relation to the NHS England safe learning environment charter.

At present, we have nursing placement capacity for 250 mental health learners, 84 adult health learners and eight child learners. Key lines of action to sustain and enhance capacity include managing timescales for investigations in areas where placements are paused, therefore re-introducing learners at the earliest opportunity, reviewing capacity for learners within other areas of the Trust and exploring blended/ simulated placement learning and hybrid approaches to placement learning. We are also in the process of developing research and innovation strategic compacts with both universities.

To revise our appraisal framework to focus on development needs and consider a career coaching service for staff and aspirant staff.

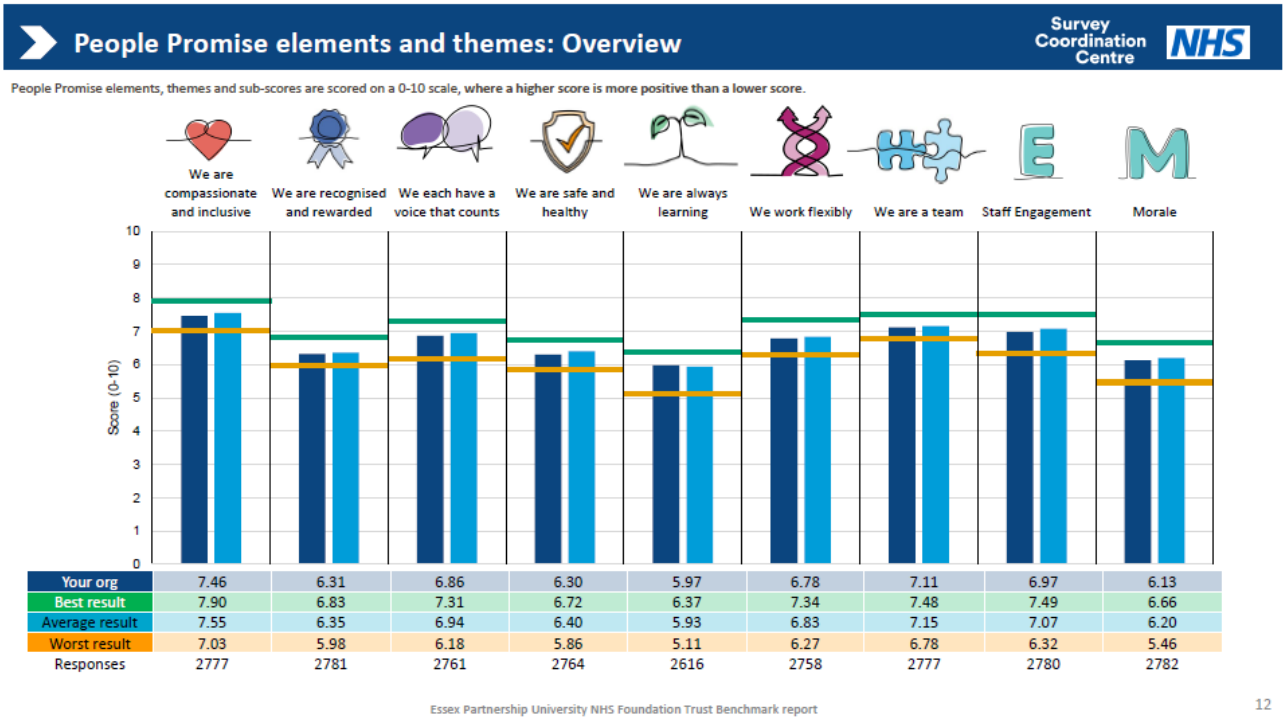
We are starting a review of our current coaching approach, evaluating the potential option for a Trust or system wide approach. This review will build upon collaborative conversations with our management teams and corporate leads to co-produce agreed content.

NHS Staff Survey

The NHS Staff Survey, run annually, benchmarks EPUT against other NHS Trusts of a similar type. Survey questions align to the seven elements of the NHS People Promise, with engagement and morale as two additional elements.

In 2024, response rate was **41.47%** against a median of 54% for peer organisations in our benchmark group. This is a decrease in response rate compared with prior years (**2021**: 46.41%, **2022**: 42.11%, **and 2023**: 43.67%).

Figure 24: EPUT's performance in each People Promise element and theme in comparison to the benchmark group average



Of the nine Staff Survey elements, EPUT performed below average compared with the benchmark group average, and performed above average in the NHS People Promise 'We are Always Learning'.

Five priorities have been identified to improve staff experience across all areas of the organisation. These include focusing on:

- Compassionate and inclusive leadership and management
- Celebrating and recognising staff
- Addressing workload and factors leading to burnout
- Improving psychological safety and a culture of safety
- Enhancing appraisals and clinical supervision

In addition to these broad priorities, 2024/25 has seen improved partnering approaches with care units, helping leaders digest and respond to the results from staff voice in their areas. A dedicated Staff Survey Senior Leadership Group (SLG) meeting was held, where leaders reflected on their local results and shared plans for improvement over the coming year.

National Quarterly Pulse Survey (NQPS)

The National Quarterly Pulse Survey (NQPS) takes place three times a year and is a consistent and standardised internal and external measure of staff experience. The survey is open for one month in Quarters 1, 2 and 4, with the national staff survey taking place in Quarter 3. The survey consists of nine questions, grouped into themes of motivation, advocacy and involvement. NQPS results are shared across the organisation, with early results also reported to the executive team.

The table below provides 2024/25 response rates to the NQPS compared to 2023/24:

NQPS Window	2023/24 Responses	2024/25 Responses	Change (%)
Q1 (April)	315	390	**+23.81%**
Q2 (July)	605	696	**+15.04%**
Q4(January)	587	492	**-16.18%**

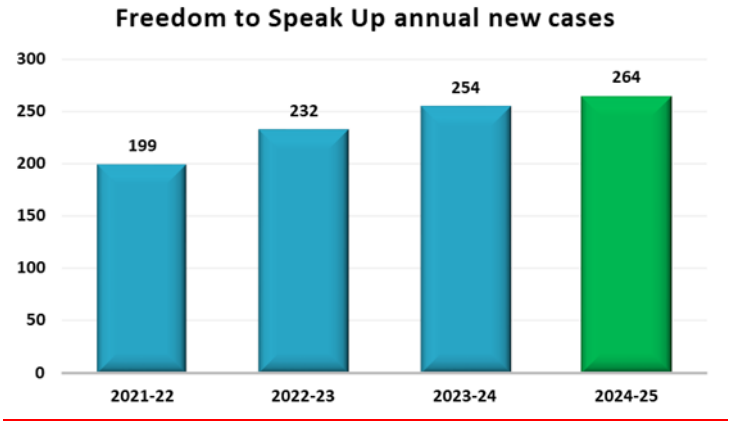
2024/25 was EPUT's first full year of using the People Pulse platform to complete the NQPS. This platform is used by many other NHS Trusts and allows results to be compared with other providers. People Pulse has provided improved functionality, including the addition of themed questions which can be compared with results from other organisations.

Our Engagement Champions Network has continued throughout 2024/25, now meeting bi-monthly.

This group includes colleagues across the Trust who are committed to increasing engagement. In the coming year, we will review the structure, format and purpose of this forum to ensure it best supports the NHS People Promise 'We each have a voice that counts'.

Freedom to Speak Up Guardian

Figure 25: Freedom to Speak Up annual new cases



We have continued our journey of developing and embedding the principles of speaking up, to encourage and enable our staff to speak up and raise any concerns about patient and staff safety with greater confidence.

Not all issues raised through Freedom to Speak Up (FTSU) are concerns. The FTSU Guardian provides the space and support for colleagues to explore and discuss concerns as well as other issues they may wish to sound out or sense check. Some issues raised are individual, whilst others relate to the wider Trust, patient care or groups of staff. The FTSU Guardian helps support and coach individuals to speak up and raise an issue for themselves, signpost them to other appropriate channels or to escalate a concern or matter with their consent. Early resolution of concerns and issues to support the advancement of organisational cultural change is preferred. We are encouraged at the slight increase in the number of new cases from previous years, as numbers of staff choosing to speak up to the Guardian evidences the importance of having an alternative and confidential route for staff to utilise.

We are monitoring patterns of speaking up and routes utilised prior to FTSU and possible reasons for this. There has been an increase in the use of anonymity over the last year. Asides from potential fear and futility driving this, emerging themes to consider are ease of reporting, loyalty, letting off steam, campaigning and the impact of other factors such as the Lampard Inquiry.

Table 14: Total number of concerns raised in 2024/25

Approach taken to Speak Up	Q1	Q2	Q3	Q4	2024/ 2025
	38	34	14	30	116
	10	13	34	13	70
	11	25	22	20	78
Total number of concerns raised	**59**	**72**	**70**	**63**	**264**

FTSU and the trust values

Speak Up – We Care

Listen Up – We learn

Follow Up – We empower

As we align FTSU to the trust values and differentiate bullying and harassment from inappropriate attitudes and behaviours, we have seen a marked reduction in the reporting of bullying through FTSU. This is significant as we look to empower colleagues to speak up and recognise/live the trust values. Further work is planned in this area.

Freedom to Speak Up Activity 2024/25

Table 15: Numbers of people speaking up and issues raised

	People Speaking Up	Patient Safety	Worker Safety / well-being	Bullying & Harassment	Inappropriate Behaviours / attitudes
Q1	59	9	22	7	29
Q2	72	12	24	6	20
Q3	70	14	34	2	36
Q4	63	15	20	11	26
Total	***264***	***50***	***100***	***26***	***111***

NB: Other issues are raised through FTSU than the broad themes captured here.
It is also important to recognise the multiple avenues that staff have to speak up about concerns or make suggestions for improvement, including line managers, the Employee Engagement team, staff briefings with the Executive team and leadership engagement visits. These all provide additional routes for staff to raise their concerns in varied formats.

Significant work has been undertaken throughout the year to align speaking up processes with national guidance and directives. This process is in its infancy and so 2025/26 will see further work, along with FTSU being a standing item within the Accountability Framework governance, increasing executive oversight.

Undertaking all three national e-learning FTSU training modules is now mandatory for all colleagues. This is part of a wider drive to ensure all colleagues can Speak Up, Listen Up and Follow Up for each other, services users and their families as well as for themselves. We are moving towards developing a wider collective responsibility for the whole cycle of FTSU, rather than Speaking Up being the prerogative of more junior colleagues with all the Listening and Following Up being the requirement of more senior colleagues.

In March 2025, another FTSU Guardian joined the Principal FTSU Guardian to help support and expand the FTSU service.

Guardian of Safe Working (for Resident Doctors)

The Board of Directors via the People Equality & Culture Committee receives reports from the Guardian of Safe Working (GSW) summarising issues, themes, and trends. The Guardian of Safe Working role protects patients and doctors by making sure doctors and dentists are not working unsafe hours. The Guardian reports directly to the Trust Board and is independent of the management structure within the organisation.

The Guardian of Safe Working role:

- Acts as the champion of safe working hours
- Receives exception reports and records and monitors compliance against terms and conditions
- Escalates issues to the relevant executive director or equivalent for decision and action
- intervenes to reduce any identified risks to doctors/dentists or to patient safety
- Undertakes work schedule reviews where there are regular or persistent breaches in safe working hours.

In 2024/25, one of our consultant psychiatrists undertook the role for the Trust, with responsibility to provide assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract.

Table 16: Number of doctors in training 2024/25

	Number
Number of Doctors in training (total inclusive of GP and FY1 / FY2)	158.75
Number of Doctors in psychiatry training (on 2016 terms and conditions)	89.25
Total number of vacancies	16
Total vacancies covered by LAS and MTI	11.25

Note. Figures quoted are an average over the reporting period.

Exception reports

Exception reporting in conjunction with work scheduling is part of the 2016 Resident Doctor Contract. The Contract supports a safe working environment in which resident doctors can meet their training requirements whilst delivering great care for patients. This works via a negative feedback loop; i.e. if there is no exception reporting then those responsible for writing the work schedule will assume their rota is fit for purpose (even if it is not). Exception reporting has replaced diary monitoring as the contractual process for monitoring working hours.

Our bi-monthly Resident Doctors Forum is well attended by representatives from all areas of the Trust. All matters discussed in this meeting are resolved in a timely way and are escalated where necessary.

Trainees raised 20 exception reports in 2024/25, an increase of one report over 2023/24. All reports were sent to the Educational Supervisor (copied to the GSW) to address concerns within the contractual timeframes.

The Trust received eight fines in 2024/25 for stepping down and additional hours worked.

Annex 1: Feedback on our 2024/25 Quality Account

Under the requirements of the Health Act 2009, NHS trusts are required to share draft Quality Accounts with key local partners for comment. Comments and statements were received from the following local partners and have been included in this section of the Account:

- Mid and South Essex Integrated Care Board
- Hertfordshire and West Essex Integrated Care Board
- Suffolk and North East Essex Integrated Care Board
- Healthwatch Essex.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex
Integrated Care Board

Thank you for the opportunity to comment on the Essex Partnership University NHS Foundation Trust (EPUT) Quality Account for 2024/25, received on 1st May 2025.

Mid and South Essex Integrated Care Board (MSE ICB) acknowledges the continued challenges across the local health and care system, of which EPUT plays an integral part.

This response reflects our perspective on Adult Community Health services in South-East Essex and Mental Health services across the broader MSE ICB footprint provided by EPUT.

The Quality Account presents a clear, comprehensive overview of the Trust's performance and priorities.

The introduction of the Quality-of-Care Strategy in April 2024 represents a significant and strategic advancement. Transitioning from the "Safety First, Safety Always" model to a broader framework grounded in safety, effectiveness, and patient experience has laid a robust foundation for improvement. Particularly commendable is the commitment to co-production, reinforcing a person-centred and inclusive approach to care.

The development of ten safety improvement plans, including those targeting ligature and falls risk, clinical handovers, and neurodiversity demonstrates a strong commitment to evidence-based and meaningful change.

We would like to acknowledge several areas of progress which deserve recognition:

- **Reduction in Restrictive Practices**: The 12% reduction in restraints and 15% reduction in restrictive practices reflects meaningful progress in embedding trauma-informed and person-centred care approaches across the Trust.

- **Infection Prevention and Control:** EPUT has made commendable progress in IPC, achieving an 18% improvement in care and environmental standards. Continued peer learning and development of the IPC programme into 2025/26 are welcome and essential for sustaining high-quality, safe care.

- **Safeguarding:** The Trust has shown clear improvement in safeguarding, exceeding its enquiry closure target with 76% closed and enhancing oversight through data tools and training. Continued focus on reducing delays, building team capability, and improving governance will be critical to sustaining progress in this vital area.

- **End of Life Care**: The high rates of compliance with patient preferred place of death (PPD), exceeding the national average in South-East Essex, demonstrates EPUT's commitment to delivering dignified and compassionate care.

- **Health Inequalities**: The systematic approach to tackling disparities in respiratory health among patients with Severe Mental Illness (SMI), and the implementation of smoking cessation services and health checks, represent a valuable focus on vulnerable populations.

- **Medicines Optimisation**: The completion of the ePMA rollout across inpatient wards and the recruitment of additional pharmacy personnel have yielded benefits in terms of patient education and safer prescribing practices.

- **Involvement and Co-Production**: The structured involvement of over 300 individuals with lived experience, in roles such as peer support workers and safety partners, is a particular strength and model of good practice.

- **Patient Safety Incident Response Framework**: The ICB commends EPUT for its leadership in implementing PSIRF, fostering a learning culture, and integrating patient voices in safety work. We acknowledge the maturity of the structures now in place and support the Trust's direction of travel, particularly in evolving its digital infrastructure and embedding impact measurement.

EPUT is to be commended for its transparent reporting, particularly in acknowledging areas where targets have not been fully met. Of note is the absence of a fully operational Quality Dashboard. We urge that this be prioritised in 2025/26 to support effective real-time monitoring and thematic analysis.

While the quality account shows encouraging progress, it also identifies several areas needing further development:

- **Training and Compliance**: The Immediate Life Support (ILS) training compliance rate remains below the 85% target. The lack of internal ILS training capacity contributes to this shortfall, and while plans are in motion, further urgency is advised.

- **Neurodivergence**: The neurodiversity priority has not progressed as rapidly as others. The development of clear baseline data and outcome tracking remains incomplete. Greater consistency and regularity in the steering group's operation would help drive forward change.

- **Suicide and Self-Harm Prevention**: The increase in non-fixed ligature incidents among children and young people is concerning, even as harm levels remain low. The evolving nature of self-harm behaviours underlines the importance of adaptable, responsive, and compassionate care planning.

- **Physical Health Training and Oversight**: While improvements have been made, gaps remain in the implementation of structured early warning protocols (e.g., NEWS2) and in tracking deterioration due to physical health concerns among mental health patients.

- **Outcome-Focused Metrics**: Much of the data currently presented pertains to activity and compliance. As the Quality Dashboard matures, a stronger emphasis on outcomes—such as recovery, wellbeing, and patient-reported experience—will be essential.

- **Data Infrastructure**: The absence of a fully operational Quality Dashboard has limited effective benchmarking and thematic analysis. The dashboard's launch in 2025/26 is essential for data-led improvement.

Recognition of 2025/26 Priorities

We are encouraged by the Trust's co-produced development of its 2025/26 priorities.

The overarching Culture and Competence priority, rooted in guidance from the Mental Health Improvement Support Team (MHIST), reflects a clear commitment to embedding quality into leadership, culture, and practice.

Strategic priorities for the coming year are well-judged:

- **Reducing Health Inequalities**: through targeted work with Black women in perinatal services and men from global majority backgrounds via the COMPASS pilot.

- **Patient Experience**: focusing on compassionate, structured involvement of service users and families following patient safety events.

- **Enhancing End of Life Care**: particularly by improving documentation and delivery of patients' preferred place of death.

- **Suicide and Self-Harm Prevention**: with renewed focus on trauma-informed care, risk reduction, and collaboration with national forums.

The consolidation of governance under a unified Quality of Care Oversight Delivery Group is a welcome development, as is the focus on evidence-based practice, cultural readiness, and capability building using frameworks such as NHS IMPACT and MHIST.

In conclusion, the 2024/25 Quality Account is a transparent, thoughtful, and aspirational document. While areas such as data infrastructure, neurodivergence, and training require further development, EPUT's direction of travel is positive and its commitment to improvement is evident.

We thank the EPUT staff, leadership, lived experience partners, and volunteers for their continued dedication to improving outcomes for patients and communities across Essex. We look forward to ongoing collaboration in 2025/26 to strengthen patient safety, share system learning, and enhance service quality.

Yours sincerely,

Dr Giles Thorpe
Executive Chief Nursing Officer
Mid & South Essex Integrated Care Board

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) response to the Quality Account of Essex Partnership University NHS Foundation Trust (EPUT) for 2024/2025.

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) welcomes the opportunity to provide this statement on the Essex Partnership University NHS Foundation Trust (EPUT) Quality Account for 2024/25. The ICB would like to thank EPUT for preparing this Quality Account, developing future quality priorities, and acknowledging the importance of quality at a time when they continue to deliver services during ongoing challenging periods. We recognise the dedication, commitment and resilience of staff, and we would like to thank them for this.

HWE ICB is responsible for the commissioning of health services from EPUT. During the year the ICB has been working closely with EPUT and the wider ICBs in gaining assurance on the quality of care provided to ensure it is safe, effective, and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, the information contained within the Quality Account has been reviewed and checked against data sources, where this is available, and confirm this to be accurate and fairly interpreted to the best of our knowledge.

Clear improvements are evident throughout the Quality Account against the 2024/25 priorities relating to patient safety, patient experience, and clinical effectiveness. The co-produced *Quality of Care Strategy,* launched in April 2024 marks a key milestone, reflecting a strong commitment to patient-centred care. The ten safety improvement plans address complex issues such as ligature and fall risk clinical handovers, and policy accessibility, demonstrating a strategic approach to quality improvement.

The ICB would like to acknowledge several areas of progress that reflect the Trust's ongoing commitment to quality improvement. The 12% reduction in restrictive practices marks a positive shift toward trauma-informed approaches that prioritise patient dignity and autonomy. EPUT's high compliance with patients preferred place of death, highlights a strong commitment to delivering compassionate end-of-life care.

The Trust's targeted efforts to address health inequalities, especially through focused interventions for individuals with Severe Mental Illness demonstrate an inclusive approach to improving outcomes for this vulnerable group. Furthermore, the successful rollout of the electronic prescribing and medicines administration system across inpatient wards, alongside the expansion of the

pharmacy workforce, has contributed to enhanced patient safety and improved education around medication use.

The ICB commends EPUT for their strong commitment to co-production with patients, carers, and staff. The Trust has made strong progress embedding lived experience through its *Working in Partnership with People and Communities Strategy*, involving over 300 individuals in key roles and contributing to around 5,500 paid hours. This reflects a commitment to an inclusive and compassionate approach to service design and delivery.

The Trust has made significant progress in improving workforce stability, demonstrated by reduced staff turnover and vacancy rates, key steps toward strengthening service quality and the safety of care delivery. The ICB acknowledges the Trusts efforts to enhance staff experience, as reflected in the NHS Staff Survey results, and welcomes the establishment of a dedicated Senior Leadership Group working closely with individual care units to review feedback and develop improvement plans.

The ICB commends EPUT for the reduction in patient complaints and maintaining oversight of the complaints process. The involvement of Non-Executive Directors in randomised independent reviews ensures continuous improvement. The Trust's analysis of complaints data to identify themes and trends supports quality improvement, system-wide learning, and enhances patient experience and safety. The implementation of the Patient and Carer Race Equality Framework will ensure patient experience data is monitored, shared nationally, and used to drive benchmarking, shared learning, and service development.

The ICB recognises the compliance with referrals for people with a first episode of psychosis treated within two weeks, and consistently meeting the target for 6-weeks and 18-weeks wait to begin treatment for Improving Access to Psychological Therapies service. The support received by service users while waiting has been identified as one of the top scores in the Care Quality Commission (CQC) Community Mental Health Survey responses.

The ICB note the Trusts transparent reporting against the 2024/25 quality priorities. While some priorities remain in progress, it is positive to see clear plans in place to carry this forward into 2025/26. The ICB welcomes the upcoming implementation of the quality dashboard, which will support benchmarking and enable more effective monitoring of improvement.

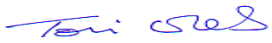
The ICB is encouraged by the Trust’s co-produced quality priorities for 2025/26 and the continued application of its Quality Assurance Framework, which supports structured governance, continuous improvement, enhanced patient safety, and regulatory compliance.

The ICB recognises the ongoing challenges faced by EPUT in reducing out of area placements and recognises the collaborative efforts with local Essex providers to maintain continuity of care. Initiatives aimed at reducing length of stay across inpatient mental health wards such as the work of the Integrated Flow Team, joint inpatient and community reviews, Multi-agency Discharge Events, and strengthened discharge planning are welcomed.

The ICB acknowledges the CQC previous inspection reports and continues to maintain oversight of the associated improvement plans. The Trust has made steady progress in addressing the concerns raised, with 95% of actions reported as completed and 53% signed off by the Evidence Assurance Group. The ICB would like to congratulate EPUT on the outcome of the CQC inspection at Clifton Lodge Nursing Home in January 2025, which resulted in an improved rating from 'Requires Improvement' to 'Good', reflecting the Trust's commitment to service improvement.

The ICB also acknowledges EPUTs continued commitment to implementing the Patient Safety Incident Response Framework (PSIRF), strengthening how the NHS learns from patient safety incidents to enhance care and outcomes. We will continue our joint working with EPUT and system partners as part of continued progression with PSIRF and the National Patient Safety Strategy and recognise that evidencing key principles such as compassionate engagement, proportionality, and system-wide approaches will be vital to ensure its ongoing success.

Looking forward to 2025/26, the ICB supports EPUT quality priorities, and we look forward to a continued collaborative working relationship, including through building on existing successes and collectively taking forward needed improvements to deliver high-quality services for this year and thereafter.



Toni Coles
Place Director, West Essex
Hertfordshire and West Essex ICB

Suffolk and North East Essex
Integrated Care Board (ICB)

Thank you for the opportunity to review and comment on the draft Quality Account 2024/25 for Essex Partnership University NHS Foundation Trust (EPUT). Suffolk and North East Essex Integrated Care Board (ICB) welcomes the continued commitment demonstrated by EPUT to improving the quality, safety, and experience of care for the communities we jointly serve.

We commend the Trust for several areas of good practice and achievement over the past year, including:

- The launch and implementation of the new Quality of Care Strategy, co-produced with people with lived experience, which provides a strong foundation for continuous improvement.
- A 12% reduction in the use of restraint, reflecting a positive shift towards less restrictive and more compassionate care.
- The Trust's proactive work in end-of-life care, with performance in some areas exceeding national averages, and a clear focus on personalised care and preferred place of death.
- The expansion of the lived experience workforce, with over 300 individuals contributing to service development, peer support, and patient safety roles.
- The Trust's strong performance in clinical research, with EPUT ranked among the top recruiting mental health trusts nationally.

We also wish to highlight and commend the Trust's performance against key national metrics:

- First Episode Psychosis: 95.7% of individuals were treated within two weeks of referral, significantly exceeding the national target of 60%.
- Talking Therapies: 100% of patients were seen within 18 weeks, with a recovery rate of 50.7%, demonstrating strong access and outcomes performance.

We recognise the Trust's ongoing efforts to reduce Out of Area Placements, which stood at 1,667 bed days as of February 2025. While this represents progress, we encourage continued focus and system-wide collaboration to further reduce the use of out-of-area beds, ensuring that individuals receive care closer to home and within their local support networks.

We also commend the Trust's commitment to improving patient experience. The receipt of 6,421 reviews via 'I Want Great Care', with 88.9% of feedback rated as positive, reflects a strong culture of listening and learning. The 1,185 compliments received further highlight the dedication of staff across services.

We note the 194 formal complaints and encourage continued efforts to ensure timely, compassionate responses and learning from concerns raised.

The results of the CQC Community Mental Health Survey are also encouraging, with particular strengths in care planning and support. We support the Trust's focus on improving communication around medication, which was identified as an area for development.

Looking ahead, we welcome the Trust's future goals for patient experience, including the implementation of a new improvement plan for compassionate engagement following patient safety incidents, the expansion of trauma-informed and neurodivergent-affirming care, and the continued development of co-produced tools to capture and act on patient and carer feedback. These initiatives align well with our shared ambition to deliver care that is inclusive, personalised, and responsive to the needs of all individuals and communities.

We also acknowledge and support the Trust's clearly defined quality priorities for 2025/26, including:

- Reducing health inequalities, with a focus on perinatal mental health and smoking cessation.
- Improving patient experience through compassionate engagement following safety incidents.
- Enhancing care for neurodivergent individuals and their families.
- Advancing suicide prevention through personalised safety planning. Reducing inpatient falls and improving the management of deteriorating patients.
- Embedding a positive patient safety culture and transforming community mental health services.
- Reducing restrictive practices through the implementation of Safewards.

These priorities reflect a comprehensive and ambitious agenda for improvement. Suffolk and North East Essex ICB pledges its support in working collaboratively with EPUT to achieve these goals. We are committed to continuing our partnership to ensure that services are safe, effective, equitable, and centred around the needs of the people we serve.

Finally, we acknowledge the challenging financial context facing the NHS and the need for all organisations to make savings while maintaining safe, high-quality care. We appreciate EPUT's openness about the uncertain future and its continued commitment to improvement despite these pressures.

The Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) confirm that EPUT have consulted and invited comment regarding the Annual Quality Account for 2024/2025. This has been submitted within the agreed timeframe and SNEE ICB are satisfied that the Quality Account provides appropriate assurance of the service.

SNEE ICB have reviewed the Quality Account and the information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous twelve month period.

SNEE ICB look forward to working with clinicians and managers from the service and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and a good service user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of EPUT to provide a high quality service.

Lisa Nobes

Chief Nursing Officer

Suffolk & North East Essex Integrated Care Board

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use peoples lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it. We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by EPUT. In this case, we have received feedback throughout the year and have been formally involved in the Lampard Inquiry. For this reason, we offer only the following comments on the trusts Quality Account.

- The trust has made great efforts to improve the experience at end of life and it's great to see that the majority of people are dying in their preferred place of death.
- It is excellent to see that the trust has spent 5,500 paid hours of lived experience contributions, and the comment from the patient which said "Being involved is better than therapy" explains why.
- EPUT rolling out the Oliver McGowan training is fantastic and will support the work stream to support the priority around neurodivergent staff and patients.
- It is disappointing to see the number of patients placed in inappropriate out of area beds in 2024/25 and we look forward to seeing this improve in 2025/26.
- It is also a shame that the baseline data sets were not consistently captured to enable appropriate measuring and success reporting next year.
- It would be good to see improvements on complaints and continuing to see the ongoing reduction in complaints received, and increase in those resolved at a local level. It would also be good to see the number of staff completing the annual staff survey increased.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of EPUT.

Samantha Glover
Chief Executive Officer, Healthwatch Essex

Annex 2: Statement of Directors responsibilities in respect of the Quality Account

The Board of Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amended Regulations 2011).

In preparing the Quality Account, the Board of Directors are required to take steps to satisfy themselves that:

- The Quality Account presents an open and balanced picture of the Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance

The Board of Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By Order of the Board of Directors of Essex Partnership University NHS Foundation Trust

30 June 2025

Glossary

EPUT	Essex Partnership University NHS Foundation Trust
ECOL	EPUT Culture of Learning
ESLMS	EPUT Safety and Lessons Management System
CPA	Care Planning Assessment
AI	Artificial Intelligence
LEA	Lived Experience Ambassador
TOR	Terms of Reference
GBO	Goal Based Outcomes
GAS	Goal Attained Scale
MHIST	Mental Health Intensive Support Team
NQPS	National Quarterly Pulse Survey
PROMs	Patient Reported Outcome Measures
PEQOL	Physical and Environmental Quality of Life
DIALOG+	A full therapeutic intervention, incorporating and utilising the DIALOG scale (DIALOG – a scale of 8 items assessing subjective quality of life (PROM) and 3 items assessing treatment satisfaction (PREM)
POEM	Patient-Related Outcome and Experience Measure
CORE 10	Clinical Outcomes in Routine Evaluation
QOC	Quality of Care
ET	Executive Team
PSIRP	Patient Safety Incident Response Plan
PSIRF	Patient Safety Incident Response Framework
IWGC	I Want Great Care
QAF	Quality Assurance Framework
OD	Organisational Development
SEIPS	Systems Engineering Initiative for Patient Safety
QIA	Quality Impact Assessment
IMPACT	Improving Patient Care Together

Essex Partnership University NHS Foundation Trust

The Lodge

Lodge Approach

Runwell

Wickford

SS11 7XX

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www.eput.nhs.uk