Essex Partnership University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING
PART 1

BOARD OF DIRECTORS MEETING PART 1

7 August 2024

10:00 GMT+1 Europe/London

Training Room 1, The Lodge, Lodge Approach, Runwell, Essex, SS11 7XX

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

#0 Part 1 BoD Agenda Aug 2024 FINAL.pdf

Meeting of the Board of Directors held in Public
Wednesday 7 August 2024 at 10:00

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

PART ONE: MEETING HELD IN PUBLIC
TRAINING ROOM 1, THE LODGE, LODGE APPROACH, WICKFORD, ESSEX, SS11 7XX

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
PRESENTATION **Lighthouse Child Development Centre Progress** Hannah Van Der Puije, Assistant Director Community Specialist Children's Services Southend & Essex				
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 5 June 2024	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	No Actions	
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	Chief Executive Officer (CEO) Report	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
7.1	Quality & Performance Scorecard	PS	Attached	Noting
7.2	Committee Chairs Report	Chairs	Attached	Approval
7.3	CQC Compliance Update	AS	Attached	Noting
7.4	Bi-Annual Safer Staffing Report for Inpatient Nursing	AS	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
8.1	Board Assurance Framework Report	PS	Attached	Approval
8.2	Emergency Preparedness and Resilience Annual Report	NL	Attached	Noting
8.3	Infection Prevention and Control Annual Report 2023/24	AS	Attached	Noting

8.4	Learning from Deaths – Quarterly Overview of Learning and Data (Q3 & Q4) 2023-2024	AS	Attached	Noting
9	**STRATEGIC INITIATIVES**			
9.1	Pharmacy & Medicines Optimisation Strategy	AG	Attached	Approval
9.2	Time to Care - Therapeutic Acute Inpatient Operating Model for Adults and Older Adults	AG	Presentation	Approval
10	**REGULATION AND COMPLIANCE**			
10.1	Duty of Candour Annual Report 2023-2024	AS	Attached	Noting
10.2	Safe Working of Junior Doctors Quarterly Report	MK	Attached	Noting
10.3	Safety First, Safety Always Strategy Year 3 Report	AS	Attached	Noting
11	**OTHER**			
11.1	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
11.2	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
11.3	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
11.4	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
12	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
13	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
14	**DATE AND TIME OF NEXT MEETING** Wednesday 2 October 2024 at 10:00, The Lodge Training room 1			
15	**DATE AND TIME OF FUTURE MEETINGS** Wednesday 4 December 2024, 10.00, The Lodge Training room 1 Wednesday 5 February 2025 10:00, The Lodge Training room 1			

Professor Sheila Salmon
Chair

1. APOLOGIES FOR ABSENCE

Information Item SS 1

2. DECLARATIONS OF INTEREST

Information Item SS 1

PRESENTATION - LIGHTHOUSE CHILD DEVELOPMENT CENTRE PROGRESS

Information Item | Hannah Van Der Puije | 10

Hannah Van Der Puije, Assistant Director Community Specialist Children's Services Southend & Essex

3. MINUTES OF THE PREVIOUS MEETING HELD ON: 5 JUNE 2024

Decision Item | SS | 2

REFERENCES

Only PDFs are attached

2024 06 05 - BOD Part 1 - DRAFT Board Minutes FINAL.pdf

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 05 June 2024
Held virtually via MS Teams

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive
Trevor Smith (TS)	Executive Director of Finance and Resources / Deputy CEO
Alex Green (AG)	Executive Chief Operating Officer / Deputy CEO
Milind Karale (MK)	Executive Medical Director
Ann Sheridan (AS)	Executive Chief Nursing Officer
Andrew McMenemy (AM)	Executive Chief People Officer
Denver Greenhalgh (DG)	Senior Director of Corporate Governance
Loy Lobo (LL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director
Mateen Jiwani (MJ)	Non-Executive Director
Jenny Raine (JR)	Non-Executive Director
Dr Ruth Jackson (RJ)	Associate Non-Executive Director

In Attendance:

Angela Laverick	PA to Chief Executive, Chair and NEDs (minutes)
Chris Jennings	Assistant Trust Secretary
Anna Bokobza	Director of Strategy (For Zephan Trent)
Martine Munby	Director of Communications
Clare Sumner	Trust Secretary's Office Administrator
John Jones	Lead Governor
Ray Lashley	Member of the Public
Shruthi Belavadi	NHS England
Amba Murdamootoo	NHS England
Zoe Tidman	HSJ
Bernadette Rochford	Freedom to Speak Up Guardian
Dianne Collins	Public Governor
Megan Leach	Public Governor

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

The meeting commenced at 10:00

SS noted that the meeting had been moved to MS Teams, due to the shortened nature of business due to pre-election guidance. SS advised that only questions that had been submitted ahead of the meeting would be taken.

048/24 APOLOGIES FOR ABSENCE

Apologies were received from:
- Zephan Trent, Executive Director of Strategy, Transformation & Digital
- Diane Leacock, Non-Executive Director

049/24 DECLARATIONS OF INTEREST

There were no declarations of interest.

Signed: …… Date: ……

In the Chair

LL advised of the cessation of two venture interests following the closure of the companies. This did not affect discussions today and had been updated via the register of interests.

050/24 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 27 March 2024 were agreed as an accurate reflection of discussions held subject to the following amendments:

Page 1 – Loy Lobo was noted as present and was not in attendance. Elena Lokteva was present.

051/24 ACTION LOG AND MATTERS ARISING

The action log was reviewed and discussed noting that one action (032/24) had been discharged and closed by Alex Green.

052/24 CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

SS presented the report highlighting the following points to note:

- The success of the Allied Health Professionals International Recruitment Drive, which had included some difficult to fill posts. This was positive in terms of workforce recruitment.
- There had been significant dynamic changes in the Board over the past months at both Executive Director and Non-Executive level. Taken together, those changes present a unitary board that is fresh and stable with experience.

The Board received and noted the Chair's Report.

053/24 CEO REPORT

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

PS highlighted the following:

- Andrew McMenemy has joined the Trust in the role of Executive Chief People Officer. Both Ann Sheridan and Andrew bring great experience and stability to the team.
- Marcus Riddell was thanked for his contribution to the EPUT journey, on behalf of the Board, PS wished Marcus the best success in his new role.
- The National Positive Practice in Mental Health Awards were held recently at the Cliffs Pavilion. This was a fantastic opportunity to celebrate some EPUT services, with colleagues recognised for their outstanding work. The Personality Disorder and Complex Needs Service User Network (SUN) were named winner of the Complex Mental Health Needs Award for their work in supporting people with personality disorders and complex needs, and their families and carers. EPUT Lived Experience Ambassador, Martine Jeremiah and Colleagues from the Urgent Care and Inpatients Care Unit were highly commended on their work to update our therapeutic engagement and supportive observations policy for all inpatient wards across the Trust.
- The Lampard Inquiry was now underway following the publication of the Terms of the Reference. As a Trust, we remain committed to doing all we can to ensure the Inquiry meets its terms of reference to deliver the answers that patients, families and carer deserve. Support mechanisms are in place for colleagues as well as patients and families.
- PS emphasised that desire for people to be confident to come forward and use Trust services during the Inquiry. With an ambition to continue to enhance services in the way the Trust works with partners and communities to improve services, building on that by

implementing a new workforce model this year as well as implementation of a new unified EPR, which will help modernise and free up colleagues to deliver care. The Trust is also committed to continue to develop and build on involvement of patients and families.
- PS welcomed the news that Tom Abell had been appointed to the MSE ICB Chief Executive role from August 2024. PS extended thanks to Tracy Dowling, outgoing interim Chief Executive, who had been a great leader for the ICB and a great advocate for mental health services.

Questions & Discussions
- It was queried how future proof the chosen EPR solution was and whether selected provider had AI capability built in. PS advised that the core functionality met minimum requirements to NHS and international standard there was ancillary software that could be added, including voice recognition, with potential to bring separate business cases for the future. The EPR Joint Oversight Committee had good insight into future developments, including AI, better analytics and a move to become cloud native, to be available securely on all devices.

The Board received and noted the CEO Report.

054/24 QUALITY AND PERFORMANCE SCORECARD

PS presented the Quality and Performance Scorecard as part of the CEO Report, with Executive Directors highlighting the following key areas.

Operations – Alex Green
- Assurance was provided that performance measures were scrutinised through the accountability framework process and Finance and Performance Committee.
- Inpatient mental health capacity remained a continued challenge, with demand for admissions high in April, which was reflected in a slight raise in occupancy rates and the Out of Area Placements position. There were 30 out of area placements reported at the end of the month; work had taken place to successfully repatriate 21 to EPUT. There had also been 135 discharges during the reporting period with 32 patients having a length of stay over 60 days, which impacted the overall length of stay position.
- Children's SLT services had seen improvement performance, with new staff embedded and an improved position for children waiting for a second appointment.
- There had been an improvement on inpatient follow up rates. This had previously been flagged as an area of concern and focus; an improved position had been seen in April for 72 hour follow up, which remains in target.

Questions & Discussions
- The data showing over-establishment was discussed with regard to the current financial context. AG advised this reflected the rise in occupancy rates and acuity of patients, with high levels of observations which was reviewed twice daily on sit rep calls. The fill rate was against historic establishments, with a clear plan to recruit substantively and reduce reliance on temporary staff and focus through accountability framework meetings on that workforce trajectory and the associated financial benefit. That work was underway and involved intricate detailed work, with HR and finance business partners working with operational leads to ensure establishments were reviewed and reflected accurately.
- The Board were clear in terms of the plan submitted for this year to NHSE to drive down and out where possible temporary staffing, to be replaced with substantive staff reflecting productivity requirement not compromising safety. This also linked with Time to Care, which should result in reduced fill rates, but there may be some transition as practice is adjusted.

Finance – Trevor Smith

- Audit of last year's financial account continues and is expected to conclude in the next 2 weeks, there were no matters to report at this stage.
- The financial plan for 2024/25 was now agreed by NHSE and included £11.1m deficit for revenue and £25m for capital resources for investment.
- At the end of Month 1, the Trust were £1.5m adrift of the forecast position. This was directly linked to patient demand, acuity and temporary staff utilisation which will be managed down through Time to Care.
- Capital incurred £1m against investments which is slightly ahead of plan at month 1.

Questions & Discussions

- The Board thanked TS and the team for compiling a complex set of accounts in good time. This included the late publication of planning guidance and complex negotiations happening within the system as the accounts were being prepared. It was noted that key stakeholders and NEDs were kept informed throughout the process.
- It was noted that the budget reflected significant plans to ensure forecast positions are met going forward. This was noted in accountability meetings, where there was a clear message to staff and budget holders, but also acknowledged there was significant change that needed to be undertaken. TS advised the plan was challenging, with an efficiency programme of over 5% and greater system efficient requirements. The delivery of plans would be dependent on recruitment for Time to Care and changes to clinical practice.
- PS advised there were changes coming in relation to staffing through time to care, and it was important the project was owned by the clinical teams. It was important for any complex and high pace change that the Board had effective oversight and scrutiny.

Nursing and Quality – Ann Sheridan

- There had been a reduction in incidents of violence and aggression, mainly across inpatient areas. Quality Improvement (QI) projects were underway, with data indicating that a high number of incidents affect staff and the majority tend to be verbal and at times have a racial element. Debriefing sessions took place after incidents with psychological support and support for managers.
- A meeting had been held with NHSE around support work relating to patient and staff wellbeing. There was also work underway in mental health and acute settings about reconditioning in these areas which was a positive piece of work that would support further improvements.
- There were a small number of patients who had been given leave and who had not returned on time. Conversations continue around how people use their time in the community.
- Restrictive practice was a key area in quality, particularly around seclusion and restraint. It is recognised that the highest number are seen in children's and female PICU services, often relating to a small number of patients. There were good QI projects in place with psychological support, involvement of therapies and how that can make a difference as well as looking at how to sustain therapeutic activity out of hours.
- There were positive areas around safety action plans, with an improvement seen in ensuring they are completed in time.

People and Culture – Andrew McMenemy

- AM extended thanks to Board members and trust colleagues for the positive welcome, which demonstrated the supportive culture of the organisation.
- The current turnover rate is good, but there was a need to understand individual feedback from those that leave the Trust.
- Sickness absence had reduced from 5.7% to 3.2%. This provided a good overall measure, with the detail being discussed at PECC.

- There had been some excellent work alongside finance colleagues with a focus on meeting the financial target, much of which is connected to efficiency of workforce, Time to Care and better recruitment.

Questions & Discussions

- The Board reflected on the role of the Quality Committee to maintain balance with the Finance and Performance Committee in terms of quality assurance and quality improvement.
- A link was made between violence and aggression to staff, particularly the racial element, and the staff survey results and action plans around Equality Diversity and Inclusion (EDI).
- The Board were advised that work was underway in terms of violence and aggression against staff, including reflective learning, including a reflection session with Professor Oliver Shanley on their experiences. The feedback for the session was positive and highlighted the importance of ensuring staff were brought along on the journey.
- The impact of staff wellbeing programmes was discussed and queried whether the impact could be determined through metrics, such as staff retention. PS agreed and felt it was important to continuously review programmes / initiatives, via metrics, to measure the impact on the workforce.

PS concluded by reflecting that the report demonstrated the significant joined up work taking place across the Trust and would continue to keep the Board up to date around progress.

The Board of Directors received and noted the report.

055/24 COMMITTEE CHAIR'S REPORT

This report summarised assurance reports from the Board of Directors Standing Committees which were crucial for governance and for the Board to be able to discharge responsibility appropriately.

Audit Committee (16 May 2024)

- EL highlighted the work of the Finance Team in the planning and preparation of the annual accounts, including providing information to the external auditors in a timely fashion.
- EL highlighted a benchmarking report into salaries overpayment, which showed EPUT as having a good process, which was efficient and shows salary overpayment below other trusts.

Finance and Performance (18 April and 23 May 2024)

- LL highlighted the Strategic Impact Report which, along with other information, was crucial to understanding whether the Trust is on track to deliver its ambitions.
- LL noted the conversations at Board and Standing Committees was driven by the Operational & Performance Scorecard. The mechanism for data collection had improved and was a key enabler of how assurance is gained, based on evidence of what is taking place in clinical services.

People, Equality and Culture Committee (PECC) (29 April 2024)

- RJ (on behalf of DL) highlighted discussions around the importance of workforce in relation to the challenges and opportunities going forward and the importance of measuring the impact of staffing initiatives.
- RJ highlighted the importance of the experience of current staff. This included a discussion on Freedom to Speak-Up and the importance of the service, including key metrics to help measure the impact of staffing initiatives. AM agreed and advised work was underway to develop workforce Key Performance Indicators.

- EL provided feedback on service visits, with staff speaking positively about areas such as Time to Care and the benefit of activity coordinators joining wards. EL was pleased to note the report reflected what had been observed during service visits.
- The report presented the Terms of Reference for the Committee for approval.

Quality Committee (11 April and 9 May 2024)

- RH highlighted discussions regarding the Board Assurance Framework and risks, acknowledging the positive progress being made.
- RH highlighted progress made around loggists, with significantly more in place and a process to identify more, which would likely see the risk score reduced.
- RH reflected on the committee effectiveness report, advising the Committee had reviewed it in detail. RH noted the issues identified by the review had already been considered, including the implementation of new governance structures and boundaries between different Standing Committees.
- RH highlighted the Power BI report, which was useful to see the development of KPI's to support the Quality of Care Strategy.
- The Committee Terms of Reference and Committee Priorities were presented to the Board for approval.

The Board of Directors:

1. **Received and noted the contents of the report and the assurance provided.**
2. **Approved the People and Culture Committee Terms of Reference 2024/25**
3. **Approved the Quality Committee Terms of Reference 2024/25**
4. **Approved the Quality Committee Priorities 2024/25**

056/24 FREEDOM TO SPEAK UP ANNUAL REPORT

NL introduced Bernie Rochford, Principal Freedom to Speak Up (F2SU) Guardian to present the annual report. NL advised work was underway to improve the function of F2SU and a questionnaire from the F2SU toolkit would be circulated to Board members in due course, with the results of the questionnaire being discussed at a future Board seminar session.

BR presented the annual report, highlighting the following areas:

- There were emerging themes from the data reviewed so far, including a lack of confidence and a hesitancy in having difficult direct conversations.
- There was staff are contacting the service in lieu of line managers. There was a need to explore this further to understand the reasons.
- There was consideration for the introduction of more local data collection, rather than relying on national categories. This would take time to develop, but would allow a better measure of changes as a result of speaking-up.
- The number of cases raised through the service had increased, with a proportion being around inappropriate behaviours or bullying. These did not relate to patient safety, which was the purpose of F2SU, but was in line with national trends.
- EPUT were in the top quartile for people speaking-up through the service, which was encouraging and demonstrated people were aware of the service. However, the numbers were higher than the national average and there was inconsistency in how issues are reported and perceived detriment. Work was underway with Mersey Care NHS Foundation Trust as a benchmark to review reporting and ensure it was more consistent.
- EPUT had more anonymous cases reported nationally, with further analysis identifying staff had selected different elements of cases to make anonymous and therefore further review was required.

Questions and Discussions

- The Board discussed the use of the service by staff instead of raising issues with their line managers and the use by staff subject to performance management. BR advised this was an issue and was discussing with Executive Directors to ensure there is a unified approach. The risk of inappropriate use of the service was that it moved away from patient and staff safety. AM agreed and noted the importance of ensuring F2SU was one mechanism to create a culture of people feeling comfortable to speak-up.
- The Board discussed how the impact of F2SU would be measured to determine how successful it was. BR advised they key element was around empowering people to speak-up for themselves.
- PS advised he received regular updates from BR, whose lived experience of detriment drove her passion regarding F2SU. Significant effort had been made in raising the profile of the service to ensure it used correctly. However, there was recognition that staff needed an avenue to speak-up and the inappropriate use provided data that would not have otherwise been identified and provided guidance in developing avenues to ensure people can speak-up in the right places.

The Board of Directors:

1. **Noted the content of the report.**
2. **Supported greater collaborative work around Speaking Up across disciplines / the Trust.**
3. **Reviewed the annual report and would use in conjunction with the Board Reflection Self-Assessment Tool and the TIAA Audit findings when available to inform the Freedom to Speak Up Strategy and priorities for 2024/25.**

057/24 PLACE 2023 REPORT

AB presented a report providing analysis of PLACE 2023 results. AB reminded colleagues that PLACE (Patient Led Assessment of Care Environment) was a series of site visits led by patient assessors who rate the environment across six domains, providing insight from those that use the services to incorporate into plans going forward.

AB highlighted the following area:

- The link between Time to Care and patients spending time on wards. The results highlighted the good use of recreational spaces and the staffing model for Time to Care enhanced the use of those spaces.

Questions & Discussions:

- LL queried whether there was any variation identified between wards. AB advised there was a link between the positive results and the level of investment in the physical estate. Variability was expected with the results feeding into the Estates Strategy.
- TS advised the results provided useful outputs to inform the Estates Strategy and Capital Plan. The multi-disciplinary approach to the assessments fed into the Capital Planning Group to aid prioritisation.

The Board of Directors:

1. **Noted the contents of the report.**

058/24 SAFE WORKING OF JUNIOR DOCTORS ANNUAL REPORT

MK presented the Safe Working of Junior Doctors Annual Report, highlighting the following:

- There were no significant issues to highlight, with the Trust remaining fully compliant with the Junior Doctors contract.
- Despite industrial action, there had been no agency use, with internal cover secured.

- Increased pressure on services had resulted in additional hours, however this had been resolved using TOIL.
- Working closely with the guardian of safe working, tutors and the medical education department, the Trust continue to support junior doctors to meet their requirements.
- The report captured breaches to contract duty, however there were several forums for support to the junior doctors including meeting with the safety guardian, regularly meeting with tutors, regular meetings with the CEO and COO as well as feedback reviewed by the education committee. The F2SU service was also widely promoted across the Trust.

Questions & Discussions:

- JR noted the positive report demonstrated the good culture for medical staff and the importance of the first few years of clinical experience for junior doctors being crucial for their long term decisions around speciality.

The Board of Directors:

1. **Noted the contents of the report.**

059/24 COMPLAINTS AND COMPLIMENTS ANNUAL REPORT

AB presented the report for approval, advising that this reflected the first full year with the new process in place. AB highlighted the following:

- There had been improvement with the complainant-led approach, but there was still improvements to be made.
- There would be a continued focus on building trust with complainants regarding the integrity of the process, triangulation of learning from the complaints and segmentation of protected characteristics and reducing inequalities.

Questions & Discussions:

- LL commented the report was good in covering a wide variety of metrics and suggested including a capitated number of complaints in future reports to provide a suitable denominator.
- RH advised the complaints process was an area of focus for the Quality Committee.
- PS highlighted the complaints process as an example of involving patients in service design for the Trust. This had been powerful and led the way for involvement in other service redesign.
- PS highlighted the data showing the profile of patients and complainants, which would be reviewed through Executive Team and linked with the PRCREF and EDI.
- DG commented the complaints process was personal to an individual and some may remain dissatisfied at the end of the process. Confidence could be taken from those raised with the Parliamentary Health Service Ombudsman (PHSO) that did not lead to further action.

The Board of Directors:

1. **Approved the Annual Complaints and Compliments Report for 2023/24**

060/24 PATIENT EXPERIENCE AND VOLUNTEERS ANNUAL REPORT

AB presented the report which provided assurance on progress relating to the experience component of the new quality of care strategy, as well as progress on people and communities strategy. AB highlighted the following:

- Good progress has been made with the number of peer support workers with lived experience joining the Trust than in previous years and a rise in the number of lived experience ambassadors.

- There would be a continued focus on the increasing the uptake of I Want Great Care (IWGC), include a video to publicise. The use of the tool is fairly embedded in inpatient areas, but not as much in other services.

Questions and Discussions:

- LL highlighted the impact table in the report as it was a great way of seeing changes over time.
- LL advised service visits had identified different services displaying the IWGC QR code in different places, which may impact response rates and suggested the development of guidance to provide a consistent approach.
- AG highlighted the positive improvements and the move to a more devolved approach, which would strengthen the lived experience voice at care unit level and would help address engagement across different services.
- SS commented on the value of the contribution of lived experience partners and patient safety partners across the Trust.

The Board of Directors:

1. **Noted the contents of the report.**

061/24 END OF YEAR GOVERNANCE REVIEW

DG presented a report providing the end of year compliance reviews against the Provider Licence and Code of Governance for NHS Providers. DG highlighted the following:

- The Provider Licence had been updated, which meant there was a change to references from previous years.
- The review confirmed the Trust was fully compliant with the provisions of the Provider Licence and with the provisions of the Code of Governance for NHS Providers
- There was one provision where the Trust had deviated, relating to NED remuneration being set by the Council of Governors, with due regard for NHS England guidance. This was in line with the “comply or explain” principles of the code.
- There were some actions identified in both the Provider Licence and Code of Governance to strengthen compliance going forward.
- The submission template for the Provider Licence had not yet been made available from NHS England and therefore the review would be retained on file and a template populated once available. It is not a requirement to submit the review to NHS England, unless specifically asked to do so.

The Board of Directors:

1. **Approved the detailed review of Trust compliance against the Provider Licence (including the Code of Governance) for submission to NHS England (as required) and declaration in the annual report.**

062/24 STRATEGIC IMPACT REPORT M12

AB presented a report providing assurance on delivery against four strategic objectives and the 5 year strategic plan. For the first time, specific sections had been circulated in draft to each committee to increase scrutiny and oversight.

The Board of Directors:

- **Noted and took assurance from the report.**

063/24 TRUST CONSITUTION REVIEW

DG presented the Trust Constitution Review advising that changes had been made to the language used, however there was no change to the content.

The Board of Directors:

- **Approved the reviewed Trust Constitution.**

064/24	USE OF CORPORATE SEAL

The Board of Directors noted that the Corporate Seal had been used on the following occasions:

- Lease of St Helen's Street, Ipswich
- Lease of Gilmore Lodge, Meesons Lane, Grays
- Lease of Avalon Bungalow, Longhouse Road, Chadwell St Mary
- Asset Summaries of Programme Works at Runwell

The Board of Directors:

1. **Received and noted the contents of the report.**

065/24	CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There was no correspondence circulated to board members since the last meeting.

066/24	NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

There were no new risks identified to be added to the Risk Register, nor any items that should be removed, noting that there was no discussion around BAF due to the pre-election period.

067/24	REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

EL commented that board papers and discussions held today clearly reflect the commitment and passion for equality. The Board discussions in relation to F2SU, assessment of the environment and junior doctors, showed that EPUT has good mechanisms for identifying potential barriers which could cause inequality and addressing them.

068/24	CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

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

- Mateen Jiwani joined at 11.45 during F2SU discussion
- 11:26 – 11:28 PS stepped out during PLACE 2023 Report

069/24	ANY OTHER BUSINESS

There was no other business.

070/24	QUESTION THE DIRECTORS SESSION

Signed: …… Date: ……

In the Chair

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

In view of guidance from NHSE due to the pre-election period, SS confirmed that only pre-submitted questions relating to the papers discussed would be taken.

071/24 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 07 August 2024.

The meeting closed at 12:02

Appendix 1: Governors / Public / Members Query Tracker (Item 070/24)

Governor / Member of the Public	Query	Response
Dr Ray Lashley	Complaints and Compliments – How are the Board satisfied the complaints / compliments annual report presents a true reflection of the experience of complainants? Specifically around preventing discrimination in the process and the investigation of complaints.	Complainants must not be discriminated or victimised. Trust policy is in line with EDI and Human Rights Policy, staff are complaint with training and there was also independence in the investigation process from someone not involved with the services. Feedback is reviewed and taken forward through supervision, training. For independence, anyone that was not satisfied with the result of a complaints investigation could report to the PHSO. The changes to the complaints process had allowed increased service user involvement and work was continuing around patient experience which will continue to improve the complaints process.

4. ACTION LOG AND MATTERS ARISING

Information Item SS 0

No actions

5. CHAIRS REPORT (INCLUDING GOVERNANCE UPDATE)

Information Item | SS | 5

REFERENCES

Only PDFs are attached

Chairs Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Chairs Report (including Governance Update)**					
Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the contents of the report

Summary of Key Points

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

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Chairs Report

Non-Executive Lead:

Professor Sheila Salmon
Chair

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Farewell to Rufus Helm, Non-Executive Director

At the end of July, the Board bid a fond farewell to Rufus Helm as Non-Executive Director, following the end of his term of office after six years in the role. On behalf of the Board I would like to thank Rufus for his contribution, dedication and commitment to EPUT and wish him every success in his future endeavours.

2.2 Welcome to Dr Ruth Jackson, Non-Executive Director

Whilst Ruth joined the Board as an associate NED in February 2024, I am delighted to report that Ruth has now been appointed and confirmed by the Council of Governors as a full non-executive director as of 1st August 2024.

2.3 Congratulations to our newly elected Governors

Following the recent governor elections, I am pleased to welcome three newly elected EPUT governors:

- Marie Newland, clinical staff Governor
- Helen Semoh, non-clinical staff Governor
- Nat Ehigie Obano, west Essex and Hertfordshire Public Governor

Governors play a crucial role in using their professional voice and experience as a counterbalance to the Board's processes, providing the support and challenge of a critical friend. Congratulations and welcome to our new Governors.

2.4 Digital Training Innovation

On 6 August, the Digital Training team are hosting a showcase event for the Virtual Reality (VR) in training project. This is an opportunity to showcase the various VR related innovations that EPUT and partner organisations will soon be utilising as part of their training portfolios. We will also share future plans as well as the longer term potential.

2.5 Lived Experience in education and service provision

EPUT is the lead Trust for the Oliver McGowan programme in the Mid & South Essex (MSE) Integrated Care System. The programme is now being delivered for EPUT, with expansion across the MSE geography taking place during the remainder of 2024. Currently we are delivering the training twice a week, increasing to around eight times a week by the end of 2024.

A new programme is currently being piloted to support preceptees engaged with the preceptorship programme. The programme is called Reflective Practice Partners and is based on the award winning Buddy Scheme. It offers preceptees the opportunity to speak to experts with lived experience about specific areas or issues related to specific questions, to enhance their reflective practice.

Our patient and public involvement in everything that we do is continuing to grow and purposefully develop across all of our services. It remains central to our operations and to the strategic development of the Trust.

2.6 Employee Experience

Listening to the voices of our staff in the survey, we launched a violence and discrimination pilot on 1 July, aimed at improving behaviours of staff and patients as well as reducing future incidents of abuse.

Five wards have agreed to participate in the pilot and a series of recommendations are being implemented, including:

- Staff and patients signing up to pledges
- Introducing opportunities to repair therapeutic relationships between staff and patients following an incident
- Maximising the use of body worn cameras

2.7 Celebrating Diversity at EPUT

Pride month in June was celebrated in collaboration with the LGBTQ+ Network (Lesbian, Gay, Bi, Trans and any other sexual orientation or gender identity) alongside our East of England and Integrated Care System partners. Throughout the month there was a lot of activity including messages from our Exec Sponsors and network members, raising awareness of the LGBTQ+ training video on our EDI Training Hub as well as additional EDI training resources being shared Trustwide.

To celebrate South Asian Heritage Month, the Ethnic Minority and Race Equality Network (EMREN) held an event, to which staff were invited to bring a dish representing their heritage and wear traditional clothing. The next EMREN meeting will also be dedicated to South Asian Heritage Month and provide an opportunity for sharing stories.

2.8 Celebrating 20 Year Anniversaries – Clifton Lodge & Rawreth Court

Clifton Lodge

Staff, residents and families at Clifton Lodge had a fantastic day celebrating the nursing home's 20th anniversary. Staff at the home organised music, entertainment, cream teas and ice cream for residents and guests for the celebration on Tuesday 23 July.

I was among the guests who attended the celebrations along with High Sheriff David Hurst, Southend Mayor Cllr Ron Woodley and Mayoress Maureen Woodley, former Southend mayor Roger Weaver – who officially opened Clifton Lodge 20 years ago - and Su Harrison from Radio Essex. I received amazing and heart-warming feedback from families recounting the high quality of compassionate and personalised care that their loved ones are receiving/have received.

Rawreth Court

Rawreth Court Care Home celebrated its 20th anniversary with a family fun day on Saturday 20 July. Staff, residents and their families celebrated the milestone anniversary with a visit from Mark Francois MP, live music, refreshments and traditional games. Mark Francois first visited Rawreth Court shortly after it opened two decades ago and thanked the staff for their service in looking after some of the most senior citizens in our community.

Professor Sheila Salmon
Chair
August 2024

6. CHIEF EXECUTIVE OFFICER (CEO) REPORT

Information Item | PS | 5

REFERENCES

Only PDFs are attached

CEO Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Chief Executive Officer (CEO) Report**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Angela Laverick, PA to the Chair, Chief Executive & Non-Executive Directors					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
Does this report mitigate the Strategic risk(s)?	Yes/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and note the contents of the report.

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

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

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

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

Acronyms/Terms Used in the Report			
MP	Member of Parliament	ECT	Electroconvulsive Therapy
PALS	Patient Advice and Liaison Service	ECTAS	Electroconvulsive Therapy Accreditation Scheme
HSJ	Health Service Journal	ICB	Integrated Care Board
ePMA	Electronic Prescribing and Medicines Administration System	RISE	Resilience Intelligence Strength and Excellence Programme
OoA	Out of Area	ARU	Anglia Ruskin University
ILC	International Learning Collaborative	WTE	Whole time equivalent
BMA	British Medical Association	AHP	Allied Healthcare Professional
HCA	Healthcare Assistant	KPI	Key Performance Indicator

Supporting Reports and/or Appendices
Chief Executive Officer (CEO) Report

Executive Lead:
 **Paul Scott,** **Chief Executive Officer**

CHIEF EXECUTIVE OFFICER REPORT

1. UPDATES

1.1 Rawreth Court and Clifton Lodge Celebrating 20 Years

Both Rawreth Court and Clifton Lodge celebrated their 20th Anniversary in July. Both Care Homes held celebration events for residents, their families and staff. Mark Francois MP attended the celebrations for Rawreth Court and David Hurst, County High Sherriff, and the Mayor of Southend, Cllr Ron Woodley, attended celebrations at Clifton Lodge. Members of our senior leadership team were also at both homes to mark this fantastic milestone.

1.2 Lampard Inquiry

The Lampard Inquiry has published an update on its website about the Core Participants and a draft List of Issues. The Inquiry received over 100 applications for Core Participant status, of which 66 were granted, falling into the following broad categories: bereaved family/friends; living current and former patients; health bodies and organisations; and staff members. A complete list of Core Participants, except those who have been given permission by the Chair to remain anonymous (via restriction order) will be published on the Inquiry website.

Ahead of the Opening Statements in September, the Inquiry has prepared a draft List of Issues. This document is intended to guide the Inquiry's investigations and enable it to effectively meet its Terms of Reference. The List of Issues will remain a live document and will be revised throughout the course of the Inquiry. More information about the Lampard Inquiry can be found on the Lampard Inquiry website.

Understandably, this can be an unsettling time for colleagues. EPUT's Inquiry Project team has dedicated staff members whose focus is to offer support to colleagues during the Inquiry, and our Here for Your psychologists offer individualised support to those impacted by the Inquiry. Patients, families and carers may also have been contacted by the Lampard Inquiry team. Support is also available for them, which can be accessed via PALS on 0800 085 7935 or by email at epunft.pals@nhs.net

1.3 Patient Safety Partners Shortlisted for HSJ Safety Award

I am delighted to announce that our Patient Safety Partners have been shortlisted for a HSJ Patient Safety Award in the Patient Involvement in Safety category for their safety walk arounds. The team of patients, lived experience ambassadors and staff are focused on elevating patient safety and enhancing patient experience. They actively engage with patients and staff to gather feedback on safety concerns, creating a collaborative environment and driving forward our continuous improvement in healthcare delivery and patient safety. Well done to the team and the best of luck for the finals in September.

1.4 Electronic Prescribing and Medicines Administration System (EPMA)

I am pleased to report that a new Electronic Prescribing and Medicines Administration (ePMA) system for prescribing, ordering, administering and recording medicines has now 'gone live' on our first pilot ward. This system will replace paper based drug charts with a digital record and link together the different teams and individuals involved in medication related activities and will provide a range of benefits including safer care and better data. The system will be implemented on three pilot wards before being rolled out across our inpatient wards.

1.5 The Lakes Electroconvulsive Therapy (ECT) Clinic Achieves National Accreditation

The Electroconvulsive Therapy (ECT) clinic at the Lakes has just received ECTAS accreditation from the Royal College of Psychiatrists. This accreditation verifies that ECT clinics are providing services to the highest standard. The clinic received special commendation for its safe environment, thorough documentation and good patient experience. This is the first time the clinic has received ECTAS accreditation and means that all three of EPUT's ECT clinics are now ECTAS accredited.

1.6 Visit from the Secretary of State for Health and Social Care to EPUT services

The new Secretary of State for Health and Social Care, Wes Streeting MP, visited services in west Essex on 1 August as part of his tour of all integrated care systems in England. We were able to showcase our work to provide virtual ward care for patients requiring medical intervention but who can be appropriately supported at home. The Secretary of State visited St Margaret's Hospital in Epping to meet our falls car team, run jointly with the East of England Ambulance Service, as well as the Care Coordination Centre and Hospital at Home hub. After a visit to a local GP practice in Harlow, regional director Clare Panniker hosted a Q&A session with the Secretary of State for health and care leaders from across the east of England, which I was also able to attend. It was welcome to hear Mr Streeting's approach and his recognition of the many issues facing services across the country.

1.7 King's Speech

The official state opening of Parliament and the King's Speech took place on 17 July, setting out the new government's priorities and legislative framework. There were five key priorities for health:

- Ensuring parity of esteem for mental health services with physical health services
- A Bill to reform and modernise the Mental Health Act, taking forward the majority of
- recommendations from Sir Simon Wessley's review in 2017
- A Bill to progressively increase the age at which people can buy cigarettes and
- impose limits on the sale and marketing of vapes
- Legislation to restrict the advertising of junk food and high caffeine energy drinks
- A Bill to ban conversion practices

The full speech and background briefing is available on the Government website.

1.8 Next steps in consultation on Community Physical Health Services in Mid and South Essex

Earlier this year, over 5,400 local people took part in a consultation run by Mid and South Essex Integrated Care Board (ICB) on proposed changes to the way that some community physical health services are run. The proposals include potential changes to where some community hospital intermediate care and stroke rehabilitation services are provided, including how the 22 beds in the Cumberlege Intermediate Care Centre are used. The draft public consultation report is now available on the ICB website.

1.9 RISE Graduation:

The Lessons team supported the RISE Graduation held on 10 July 2024 working alongside the RISE Programme team and co-presented at the event, where 40 EPUT staff graduated on the programme. The graduates are working through several quality improvement projects that are aimed at contributing to the delivery of the Trust's quality priorities. The Lessons team will be collaborating to deliver the project on the Inflight Safety Briefing Video, which is aligned to the Trust's Culture of Learning Framework and draws on learning from the Inflight Safety Briefing within the aviation industry. This project was initiated following a workshop with the Civil Aviation Authority and demonstrates our commitment to learning from a high-risk industry and benchmarking against excellent practice.

2. UPDATES

2.1 Operations – Alex Green, Executive Chief Operating Officer / Deputy CEO

- The average length of stay for adult inpatients has increased in June, although there was a marked increase in discharges in May (75%).

- The number of Out of Area (OoA) patients remaining placed at end of month has increased to 40. However, this rate of growth has slowed, with June seeing the fewest number placed out of area since November 2023, coupled with greater repatriation to EPUT wards.

- Following the successful recruitment of therapists for the Children's Speech and Language Service, the team continues to experience resource challenges with two staff due to leave post soon.

- Mental health inpatient follow ups have fallen below the 7 day target of 95% (86% in June). The 72hour target, which has now superseded the 7 day target, shows a slight reduction but is reporting above target at 82%. Breaches are reported via Datix and followed up.

- NHS Talking Therapies (IAPT) services have seen a seasonal reduction across all areas. Limbic continues to prove a popular route into north east Essex services with over 2,000 referrals received between January and June 2024.

- The Trust's Chief Clinical Information Officer began improvement work for patients not seen in 12 months, working through both the adult and older adult consultant caseloads. This scrutiny of the caseloads has proven successful with improvements seen in June.

2.2 Finance – Trevor Smith, Executive Chief Finance Officer / Deputy CEO

Key financial headlines at Quarter 1

- The Trust deficit of £5.6m is £1.3m off plan due to high levels of patient demand and patient acuity; a range of measures and actions are being taken to return to plan and deliver the planned deficit for the year.

- The Capital programme is ahead of plan with £3.6m expenditure year to date.

- Cash balances are currently lower than planned at £28.1m due to the financial performance, Inquiry costs and lower than planned receivables.

2.3 Nursing and Quality – Ann Sheridan, Executive Nurse

Quality Improvement Forum:
Over the past few months ARU, in collaboration with provider partners, have introduced a Quality Improvement Forum with the core aim to drive improvements to the quality of practice learning and experiences of learners and educators at a system and individual level. Rebecca Pulford will co-chair the forum alongside the Deputy Chief Nurse of NWAF, enabling the voice of Community services and MH services to be articulated, and have a direct input into delivering on areas requiring education focus to our undergraduate population that impacts on care delivered to our patients.

Fundamentals of Care:
As part of the Fundamentals of Care Programme, six members of EPUT staff attended an international Fundamentals of Care Conference at Oxford University. The conference focussed on care delivery and practice and presentations were evidence based and delivered by members of the International Learning Collaborative (ILC) worldwide. After the event, five members undertook the International Learning Collaborative Leadership Programme resulting in firm action plans to deliver in practice, supported by mentors worldwide. Such is the commitment of the ILC to supporting mental health and community services and EPUT particularly, four of these places were offered complementary. As members of the ILC, EPUT now has access to a worldwide community of practitioners driving up standards of care through practice delivery.
An Away Day with ward managers, unit leaders and key staff from Specialist MH services was conducted on 12 July 2024 as part of the Fundamentals of Care Programme roll out.

Sexual Safety:
On the 02 July 2024, the Sexual Safety Sub-Committee met and discussed the utilisation of the Sexual Safety Charter for patients. The current format of the Charter is a poster signed by the manager and displayed in communal areas. Members agreed that a smaller version of the

Charter should be created to stimulate conversation during initial admission for all patients, which will assist is setting out expectations of appropriate behaviours regarding sexual safety.

All sexual safety posters have a QR code that the patients can use to report any sexual safety concerns which is positive as it promotes autonomous reporting by patients or visitors, as they will not need be required to report via staff members.

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 advised and agreed though the review of national, regional, local and research based evidence on a chosen topic that is an agreed priority for the Trust. The Quality Senate forms part of the delivery of effectiveness within the Trust's Quality of Care delivery programme and provides recommendations on how our services can ensure care is evidenced based and effective, building towards greater consistency, reliability, equity and driving improved outcomes for all.

There have been two Senates held to date with good attendance and representation from care units, professional leads and lived experience, although there is more to be done to expand this group further and to include carer representatives.

Quality Senate topics have been 'Trauma Informed Care' and 'Moving Away from Care Programme Approach'.

2.4 People and Culture – Andrew McMenemy, Executive Chief People Officer

Workforce Trajectories
The Trust is currently operating at 3% above planned workforce trajectories. In June, the Trust continued its downward trend in temporary staffing use. Agency whole time equivalent (WTE) is 8% below planned trajectories for June, but despite decreases in bank use the Trust continues to operate at 21% above planned trajectories because of high numbers of unqualified nursing vacancies. Unqualified nursing roles account for 62% of bank use in the Trust. Targeted plans are in place to recruit to all healthcare support worker vacancies by the end of this year.

As of 1 July, we have eliminated all off framework agency use in line with the 2024/25 operating planning guidance. Work is underway to reduce medical agency costs through transferring medical locums to compliant direct engagement assignments. From June the Trust is no longer accepting any new non-direct engagement assignments.

Recruitment & Retention
The Trust has a vacancy rate of 11.1% against our target of 12%. Further consideration by staff group shows a vacancy rate for nursing at 15.9%, HCAs at 20% and AHPs at 12.4%. Time to Hire is now tracked split by KPI and further split by care unit. Overall, it averages out at 72 days from job approval to start date, inclusive of candidate notice period.

Retention will be an area of priority, focusing on career opportunities, learning and education and staff wellbeing. This will be enhanced further with EPUT being granted exemplar status for the NHS People Promise by NHS England. Exemplar status brings funding to support a 12-month People Promise manager role at Band 8a to oversee initiatives that will directly support the retention rates. Status also brings together local and national experts and experience to offer information, tools and practical support for systems and organisations to help deliver the NHS People Promise.

Junior Doctors – Industrial Action
The 11th period of industrial action taken by junior doctors in England ran from 27 June to 2 July. The junior doctors' strike mandate in England was recently renewed for another six months to last from 3 April to 19 September. A new pay offer was accepted by the BMA on 29 July and is now being put to members.

105 patients and 58 clinics are being rescheduled following the June/July strike. The Trust has reported a total financial impact of industrial action for the financial year 2023/24 of approximately £0.6m.

7. QUALITY AND OPERATIONAL PERFORMANCE

7.1 QUALITY & PERFORMANCE SCORECARD

Information Item PS 15

REFERENCES

Only PDFs are attached

Quality & Peformance Scorecard 07.08.2024 Amended Version.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	

Report Title:	**Quality & Performance Scorecard**					
Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Janette Leonard, Director of ITT					
Report discussed previously at:	Finance and Performance Committee Clinical Governance & Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report				
Summary of risks highlighted in this report	All inadequate and requiring improvement indicators			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety			✓
	SR2 People (workforce)			✓
	SR3 Finance and Resources Infrastructure			
	SR4 Demand/ Capacity			✓
	SR5 Lampard Inquiry			
	SR6 Cyber Attack			
	SR7 Capital			✓
	SR8 Use of Resources			✓
	SR9 Digital & Data Strategy			
Does this report mitigate the Strategic risk(s)?	No			
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No			
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A			
Describe what measures will you use to monitor mitigation of the risk	N/A			
Are you requesting approval of financial / other resources within the paper?	No			
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When	
	Executive Director			
	Finance			
	Estates			
	Other			

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

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

Full Report

The full Power BI EPUT Quality & Performance Board Report can be found **HERE.**

Summary of Key Issues

This report to Board provides an interactive and detailed summary of performance across the Trust. It incorporates items from the NHS System Oversight Framework, Safer Staffing, and CQC. Each Key Performance Indicator (KPI) can be selected and viewed alongside trend analysis and informative narrative.

Mental Health Inpatient Capacity -
In June the average length of stay for adult patients increased slightly to 65 days against a target of <35. When monitoring this performance with assessment units included; we see an average length of stay positon of 44 days. There were 125 discharges (55 from assessment units), 24 of whom were long stays (60+ days).
Older adult average length of stay increased in the month to 130 days, however still remains above the target of 74. There were 27 discharges, 20 of whom were long stays.
PICU average length of stay reduced back to target in June at 41 days, this is against a target of <50 days. There were 5 discharges, 2 of which were long stays.

Adult and Older Adult bed occupancy rates continue to be higher than their respective targets, whilst PICU occupancy remains comfortably within target. In June, adult occupancy rose to 96% (target <93%) which is comparable with year to date performance.
Older adult occupancy also remains stable at 90%, against a target of <86. PICU occupancy increased to 64%, however this is within the 88% target whilst they continue to work with reduced beds.

Rates of patients who are clinically ready for discharge remains within targets across all ward types.

Inappropriate Out of Area Placements –
At the end of June there were 41 patients in an out of area bed, which represents an increase from 37 in May. However just 16 patients were newly placed in an OOA bed during the month, which is the lowest since November 2023. Efforts were made to repatriate and a total of 13 clients were successfully brought back to EPUT wards.

The Operational and Flow Teams continue to work to operating plan targets, however the June target of 12 patients in an OOA bed was not met. Work to reduce and eliminate the need for people to be placed outside of Essex is ongoing. The improving flow programme of work within EPUT is focused on ensuring inpatient assessment & treatment is offered where there is a clear purpose to admission with therapeutic benefit that can only be offered within hospital. Quality improvement work to the daily safer staffing, demand and capacity call has taken place, ensuring a renewed focus on exploring opportunities to return people place out of area into Essex.

MH Inpatients Follow Ups –
72 hour follow ups reduced in June to 82% (target 80%), however this remains above target. There were 17 discharges not followed up within 72 hrs, of these; 11 were out of area, 3 were due to weekend/miscommunication to community teams, 1 did not attend their planned appointment, 1 was due to staff sickness, and 1 was temporarily out of area.

Whilst 7 day follow ups has been superseded by 72hrs, we do continue to represent its performance in the report. In June, the 7 day follow up performance reduced from 92%, to 86% (target 95%). There were 13 discharges not followed up within 7 days in June.

These indicators can now be monitored by the Operational Productivity team via a Power BI Report, this report is refreshed several times a day & has an interactive narrative function where breach reasons can be recorded.

NHS Talking Therapies (IAPT) –
North East Essex access rates continue to be the most challenged area, and witnessed a reduction to 624 patients accessing treatment in June, against an 844 target. Limbic access continues to prove beneficial with 2,120 referrals received to North East Essex services via Limbic from Jan24-June24.

Castle Point and Rochford continues to meet its target of 311, with June seeing 321 patients accessing treatment. Southend performance reduced below the target of 380, to 340. Performance against all areas continues to be monitored regularly through the Integrated Performance Report, The Accountability Frameworks, and Commissioner reporting.

Across other Talking Therapies KPIs; all areas consistently meet 100% for clients beginning treatment both within 6 weeks and 18 weeks. The percentage of clients moving to recovery also maintains consistent target attainment.

Temporary Staffing –
The Trusts position for agency staffing continues to improve. In June; the proportion of staff spend on agency reached its lowest since reporting began at 2.3%, and the number of shifts and hours booked for agency staff also continues to reduce.
Bank usage did increase in June however the number of booked shifts and hours remains lower than levels reached throughout 2023. Bank spend reflects this.

Reducing temporary staff continues to be a main theme of the Time to Care programme and focused work being carried out by the HR Business Partners. In addition, regular discussions and monitoring of this performance takes place within the Accountability Frameworks.

Sickness Absence –
Overall absence rates have continued to exceed the benchmark of <5% since September 2023. In June the sickness rate rose to 6%, and comparatively is higher than the same point in 2023 which was 4%. Nationally, EPUT is reporting slightly higher than the England average however the most reported reason for absence across all areas remains to be anxiety/stress/depression/other psychiatric illness.

The care units with the highest sickness rates in June were Central Budgets at 7.5% (largely driven by smaller numbers), Specialist care unit at 7.2%, and West Essex at 6.6%.

Finance –
Trust Income & Expenditure
M3 results are a YTD deficit of £5.6m, £1.3m adverse variance to plan. The adverse variance includes overspends in Inpatient areas associated with acuity, observations, capacity and costs associated with out of area placements. The efficiency programme is behind plan but mitigations, including vacancy and establishment controls are in place. There remains continued progress on reducing agency spend with focus on mobilisation of the Time To Care supporting temporary staffing reductions. Enhanced pay and non pay controls remain in place.

Efficiency Programmes
In order to deliver the 24/25 financial plan, the Trust has to deliver £28.6m of efficiencies equivalent to 5.2% of operating spend. The Month 3 YTD position is delivery of £2.2m (£2.7m below plan) including savings against workforce trajectories. Mobilisation of the Time To Care project is supporting delivery of further reductions in temporary workforce costs. Mitigating actions in place include establishment, vacancy and non pay controls.

Temporary Staffing
Total temporary staffing spend in month 3 was £5.6m (£5.8m month 2) with a continued reduction in agency expenditure. Bank usage continues to be an area of focus including enhanced controls and mobilisation of the Time to Care project.

Capital Expenditure
The Trust has incurred capital expenditure of £3.6m at the end of M3, which is £0.3m ahead of plan. This variance is primarily due to the accelerated progress on a number of schemes. Following the approval of the EPR FBC, the Trust's EPR external funding has been rephased with £5.2m of expenditure being made

available in future years. Consequently, the overall capital forecast outturn will be reset to £19.2m with the original plan of £24.4m.

Cash Balance
Cash balance as at end of M3 is £28.1m, behind plan by £5.8m which includes the impact of the income and expenditure position.

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

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

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

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

Supporting Reports/ Appendices /or further reading
EPUT Quality & Performance Board Report **HERE.**

Executive Lead
Paul Scott **Chief Executive Officer**

7.2 COMMITTEE CHAIRS REPORT

Decision Item | Chairs | 10

REFERENCES

Only PDFs are attached

Committee Chairs Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Committee Chairs Report**					
Committee Lead:	Chairs of Board of Director Standing Committees					
Report Author(s):	Chairs of Board of Director Standing Committees					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	N/A		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		✓
	SR7 Capital		✓
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		✓
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

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

Recommendations/Action Required

The Board of Directors is asked to

1. Note the report and assurance provided.

Summary of Key Points

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

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

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

- Assurance – any key assurances to be provided to the Board.
- Information – any issues previously identified which have now been resolved, including lessons learned.
- Alert – any issues / hotspots for escalation to the Board.
- Action – any issues where the Standing Committee is requesting action from the Board.

The attached report provides updates in relation to the following Standing Committees:

1. Audit Committee (Elena Lokteva)
2. Finance & Performance Committee (Loy Lobo)
3. People, Equality & Culture Committee (Diane Leacock)
4. Quality Committee (Dr Rufus Helm – Dr Mateen Jiwani from August 2024)

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

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

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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices
Committee Chairs Report

Executive/ Non-Executive Lead / Committee Lead:
Chairs of Board of Director Standing Committees.

NHS
Essex Partnership University
NHS Foundation Trust

Committee Chairs Report

Board of Directors Part 1

7 August 2024

EPUT

1. INTRODUCTION

Purpose of the report

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

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

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

- **Assurance** - Any key assurances to be provided to the Board
- **Information** – Any issues previously identified which have now been resolved, including the identification of lessons learned
- **Alerts** - Any issues / hotspots for escalation to the Board
- **Action** - Any issues where the standing committee is requesting action from the Board

NHS
Essex Partnership University
NHS Foundation Trust

2. AUDIT COMMITTEE

Chair of the Committee: Elena Lokteva, Non-Executive Director

Committee meeting held: Friday 12 July 2024

Assurance – Any key assurances to be provided to the Board

Internal Audit Progress Report & Follow Ups
The Data Security and Protection Toolkit for 2023/24 has been finalised and received 'substantial' assurance.

The Committee requested that P1 and P2 recommendations, once embedded, are adhered to with follow up audits if necessary. The Committee requested executive review if P1 recommendations implemented during the last two to three years are embedded in day to day operations.

The Committee formed the reasonable level of assurance over recommendations and implementations.

External Audit Progress Report
An 'unqualified' opinion was received following the Annual Audit Review (Financial Statement and VFM Opinion) for the 2023/24 year.

Clinical Audit – Assurance on Process & Delivery
The Committee received a report providing assurance with regards to gaps identified around learning. It was noted that quarterly meetings are being held to review lessons learned which will be included in future clinical audits. The Committee requested additional information and data to prove that clinical audits improve EPUT practice and therefore, to be able to assess the level of assurance around the Clinical Audit process.

Information – Issues previously identified which have now been resolved / lessons learned

Anti-Crime Progress Report
The Committee received an update on Counter Fraud activity. The rolling out of the E-Learning module to staff has commenced.

The NHS Counter Fraud Authorities Local Proactive Review regarding procurement is due to be undertaken, following a previously completed review. The previous review identified two areas of concern, due diligence and contract management and the upcoming will focus on these areas. The outcome of exercise is due to be presented to the next Audit Committee.

Waiver of Standing Orders
During the period from 1 April 2024 – 31 May 2024 competitive quotations were received on 14 occasions totalling £1,041,601, including VAT.

There has been an increase in both volume and value compared to the same period last year where 12 competitive quotations were waived at a value of £659,797, including VAT.

During this period, four of the 14 waivers were retrospective requests, meaning 21% of the requests were submitted retrospectively. In the same period, seven of the 14 waivers were requested on the grounds of sole/single supplier, representing 50% of requests.

3. FINANCE & PERFORMANCE COMMITTEE

Chair of the Committee: Loy Lobo, Non-Executive Director

Committee meeting held: Thursday 25 July 2024

Assurance – Any key assurances to be provided to the Board

Quality & Performance (Including Accountability Framework) – The month 3 Quality & Performance updates were led by the Executive Chief Operating Officer. Areas of performance discussed were the staffing challenges being experienced by the Children's Speech & Language service, mental health inpatient capacity, out of area placements, NHS Talking Therapies, and patients on a consultant caseload not seen for 12 months. In addition, the Committee reviewed the Q1 Accountability Framework report, noting areas of highest risk and areas of improvement.

Finance M3 – The Committee discussed special measures and the Trust's involvement in a system exercise of Investigation and Intervention to help support financial recovery. The YTD actual deficit is £5.6m, £1.3m adverse to plan with a £0.3m run rate improvement. The Chief Finance officer noted that five of the six care units are within financial targets, with Inpatient Services being the only exception - overspend is driven by the need for out of area placements and temporary staffing. Colleagues noted this recovery will be realised through the Time to Care programme.

Demand & Capacity – The Committee received a presentation deep dive in to the Trust's demand and capacity. This is one of the Trust's BAF risks and there are a number of management actions and controls in place. Presentations covered system flow and why this is a priority, sources of admission demand, out of area placement plans, delayed discharges, length of stay, and occupancy, and the Time to Care programme's objectives and scope, key stages and progress to date, noting the model is due for roll out in September 2024.

The Chair of the committee praised colleagues for evidencing a great understanding of the challenges, finding practical solutions, and for allocating resources to the right places.

Board Assurance Framework (BAF) – The Committee reviewed and reflected in the BAF report to Board areas covered by the business of the meeting. These include flow and capacity, cyber security, capital and cash, and the unified electronic patient record.

NHS
Essex Partnership University
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4. PEOPLE, EQUALITY & CULTURE COMMITTEE

Chair of the Committee: Diane Leacock, Non-Executive Director

Committee meeting held: Monday 1 July 2024

Assurance

Workforce Update
- Work to drive workforce efficiencies is progressing well.
- The Trust is currently operating 2% above the expected workforce plan. Rostering, establishment control and recruitment processes are under review to resolve this.
- The Trust's vacancy rate has increased slightly to 11.1%, due to the rollout of Time to Care.
- There has been a 24% reduction in time to hire since January 2024.
- Sickness rates have increased to 5.7%, which is above the Trust's target of 5.3%. The overall sickness trend decline since October 2023 continues.
- Bank usage is 14% above planned levels, although agency usage has decreased.
- Off framework agency usage has reduced to zero.
- Training compliance for substantive staff is above target at 93% against a target of 90%.
- Training compliance for temporary staff is below target at 76% against a target of 90%.
- Supervision and appraisal compliance is below target, but this is expected to improve with the appraisal process which is due to be completed by October 2024.
- There are currently six ongoing employment tribunal cases, with the majority relating to disability discrimination.

Industrial Action
- Industrial Action announced by the British Medical Association Junior Doctors Committee, taking place from 27 June to 2 July 2024, was well managed with no workforce gaps or significant issues to report.

Behaviour Framework
- The Behaviour Framework approved in April 2023 has been implemented across the Trust and embedded into supervision and appraisal processes.
- There is now discussion about widening the framework out across systems and care groups, and around how the impact of the framework can be measured.

Information

Chief People Officer Emergent & Topical Issues
- The Executive Director of People & Culture has been meeting with Lived Experience Ambassadors and operational staff to obtain information about current issues.
- A workforce directorate away day was held in June, with open discussion around the directorate's current position and future aspirations. There will now be consultations with the wider teams under the pillars of Operational & HR, Education & Learning, OD & Culture and Resourcing.
- The Trust has been identified as a People Promise Exemplar site by NHSE. The award includes funding for a 1-year Band 8a role to develop staff retention initiatives. This post will be advertised internally for expressions of interest.
- The Work Plan for the Committee will be reviewed by the Executive Director of People & Culture, and an updated version presented at the next meeting.

Time to Care
- There has been significant progress on the rollout of Time to Care, with 74 WTE roles approved within Specialist and Inpatient services.
- Spend at the end of month 2 stood at £839,929.

Social Impact Strategy
- The Committee received an outline of progress made since the strategy was approved in September 2023, along with proposed activity for the upcoming six months.
- The Trust will be adopting UCLP's *'How Strong is Your Anchor'* tool to measure the success of projects.
- £400,000 in local authority grants has been secured by Enable East to deliver the numeracy programme *Multiply* for mental health inpatients across the East of England.

PEOPLE, EQUALITY & CULTURE COMMITTEE

Assurance (cont'd)

Workforce Disability Equality Standard (WDES)
- There has been improvement in nine of the 10 WDES indicators.
- There continue to be inconsistencies in the provision of reasonable adjustments by managers, which is reflected in current employment tribunal cases.
- Positive feedback has been received about the Trust's new Occupational Health Provider. Their specialist neurodiversity service will be useful for staff and managers.
- A WDES Action Plan will be presented at the next PECC meeting.

Workforce Race Equality Standard (WRES)
- There has been improvement in six of the nine WRES indicators.
- Current issues include a decline in BAME appointments following shortlisting, an increase in disciplinary cases involving BAME staff, and an increase in bullying and harassment of staff by patients.
- A WRES Action Plan will be presented at the next PECC meeting.

Board Assurance Framework Report
- The Committee received an update on the Board Assurance Framework Strategic & Corporate Risk Register for the period ending 31 May 2024.
- The Executive Director of People & Culture will be reviewing the risks, and an updated Board Assurance Framework Report will be provided at the next PECC meeting.

Information (cont'd)

Appraisal, Talent Mapping & Succession Mapping
- A review of the Trust's appraisal, talent mapping and succession planning is underway.
- The changes are based on a range of information including Staff Survey results and best practice from other organisations.
- Managers will be given support and training including dealing with difficult decisions and conflict resolution, to ensure the processes are carried out effectively.

Staff Survey Improvement Plan
- 2,795 responses were received for the 2023 Staff Survey, which was 2 percentage points higher than the 2022 response rate.
- Areas of improvement identified from the results, to be developed during 2024/25, include:
  - Reward & Recognition
  - Freedom to Speak Up
  - Staff Engagement
  - Appraisal & Supervision
  - Leadership

5. QUALITY COMMITTEE

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

Committee meeting held: Thursday 13 June & Thursday 11 July 2024

Assurance

Executive Chief Nurse / Executive Medical Director Emergent Issues
- The awaits the CQC inspection report for Brockfield House.
- Work to simplify the PSIRF process was underway.

Quality Performance Report
- The format of the report has been updated to provide data in a more visual way to enhance understanding and learning from the data, and broken into the areas of Safety of Care, Effectiveness of Care and Experience of Care.
- Seclusions & Restraints data remained consistent with similar periods.
- A deep dive into patient incidents had highlighted a high number of moderate incidents. Metrics will be reviewed to ensure the correct information is being collected.

Safeguarding Report
- A Quarterly Report and Annual Work Plan was presented to the Committee.
- Four areas for improvement were identified in the report, and work had commenced:
  - Domestic Abuse
  - Section 42 Enquiries
  - Children
  - Learning and Awareness of Safeguarding Agenda.

Physical Health Annual Work Plan & Progress Report
- The Committee received the Physical Health Annual Work Plan, and a brief update on the status of ongoing actions.

Information

Mapping of the key SIP Themes
- A thematic analysis on Prevention of Future Deaths was presented.
- The Committee received a report on PFD's issued to the Trust . These had been split into six key themes :
  - Communication
  - Training and supervision
  - Record keeping
  - Discharge planning
  - Care planning
  - Risk Assessment
- 10 Safety Improvement Plans were in place, and deep dives would be presented at future meetings.

Quality Account 2023/24
- The Quality Account 2023/24 was approved for presentation to the Board of Directors on 24 June for approval and publication.

Learning from Deaths Report
- The Committee received learning from deaths data for quarters 3 and 4 2023/24. This will be presented to the Board of Directors as a separate agenda item.

Mental Health Act Report
- There were five CQC visits during April 2024, with key themes including:
  - Care planning.
  - Capturing patients' voices.
  - Mental health capacity assessments on admission.

Assurance (cont'd)

Ligature Risk Reduction Annual Report
- The Committee received assurance on Ligature Risk Reduction activity in 2023/24.
- A Ligature Risk Reduction Deep Dive will be carried out shortly.

CQC Compliance Update Report
- The Trust continues to be fully registered with the CQC.
- 88% of Must Do/Should Do CQC Action Plan items have been completed.
- The Trust has submitted a response to a consultation on changes to CQC regulations.

Board Assurance Framework
- All risks overseen by the Committee are under review, with reductions to scores expected.

Assurance Reports:
- The Committee assurance reports on:
  - EPRR 2023/24
  - Infection Prevention & Control 2023/24.
  - Safety Improvement Plans for Falls and Ligatures.
  - Reducing restrictive Practice.
  - PSIRF.
  - Clinical Audit Progress & Delivery.

Information (cont'd)

End of Life Annual Work Plan
- The Committee approved the End of Life Work Plan 2023/24.

Sexual Safety Report
- The CQC and other partners have provided positive feedback about the Trust's work, and some initiatives have been replicated across the system.
- Developments include:
  - Introduction of a telephone line for staff to report sexual safety incidents.
  - Intranet page update.
  - Dedicated Datix Category.

Safer Staffing Report for Inpatient Nursing
- The Committee approved the report for presentation to the Board of Directors on 7 August.

Safety First Safety Always Year 3 Closure Report
- The Committee approved the report for presentation to the Board of Directors on 7 August.

Embedding Quality Improvement (QI) at EPUT
- A plan for embedding QI across the Trust was discussed by the Committee.

Quality Senate
- The Committee approved a proposal to hold a series of Quality Senates.

Change of Committee Chair
- Dr Mateen Jiwani, Non-Executive Director, will assume the role of Chair of the Quality Committee commencing from the next meeting, following Rufus Helm's departure from the Trust after serving the maximum term.

7.3 CQC COMPLIANCE UPDATE

Information Item | AS | 5

REFERENCES

Only PDFs are attached

CQC Compliance Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**CQC Compliance Update**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Chief Nurse					
Report Author(s):	Nicola Jones, Director of Risk and Compliance					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	Maintaining ongoing compliance with CQC registration requirements		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	~~Yes~~/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with: 1. An update on CQC related activities that are being undertaken within the Trust. 2. An update and escalations as required on progress made against the Trust CQC action plan.	**Approval**	
	Discussion	✓
	Information	✓

3. Internal Assurance of CQC Quality Statement compliance 4. Details of CQC guidance/updates that have been received since the previous reporting in June 2024		

Recommendations/Action Required
The Board of Directors is asked to: 1. Receive and note the contents of the report for assurance of oversight of progress against the CQC improvement plan.

Summary of Key Points
• EPUT continues to be fully registered with the CQC. There has been one registration change in this reporting period, with Andrew McMenemy Executive Chief People Officer being registered with the CQC. • The Trust continues to focus on the implementation of the CQC improvement plan. Good progress continues to be made with implementation of actions with 88% of actions reported complete and 18% being agreed for closure through the Evidence Assurance Group. • The Trust awaits the CQC inspection report of our Forensic / Secure Services at Brockfield House in March 2024. • A new joint quality visits framework has been developed and being piloted. The joint quality visits framework is part of the Trust Quality Assurance Framework and seeks to achieve a joint approach with ICBs to undertaking quality visits to EPUT Services. Piloting is underway through June – September 2024. • The internal CQC focused programme assessing services against the new Quality Statements has now completed a full year of assessment which has included a sample of teams/wards across all core services. This enables analysis of key themes to identify potential gaps for learning. • The CQC raised 3 enquiries during the reporting period. They have all been taken forward in line with Trust response processes.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓

Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			✓
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	EPUT	Essex Partnership University Trust
ICB	Integrated Care Board	EOT	Executive Operational Team
DHSC	Department of Health & Social Care	CHS	Community Health Services
STaRs	Specialist Treatment and Recovery Services	TASI	Therapeutic and Safe Interventions

Supporting Reports and/or Appendices

CQC Compliance Exception Update
Appendix 1 - CQC Action Plan Update July 24

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan
Executive Chief Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Exception Update

1. Purpose of the report

This report provides the Board of Directors with:

1. An update on CQC related activities that are being undertaken within the Trust.
2. An update and escalations as required on progress made against the Trust CQC action plan.
3. Internal Assurance of CQC Quality Statement compliance
4. Details of CQC guidance/updates that have been received since the previous reporting in June 2024

2. CQC Registration Requirements

2.1. Registration

EPUT continues to be fully registered with the CQC.

Regulations require all Board members (both voting and non-voting) to be registered with the CQC, Andrew McMeneny, People of Culture Executive Director has been registered.

3. CQC Inspections and Improvement Plans

3.1. CQC Improvement plan Implementation

The Trust has continued to focus on implementation of the CQC improvement plan.

As of the 10 July 2024:

- 69 (88%) of the Must do / Should do actions have been reported as completed by action owners. Of these, 14 (18%) have been closed following review at the Evidence Assurance Group. The next step for the remaining 55 is for the evidence to be presented.
- 332 sub-actions complete
- 12 sub-actions past timescale as at 10 July 2024 (Nb. Associated with 7 overall actions status) recovery plans are in place, this being an improved position from previous reporting.
- The Internal Inquiry 54 sub-actions are fully complete. The next step is for the evidence to be presented.

The last EAG meeting was held on the 2 July 2024 chaired by the ICB Director of Nursing. The meeting was positive with constructive challenges and questions from ICB partners, which our operational teams were able to effectively respond to. The next EAG meeting is scheduled for the end of July 2024 with 3 actions scheduled for closure.

89 Assurance Metrics / Measures have been identified to help demonstrate that actions being taken in the CQC improvement plan will have sustained impact. As at 10 July 2024, 40% of these indicators have been developed and will be taken forward.

3.2. Unannounced Forensic / Secure Services CQC Inspection

The CQC report following the unannounced inspection of our Forensic / Secure Services at Brockfield House in March 2024, is awaited.

3.3. CQC Enquiries

The CQC raised a query on 20 May 2024 regarding staffing at Broomfield Hospital Mental Health Wards for period 01 March to 20 April 2024. The request was responded to lead by the Director of Nursing, Infection Prevention and Control. The information highlighted two wards being above target rates for vacancy rates and other wards above target for sickness rates over the period requested.

The CQC raised a query on 22 May 2024 following a patient reported concern at Brockfield House. This is currently being reviewed by the Deputy Director of Quality and Safety who will respond.

The CQC raised a Safeguarding query on 17 May 2024 regarding Galleywood Ward. This is currently being taken forward by the Safeguarding Team and the Deputy Director of Quality and Safety who will respond.

4. Annual Programme 2024-25

4.1. CQC Assurance Programme

The Compliance team have continued to take forward the development of the CQC Assurance Framework. Adaption of our internal processes being reviewed due to the change in CQC approach under the new Single Assessment Framework and its supporting quality statements (which replaced the Key Lines of Enquiry).

The Compliance Team have a work plan to implement changes, the key areas are outlined below:

1. Joint Quality Visit Framework

   A new visits framework has been developed and received support from Trust Board, Council of Governors and ICB Colleagues. Piloting of the new visits framework is now underway and is due to complete in September 2024. Next steps continue to seek feedback during pilot and revise framework in response.

2. Re-development of ward heat-maps moving from manual system to an automated dashboard.

3. Plan to utilise Tendable (service based audit platform) for internal assurance reviews / self-assessment tools.

4.2. Internal CQC Compliance Programme

The Trust annual compliance team assurance visit programme to promote and monitor adherence to the CQC Quality Statements for 2024-25 continues. For quarter one 2024, the Compliance Team focused on the following Core Services:

- Substance Misuse
- Mental Health Specialist

- CAMHS Inpatient
- LD Inpatient

Following each visit, feedback was provided for each core service capturing the good practice and any areas for improvement. This is shared with the Service and Care Unit leadership for review, implementation of change.

A full year cycle of internal inspection against the new CQC Quality Statements has been completed. With the Compliance Team being able to visit a sample of wards/teams from all core services and apply an internal assessment aligned to the new CQC rating guidance. The Compliance Team are using the information gathered across internal work to highlight gaps against the new Quality Statements. This information enables identification of learning which is being shared across the Trust via the Culture of Learning and is reviewed in detail by the Safety of Care and Effectiveness of Care Groups.

5. CQC Guidance / Updates

No new guidance within reporting period

6.0 Recommendation

The Board of Directors is asked to:

1 Receive and note the content of the report

2 Note the assurance on progress against the improvement plan

Report Prepared by:

Nicola Jones
Director of Risk and Compliance

On behalf of

Ann Sheridan
Executive Nurse

Appendix 1:

CQC Improvement Plan Update – 10 July '24

CONTENTS

Introduction

Essex Partnership University NHS Foundation Trust

The purpose of this report is to provide an update on implementation and assurance status against the trust CQC action plan.

The CQC action plan has been developed in line with new trust process which focused on engagement, sustainability and ownership of actions developed.

Work has been undertaken to bring together core CQC and other related plans into one document to ensure consistency of delivery, avoidance of duplication and consistent assurance routes. This includes:

- Initial S29 plan (Willow and Galleywood Wards – Oct '22)
- Intra-inspection feedback of acute wards for adults and PICU (Nov '22)
- Internal report for 2 Adult Acute Wards (Jan '23)
- CQC report Acute Wards for Adults and PICU (published Apr '23)
- CQC report Core Services and Well Led (published July 23)
- CQC report Rawreth Court (published Nov '23)

Level of Assurance: Level 1

Key Messages

There are currently 78 'must do' / 'should do' actions being taken forward (Note: combination of some actions into one), with 346 sub-actions (as at 10 July '24) associated with CQC activity.

All 54 actions associated with EPUT internal inquiry following the Dispatches Programme are now complete.

Overview as of the 10 July 2024:

- 69 (88%) of the Must do / Should do actions have been completed.
- 14 (18%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group.
- 332 sub-actions complete

12 sub-actions past timescale as at 10 July '24 (Nb. Associated with 7 overall actions status) recovery plans are in place, which is an improvement from previous June reporting.

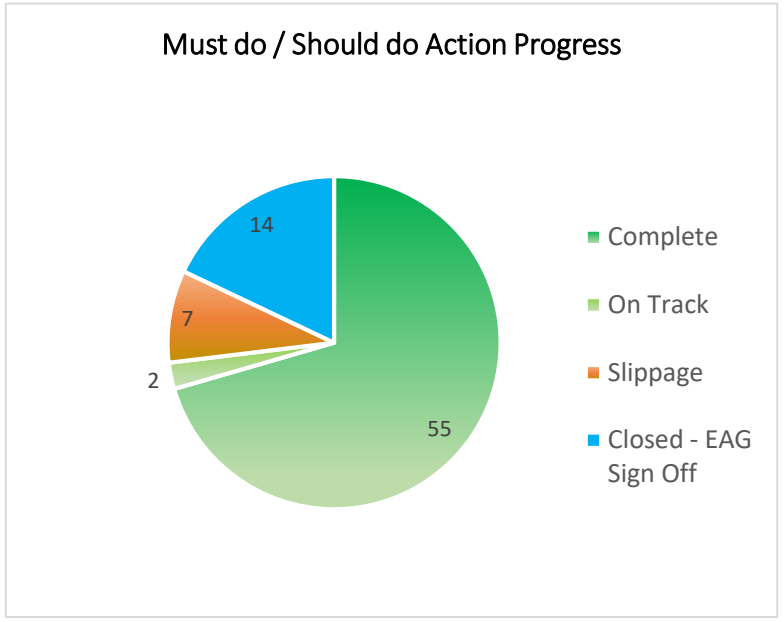
The CQC Action Leads meeting continues to hold action owners to account for delivery. The meeting is chaired by the Senior Director of Corporate Governance and attended by Executive Chief Nurse.

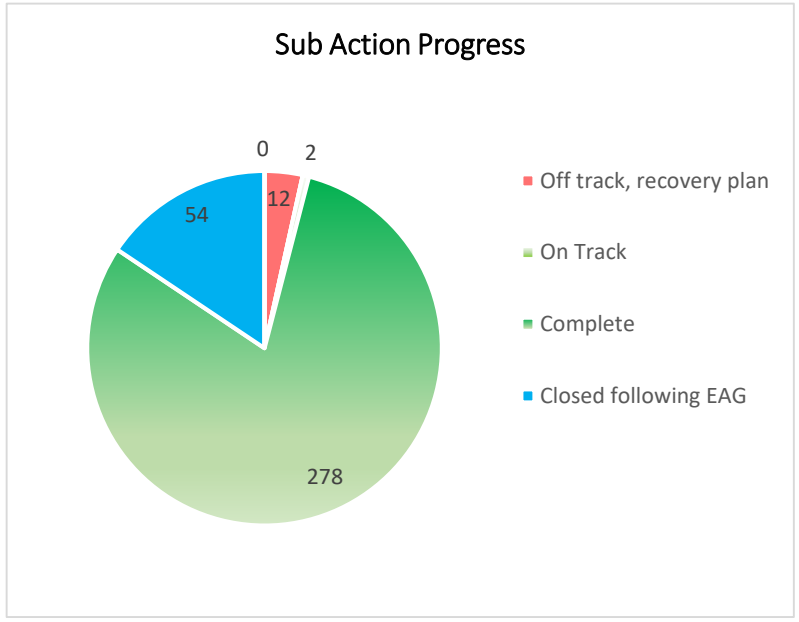
Action Progress Update

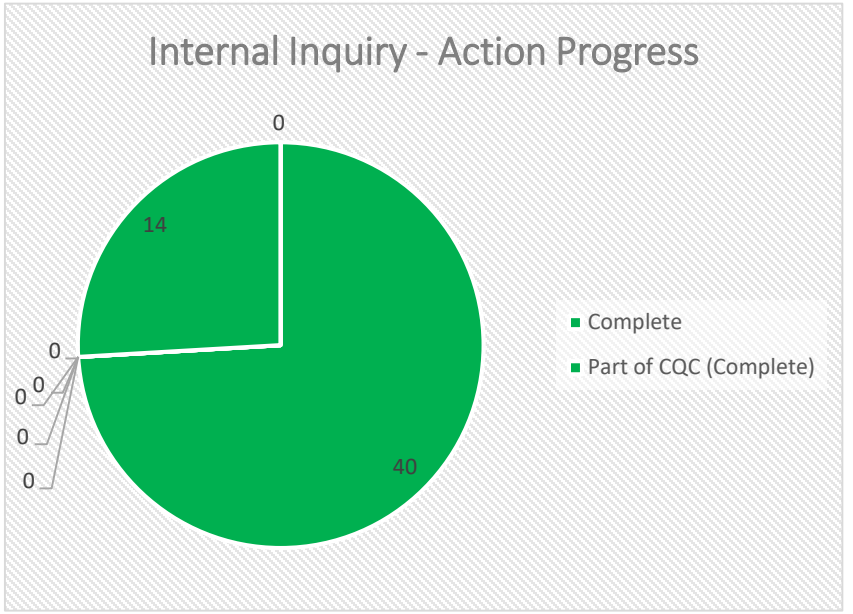
NHS Essex Partnership University NHS Foundation Trust

Summary of implementation status

- 78 Must do / Should do actions as at 10 July ’24 and 346 Sub-Actions identified as at 10 July ‘24
- 14 (18%) have been closed following review at CQC Leads Meeting and Evidence Assurance Group (EAG).
- 69 (88%) of the Must do / Should do actions have been completed. (next step for the 55 that have not been closed following a review at CQC Leads Meeting and EAG; is for the evidence to be collated and presented for final closure)
- 332 sub-actions complete
- 12 sub-actions past timescale as at 10 July ’24 (Nb. Associated with 7 overall actions status) recovery plans are in place
- All 54 actions associated with EPUT internal inquiry following the Dispatches Programme are now complete.







Summary of activities and highlights

NHS
Essex Partnership University
NHS Foundation Trust

Summary of key activities completed in the last month:

- Actions with recovery plans remain on track
- S22 (Older Adults) Tendable data now linked with the data platform therefore action can progress

Actions Closed

4 Actions closed by EAG in the period (14 closed in total):

55 must do/should do actions complete and ready for closure. These are being prepared to be taken through evidence assurance processes.

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	Lead
M3: The trust must ensure they improve the quality of their data, the effectiveness of their systems and the accuracy of the assurance they receive about the quality of care being delivered. M5: The trust must ensure that they have a robust and timely plan for the implementation of a consistent patient record in line with their current strategic aim. (4/11 actions complete / 2 on track)	M3.4.1 Complete Paris upgrade which will include waiting list management	Supplier (Civica) is actively supporting the trust for the upgrade of Paris following setbacks in the testing of the new version. Upgrade is now underway and is expected to complete by July due to some minor technical issues with Civica	Go Live **New Timescale:** July 2024	Jan Leonard
	M3.5.1 Enhancement of the Shared Care Record (SCR)	EPUT is ready for go live for Mid June for Mobius and SystmOne – Paris upgrade remains an interdependency. A risk has been escalated as a result of contract end with incumbent supplier that impacts cross system record sharing. DDAT are supporting discussions with suppliers.	Suppliers negotiations for resolution to share care record access between ICS's **New Timescale:** July 2024	Jan Leonard
M6: M1 (April 2023) and M6 (May 2023) The trust must ensure that systems and processes are in place to assess, monitor and ensure staff follow the trusts' policies and procedures for the recording and reporting of incidents	M6.5 Identify solution to current technical barriers which prevent wide access to closed-circuit television (CCTV) to enable use for training / learning	Possible software to enable CCTV to be remotely accessed has not passed our cyber security assessment. Therefore unable to roll out for remote access until a solution is identified.	Solutions to be identified and reviewed between IIT, Estates and Action Leads to identify an effective method to access CCTV in a more timely manner as and when needed	Tendai Ruwona
M21: The trust must ensure staff used systems and processes to safely prescribe, administer, record and store medicines. The trust must ensure that staff regularly review the effects of medications on each patient's mental and physical health. (7/8 actions complete)	M21.2 Implement revised medicines management training program based on the outcome of the scoping exercise (M21.1)	Roll out of new training process is underway.	Roll out of plan is being overseen by Medicines Management Group **New Timescale: Roll out beginning of July 2024**	Dr Gbola Otun

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	Lead
M32: The trust must ensure that all patients have fully completed discharge plans and that there are systems and processes in place to secure timely discharge for patients using the recovery and wellbeing part of the service as part of their recovery.	M32.1 Change care plans to prompt clinicians to set discharge date M32.2 Create clear identification for cases where there are factors that limits the patients from being discharged and extends length of time on caseload M32.3 Benchmark workforce establishment to understand resourcing and availability to complete discharge M32.4 Training needed to identify when and how to have goal setting and discharge conversations and also the tactical preparation for discharge planning. Connect this in with the work already on the safety improvement planning work.	Work is underway with team to ensure discharge plans are clearly articulated and for the people who remain with the services for extended period legitimately (such as Depo injections, S117 after care, CTO etc.) this is clearly documented within the record. Memo has been circulated to colleagues detailing requirements for care coordinators to ensure care plans include discharge planning Instruction given to care coordinators to document discussion had with service users within the My Recovery Goals / needs and actions section of the care plan around the expected length of treatment	Questions to be added to care note audit to test these are in place moving forward **New Timescale: August 2024**	Lynnbritt Gale
M42: The provider must ensure that all care and treatment records are complete and accessible (6/8 actions complete)	M42.5 Positive Behaviour Support (PBS) training for staff facilitated by Hertfordshire Partnership Foundation trust (HPFT) and EPUT (3, ½ day sessions)	Confirmation that training is being rolled out in July to cover all the remaining staff	Rolling out additional PBS training. **New Timescale: July 2024**	Janet Childs
S19 The trust should ensure that care plans are easy to use and understand. (2/3 actions complete)	S19.2 New smart care plan to be launched later this year late Q3 (key principles of SMART, Simple and uncluttered, short and to the point, includes primary outcome measure and secondary outcome measure)	Care plan signed off at Project Board. System now being aligned with new care plan Go live extended to September 2024	Continue training in preparation for go live **New Timescale: September 2024 – go live / Training will be ongoing**	Tendai Ruwona

Summary of activities and highlights

NHS Essex Partnership University NHS Foundation Trust

Key Slippages (12 Sub-actions are past timescale)

Must do / Should do Action	Sub-Action past timescale	Current Position	Recovery Plan	CQC Lead
S22 The trust should ensure all wards follow its governance systems and processes to maintain patient safety, in particular for clinical equipment monitoring, assessment and management of patient risk, and medicines management (2/3 actions complete)	S22.3 Tendable data to be made available on safety dashboards to ease accessibility of data.	Tendable data now linked with data platform	Scope to be developed now link available with the platform – recovery timescale will be agreed following the meeting	Moriam Adekunle
RC10: Queries – Nursing Home admission criteria	RC10.3: To review home admission criteria	ICB partners currently considering scope for the unit	To continue to engage with ICB partners to review criteria **Touchpoint end July '24**	Tendai Ruwona

Risk Management

No new risks identified

Next steps

NHS
Essex Partnership University
NHS Foundation Trust

Areas of focus for the next month

- Continued focus on delivery of action plan
- CQC Leads with support from Compliance Team to build evidence assurance presentations for completed actions to undertake internal check and challenge and submission to the Evidence Assurance Group with ICBs
- Further development and reporting of Metrics report to ensure monitoring the impact changes are making
- Ongoing implementation of the practice assurance toolkit for wards/services to provide assurance of delivery and change at local level

7.4 BI-ANNUAL SAFER STAFFING REPORT FOR INPATIENT NURSING

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Safer Staffing Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Bi-Annual Safer Staffing Report for Inpatient Nursing**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan - Executive Nurse					
Report Author(s):	Angela Wade - Director of Nursing and DIPC and Charlotte Hoctor - Head of Clinical Education and Safer Staffing					
Report discussed previously at:	Executive Committee and Safety of Care Group					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with an update of the annual safer staffing review in relation to inpatient nursing in line with NHS England and CQC expectations.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Confirm acceptance and assurance given in respect to safer staffing regulations and standards

Summary of Key Points

This 6-monthly report provides oversight and assurance to the Board that we are meeting the safer staffing regulations and standards with systems and processes in place to oversee safe staffing across our Inpatient Services. This report presents the initial Mental Health Optimal Staffing Tool (MHOST) data for mental health inpatient wards following its implementation in the Trust in 2023, and provides detail of national evidenced based tool used to provide Board members insight into the methodology as it is the first time EPUT has used this evidenced based approach.

The Trust has seen a significant reduction in nursing vacancies across all inpatient wards with less reliance on bank and agency against existing budgeted establishments, historically set without the benefit of applying the nationally recommended tools. Recruitment of both internationally educated nurses and newly registered RMNs through local universities has seen a total of 186 internationally nurses recruited in 2022, and an additional 54 in 2023 with 91 newly registered nurses recruited across our inpatient services.

For quarter 4 2023/24, inpatient vacancy rates were 8.5% Trust-wide (target ≤ 12%), an improving picture compared to previous months. Care units have been undertaking a drive to reduce agency usage, which has resulted in a shift to higher bank usage. Agency staff have also been converting to bank and substantive posts.

Our planned verses actual fill rates show periods of fill rates over 100%. This can be explained by people we care for having changes in acuity of their presenting conditions that have been assessed to need if additional staff to ensure their care needs are met. The process is managed within the care units SitRep twice-daily calls chaired by clinical service managers, who also risk mitigate when actual fill rates fall below 90%.

During 2023, EPUT undertook its first review of the inpatient mental health ward nursing staff establishments using the nationally approved Mental Health Optimal Staffing Tool (MHOST). The MHOST first year of data collection provided the opportunity to use evidenced based acuity and dependency scoring to indicate required Care Hours per Patient Day (CHPPD) for the patients receiving care in our in-patient services. CHPPD results are then considered in the context of professional judgement and quality indicators to influence future workforce planning.

MHOST census periods (2 three-week periods in different months of the year) took place in 2023/24 to build a picture of the needs of people we care for in inpatient services. We will continue to run MHOST census periods during 2024 in order to be in a position to accurately support workforce planning into 2025/26. It is important to recognise that 2024 will see the impact of launching the Inpatient operating models and recruiting to the Time to Care programme workforce roles to deliver the operating models.

The Trust launch of Quality of care will also provide through quality priorities within safe, effective, and experience principles, evidenced based care and quality outcome measurements to support impatient care delivery and measure impact. Time to Care funding is secured to recruit during 2024 to the increase registered ward staff, which will reset funded establishment to be more reflective of the care needs.

Future bi-annual reports will also provide safer staffing assurance and progress across EPUT Community Health wards through the introduction of the establishment review tool Safer Nursing Care Tool (SNCT) for community rehab wards. Additionally, our Community Health teams will continue to work with the national team in the development and readiness of CNSST- Community Nursing Safe Staffing Tool.

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

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

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

Acronyms/Terms Used in the Report			
MHOST	Mental Health Optimal Staffing Tool	CNSST	Community Nursing Safe Staffing Tool
CHPPD	Care Hours per Patient Day	TTC	Time to Care
SNCT	Safer Nursing Care Tool	RMN	Registered Mental Health Nurse
PICU	Psychiatric Intensive Care Unit	RGN	Registered General Nurse
CAMHS	Child and Adolescent Mental Health Services	PC	Provider Collaborative
NQB	National Quality Board	WTE	Whole Time Equivalent

Supporting Reports and/or Appendices
Bi-Annual Safer Staffing Report for Inpatient Nursing

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Nurse

Bi-Annual Safer Staffing Report for Inpatient Nursing

1. Executive Summary

This 6-monthly report provides oversight and assurance to the Board that we are meeting the safer staffing regulations and standards with systems and processes in place to oversee safe staffing across our inpatient services. This report presents the initial Mental Health Optimal Staffing Tool (MHOST) data for mental health inpatient wards following its implementation in the Trust in 2023, and provides detail of National evidenced based tool use to provide Board member insight into the methodology as it is the first time EPUT has used this evidenced based approach.

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2. Introduction and Background

The purpose of this report is to update the Trust Board of the bi-annual safer staffing review in relation to inpatient nursing for registered and unregistered staff in line with NHS England and NHS Improvement expectations and those of the Care Quality Commission.

In accordance with the National Quality Board (NQB) 2018-updated guidance, organisations are responsible and accountable to Trust Boards for ensuring safe, sustainable, and productive staffing levels.

This report offers a bi-annual update reflecting the inpatient ward nursing services.

To support and monitor with our ward establishment reviews, the Trust has started to use evidence-based tools, Mental Health Optimal Staffing Tool (MHOST) and the Safer Nursing Care Tool (SNCT) to measure patient acuity and dependency, this can then determine optimal staffing levels and workforce.

There have been enduring nursing vacancies across our inpatient areas, as well as increased patient acuity, requiring additional staffing. This presented both a clinical and operational risk as well as a cost pressure on the organisation due to the reliance on temporary staffing.

During 2023/24 the Trust has progressed with the development of the Time to Care (TTC) programme. The overall objective is to release significant and quantifiable time to care on inpatient mental health wards through the delivery of the following four core components:

i. Staffing model redesign: Review and redesign of the inpatient mental health staffing model to match patients' needs, increase capacity and improve quality of care through the design and implementation of an inpatient care operational model that enables purposeful admission, trauma informed, therapeutic care and promoting recovery through discharge to community settings. Our staff will be confident, competent and supported in a culture of care that promotes positive experience, so that the care model can be delivered. This will include review and redesign of existing and new roles to achieve this.

ii. Process Improvement: Identification of 'quick wins', medium-and longer-term solutions to optimise ways of working and streamline processes to free up the time of staff involved in direct patient care.

iii. Data & technology improvement: Optimise the use of data and technology to support frontline teams and the delivery of care. This includes working with the Trust Digital team to identify opportunities and design solutions for further optimisation of systems.

iv. Engagement & inclusivity: Co-creation and implementation of solutions with Trust staff, whilst also recognising and adapting engagement and solutions to take account of the challenges and impact on staff wellbeing.

The core inpatient staffing model proposed in TTC includes the increase to 3 professionally registered staff on each ward shift, and 4 professionally registered in PICU and Assessment Units. It has also included an increase to the nationally recommended 22% headroom as detailed within the MHOST section of this paper.

To address the vacancies EPUT implemented an international recruitment programme as an alternative way of sourcing nursing staff for inpatient areas. However, there was limited availability of registered mental health nurses (RMN), therefore, a large number of registered general nurses were recruited to the vacant posts for the mental health wards

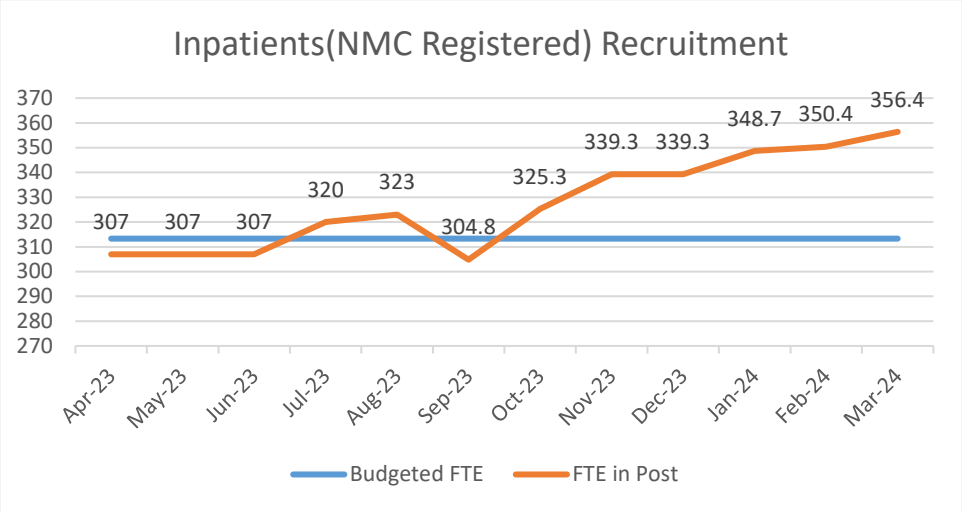
and well as to our community rehab wards. There was also an opportunity to recruit newly registered RMNs through our local universities.

Recruitment of both internationally educated nurses and newly registered RMNs has seen a total of 186 internationally nurses recruited in 2022, and an additional 54 in 2023 with 91 newly registered nurses recruited across our inpatient services.

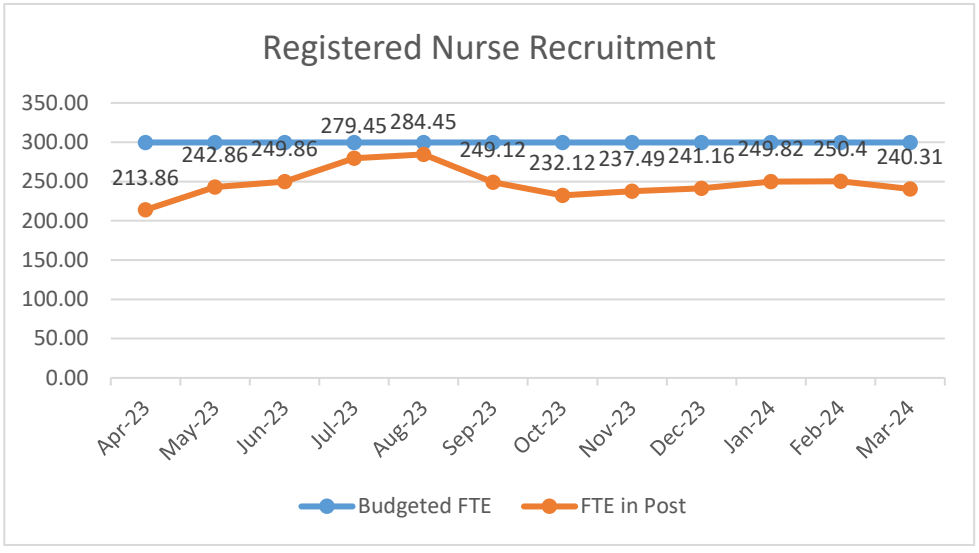
It is recognised in Time to Care workforce modelling, the inclusion of the Professional Nurse Educator roles. These roles will provide expert knowledge and clinical leadership to ward teams, facilitating the application of theory to practice. These roles will further enhance our new registrants in their preceptorship period whilst they consolidate their learning and transition into expert practitioners.

The charts below illustrate recruitment for registered nursing staff for inpatients and urgent care, and specialist services. The budgeted establishment have not been adjusted to reflect the establishments agreed within the Time to care programme during 2023/24, this will commence in 2024/25. However, active recruitment of substantive staff was taken at risk, in readiness for delivery of the time to care model and reduce reliance on temporary workforce. The charts reflect that substantive recruitment was more successful in inpatient and urgent care than in specialist services inpatient areas.

Mental Health Inpatient and Urgent Care Registered Nursing 2023/24



Secure Services Registered Nursing 2023/24



For quarter 4 2023/24 inpatient vacancy rates were 8.5% Trust wide (target ≤ 12%) which showed an improving picture compared to previous months. Care units have been undertaking a drive to reduce agency usage, which has resulted in a shift to higher bank usage. Agency staff have also been converting to bank and substantive posts.

3. Safer Staffing Reports

This section provides insight into the systems and data used to monitor safe staffing for the Trust's Inpatient services in the reporting period.

3.1 HealthRoster and Safecare

EPUT uses Healthroster and Safecare which are modules within an electronic roster management system to enable the effective, safe and equitable utilisation of staff and resources across Trust. They enable managers to more effectively forward plan and roster staffing requirement by time of day, day of week and by skill level, ensuring that the 'right people, with the right skills, at the right time' are available.

The tools provide visibility in real time by automatically calculating the total number of staff hours and skills required to deliver safe care, enabling clinical leads (Ward Managers and Matrons) to report on staffing levels and patient acuity on a shift-by-shift basis. Clinical leads are required to use their professional judgement when making decisions about staffing and is an important part of the systems functionality. Skill mix for each shift is broken down so leads can risk assess and take mitigating actions as required. The skill mix breakdown includes the professional registration of the nurse as well their documented skills. Safe staffing escalations are raised when required following care unit safe staffing level oversight and assurance reviews during SitRep meetings.

During 2023, a rota cleansing exercise was been completed to ensure Healthroster templates are aligned to the funded establishment for each ward following historic roster adjustments made during the Covid -19 period . Additionally, work has been conducted to strength the governance of the rosters, including review the 'rules' to support with safe rostering as well as some focussed work on reducing 'hours owed' by staff. Inpatient wards are supported with safe rostering by the Inpatient e-rostering team.

To promote good work life balance rosters are created a minimum of 12 weeks in advance in accordance with the Trust's Good Rostering practice guidance. The rostering team compile the monthly compliance report that demonstrates each ward/units performance against our safe staffing and e-rostering policy. The report highlights where further work needs to be focussed to see improvement at local leadership level to consistently meet the recommended guidance, whilst overall demonstrating a continued trend of improvement since 2023.

Examples of the Safecare sunbursts and the safe staffing escalation tool are shown in appendices.

3.2 Safer Staffing trends

For the Trust to be compliant with safe staffing reporting requirements, publication of staffing fill rates is required for all mental health inpatient wards. We also monitor ratios of RMN to RGN's within our ward areas to ensure the professionally registered skill mix meets our patients' needs and the quality of care is not compromised. Our minimum standards are we have an RMN rostered for every shift, as well as the supernumerary ward manager to lead quality care and staff support and development.

Table - Summary of staffing level fill rates from September 2023 to March 2024 for registered and unregistered nursing staff for our mental health inpatient wards.

	Sep 2023		Oct 2023		Nov 2023		Dec 2023		Jan 2024		Feb 2024		Mar 2024	
Ward	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rat
MEADOWVIEW														
REGISTERED	99.6%	119.3%	104.3%	112.9%	106.9%	120.1%	96.2%	124.1%	111.8%	104.8%	102.4%	119.0%	122.5%	130.6%
UNREGISTERED	105.1%	120.6%	151.8%	183.2%	176.6%	223.9%	148.7%	165.9%	163.4%	241.9%	161.3%	217.5%	182.7%	233.9%
PETER BRUFF UNIT														
REGISTERED	92.3%	116.8%	101.2%	109.8%	126.4%	137.3%	123.4%	132.7%	127.1%	118.3%	124.9%	122.4%	112.9%	109.7%
UNREGISTERED	156.7%	160.9%	125.9%	134.1%	124.7%	144.2%	136.9%	158.1%	111.4%	145.6%	104.5%	129.3%	107.9%	127.4%
RODING WARD														
REGISTERED	121.4%	165.8%	149.8%	183.9%	142.8%	180.3%	147.0%	184.2%	138.7%	171.0%	131.5%	186.2%	125.1%	174.2%
UNREGISTERED	153.3%	163.1%	179.2%	198.5%	171.1%	170.0%	155.1%	156.5%	183.8%	152.5%	170.3%	143.1%	155.2%	140.3%
RUBY WARD														
REGISTERED	105.5%	220.6%	99.9%	199.9%	94.4%	200.3%	91.1%	196.9%	88.6%	199.9%	93.6%	200.0%	85.6%	200.1%
UNREGISTERED	465.2%	459.9%	384.2%	320.6%	304.7%	224.6%	350.9%	280.6%	326.5%	333.5%	365.0%	453.0%	274.4%	316.0%
STORT WARD														
REGISTERED	121.1%	135.3%	118.3%	123.6%	115.6%	120.9%	126.5%	129.3%	148.3%	120.2%	143.3%	130.5%	118.3%	134.7%
UNREGISTERED	258.2%	489.3%	229.0%	363.8%	258.8%	433.3%	258.6%	481.6%	234.9%	452.2%	227.1%	429.1%	236.0%	435.9%
TOPAZ WARD														
REGISTERED	131.2%	102.6%	142.2%	110.9%	146.4%	106.9%	145.0%	103.5%	144.1%	108.4%	138.4%	100.2%	116.9%	126.7%
UNREGISTERED	94.3%	311.5%	92.6%	297.4%	78.2%	253.3%	99.1%	303.2%	94.6%	347.9%	85.9%	307.0%	100.0%	283.6%
TOWER														
REGISTERED	118.3%	100.0%	114.8%	97.1%	115.6%	96.5%	134.0%	102.0%	142.9%	101.7%	124.7%	102.6%	139.5%	96.8%
UNREGISTERED	155.0%	146.6%	161.9%	136.8%	176.3%	145.4%	147.3%	133.7%	179.7%	166.7%	173.5%	158.6%	147.7%	128.0%
WILLOW														
REGISTERED	112.7%	111.7%	144.6%	114.7%	144.8%	110.6%	167.3%	111.6%	170.0%	152.7%	170.5%	147.1%	167.6%	160.0%
UNREGISTERED	320.9%	369.3%	313.7%	359.0%	298.9%	377.4%	302.3%	369.3%	286.1%	369.7%	287.4%	344.5%	281.6%	357.3%

	Sep 2023		Oct 2023		Nov 2023		Dec 2023		Jan 2024		Feb 2024		Mar 2024	
Ward	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rat
FINCHINGFIELD WARD														
REGISTERED	63.4%	193.6%	73.7%	168.1%	85.7%	186.5%	73.4%	190.2%	68.1%	204.3%	68.0%	230.2%	92.2%	244.3%
UNREGISTERED	80.9%	231.1%	79.9%	240.3%	73.2%	211.9%	76.8%	232.2%	111.6%	292.5%	140.3%	188.3%	161.8%	194.5%
GALLEYWOOD WARD														
REGISTERED	103.1%	100.0%	107.2%	112.7%	117.5%	123.3%	86.6%	118.9%	88.0%	112.0%	108.9%	110.8%	96.7%	107.1%
UNREGISTERED	103.3%	160.0%	87.0%	133.7%	98.7%	139.2%	103.9%	118.4%	89.5%	135.4%	116.4%	175.0%	117.7%	181.2%
GLOUCESTER														
REGISTERED	130.0%	113.3%	127.4%	116.1%	115.2%	106.7%	130.2%	121.0%	123.0%	106.6%	114.6%	115.5%	120.1%	120.8%
UNREGISTERED	125.8%	163.6%	125.6%	140.7%	110.0%	114.6%	109.0%	120.8%	118.6%	149.6%	117.1%	141.2%	113.4%	131.3%
GOSFIELD WARD														
REGISTERED	113.7%	119.3%	119.4%	122.2%	106.5%	115.0%	126.9%	119.7%	127.8%	100.0%	113.2%	110.7%	125.3%	110.3%
UNREGISTERED	357.0%	694.5%	225.1%	445.4%	229.5%	420.0%	214.6%	451.6%	221.7%	466.4%	233.3%	355.2%	239.3%	362.1%
HADLEIGH PICU														
REGISTERED	11.7%	11.8%	11.8%	11.4%	38.2%	28.3%	138.5%	103.1%	130.6%	112.8%	144.4%	121.2%	140.1%	135.7%
UNREGISTERED	2.6%	7.8%	2.4%	7.5%	16.6%	30.0%	48.7%	127.8%	68.6%	180.7%	57.9%	162.9%	70.7%	208.3%
HENNEAGE WARD														
REGISTERED	140.9%	113.2%	122.8%	107.0%	121.7%	118.5%	147.0%	125.0%	144.5%	113.0%	135.0%	129.2%	132.7%	109.7%
UNREGISTERED	246.4%	449.9%	272.7%	459.7%	278.5%	452.8%	273.3%	454.8%	293.6%	593.4%	298.4%	500.0%	226.3%	412.9%
KELVEDON														
REGISTERED	138.3%	117.1%	150.2%	114.5%	170.7%	121.7%	133.0%	103.5%	130.8%	109.7%	139.9%	108.6%	135.7%	106.4%
UNREGISTERED	236.5%	308.3%	222.9%	277.4%	211.5%	253.3%	187.3%	225.8%	204.3%	227.3%	182.1%	201.6%	200.6%	236.9%
KITWOOD WARD														
REGISTERED	163.9%	146.7%	130.0%	138.7%	179.7%	173.3%	196.7%	145.2%	177.2%	145.2%	179.5%	141.4%	145.8%	170.0%
UNREGISTERED	194.1%	247.9%	252.0%	250.5%	234.4%	264.2%	228.6%	292.3%	238.4%	317.7%	232.3%	285.9%	264.1%	259.7%

	Sep 2023		Oct 2023		Nov 2023		Dec 2023		Jan 2024		Feb 2024		Mar 2024	
Ward	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rat
439 IPSWICH ROAD														
REGISTERED	148.9%	112.3%	129.4%	124.8%	115.5%	130.6%	148.8%	123.3%	140.2%	121.2%	136.7%	132.7%	138.4%	117.3%
UNREGISTERED	95.0%	100.0%	129.4%	125.8%	104.7%	100.1%	103.3%	94.3%	88.3%	98.5%	103.1%	108.2%	97.1%	101.7%
ARDLEIGH WARD														
REGISTERED	87.9%	71.3%	129.3%	118.1%	109.3%	89.0%	119.9%	89.2%	108.9%	90.5%	110.7%	98.6%	108.8%	104.6%
UNREGISTERED	116.8%	118.8%	238.8%	267.5%	144.8%	157.7%	141.0%	165.4%	162.9%	171.2%	133.7%	131.0%	115.7%	127.1%
BASILDON MHAU														
REGISTERED	111.2%	101.2%	118.1%	105.0%	121.9%	111.8%	105.6%	116.3%	110.2%	108.7%	114.2%	100.3%	110.5%	93.8%
UNREGISTERED	311.1%	328.8%	308.5%	343.0%	283.8%	329.5%	262.9%	318.2%	274.4%	331.0%	215.5%	285.9%	236.6%	279.2%
BEECH (ROCHFORD)														
REGISTERED	156.4%	77.9%	142.3%	80.4%	139.0%	94.8%	143.3%	100.0%	163.9%	115.8%	152.7%	120.7%	134.6%	126.5%
UNREGISTERED	202.1%	440.7%	206.7%	374.5%	180.3%	398.4%	200.5%	455.9%	193.7%	403.7%	164.6%	392.5%	174.0%	351.0%
CEDAR														
REGISTERED	134.3%	114.6%	88.0%	71.7%	182.7%	129.0%	170.5%	156.8%	178.3%	149.3%	199.9%	134.4%	179.1%	146.6%
UNREGISTERED	228.2%	275.1%	152.7%	162.6%	201.1%	245.0%	211.2%	252.7%	247.6%	293.1%	241.1%	312.0%	232.2%	294.4%
CHELMER WARD														
REGISTERED	135.2%	130.8%	133.3%	129.0%	137.1%	131.2%	109.6%	104.8%	132.1%	110.0%	128.8%	116.3%	122.5%	118.6%
UNREGISTERED	317.3%	467.0%	326.7%	451.7%	337.7%	1558.5%	363.4%	790.0%	355.5%	794.5%	283.4%	827.7%	433.9%	802.0%
CHERRYDOWN														
REGISTERED	192.2%	107.3%	190.1%	107.0%	221.1%	121.7%	210.3%	100.3%	217.9%	100.6%	164.0%	101.0%	188.8%	101.9%
UNREGISTERED	250.0%	451.0%	309.6%	508.1%	306.0%	492.6%	353.3%	598.2%	364.6%	595.4%	312.5%	509.7%	354.9%	574.8%
CHRISTOPHER UNIT														
REGISTERED	141.0%	100.0%	128.5%	98.4%	195.5%	91.7%	160.5%	98.0%	139.5%	104.6%	152.0%	106.1%	148.5%	100.6%
UNREGISTERED	213.1%	311.8%	170.1%	224.4%	177.5%	261.3%	169.1%	238.7%	219.9%	326.4%	206.2%	326.7%	160.3%	222.5%

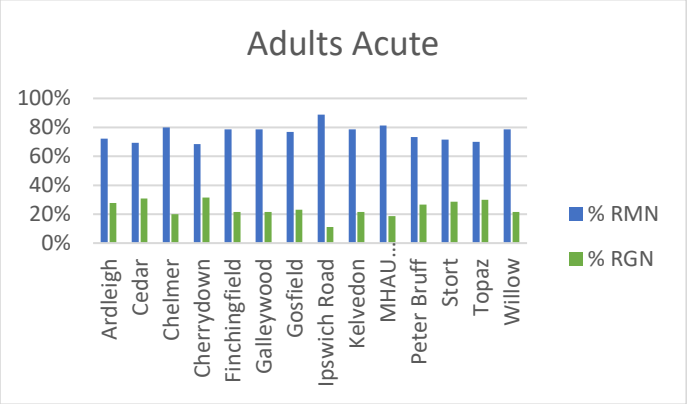
Table - Summary the staffing level fill rates from September 2023 to March 2024 for registered and unregistered nursing staff for our Specialist inpatient wards.

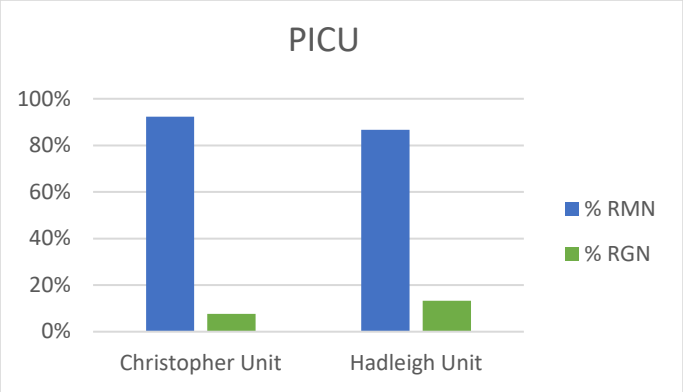
	Sep 2023		Oct 2023		Nov 2023		Dec 2023		Jan 2024		Feb 2024		Mar
Ward	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates
ALPINE													
REGISTERED	106.2%	97.5%	112.6%	105.1%	114.1%	97.0%	97.0%	92.2%	109.1%	103.8%	127.9%	100.2%	104.4%
UNREGISTERED	106.9%	115.9%	115.1%	114.6%	104.0%	100.7%	108.7%	115.3%	134.2%	121.2%	93.1%	101.3%	101.7%
AURORA													
REGISTERED	151.4%	100.4%	135.4%	100.0%	144.1%	136.3%	166.5%	100.9%	124.5%	113.1%	108.9%	100.3%	101.0%
UNREGISTERED	79.3%	100.2%	97.1%	100.0%	87.7%	63.3%	77.6%	100.0%	78.4%	87.8%	112.3%	100.7%	113.4%
BYRON COURT / HEATH CLOSE													
REGISTERED	84.2%	84.1%	85.1%	75.4%	85.1%	102.0%	105.7%	77.7%	97.4%	97.2%	84.4%	94.6%	94.8%
UNREGISTERED	249.1%	316.0%	242.5%	264.5%	237.4%	244.3%	184.8%	180.0%	200.8%	179.1%	169.6%	169.8%	155.3%
CAUSEWAY													
REGISTERED	102.6%	95.2%	102.3%	100.0%	104.1%	98.6%	116.2%	97.1%	113.6%	100.0%	93.2%	98.8%	102.5%
UNREGISTERED	108.1%	103.3%	115.4%	96.7%	127.5%	106.7%	107.8%	101.5%	86.3%	88.6%	88.6%	100.1%	96.7%
DUNE													
REGISTERED	98.7%	86.7%	98.3%	87.1%	95.7%	98.4%	99.2%	100.5%	101.8%	102.2%	114.5%	98.8%	141.0%
UNREGISTERED	104.7%	113.3%	95.6%	111.2%	101.8%	96.7%	95.0%	99.8%	95.2%	93.4%	99.9%	98.3%	94.6%
EDWARD HOUSE													
REGISTERED	102.0%	133.5%	95.3%	130.6%	109.6%	146.8%	97.7%	127.5%	101.5%	137.1%	97.1%	140.3%	99.0%
UNREGISTERED	129.4%	94.2%	126.7%	106.5%	112.1%	98.8%	79.7%	67.8%	76.4%	67.7%	82.9%	88.7%	109.6%
FOREST													
REGISTERED	151.1%	96.0%	134.5%	98.2%	155.2%	99.9%	167.0%	98.4%	155.0%	80.2%	130.0%	102.1%	140.3%
UNREGISTERED	126.9%	98.2%	134.6%	101.7%	137.7%	101.7%	156.3%	99.9%	147.5%	121.0%	148.9%	101.0%	147.1%

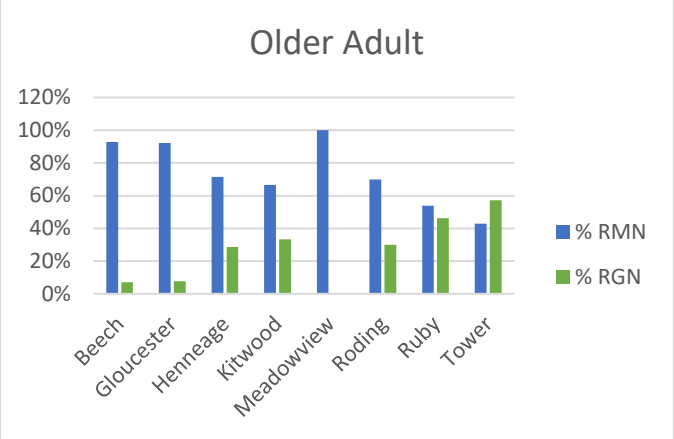
	Sep 2023		Oct 2023		Nov 2023		Dec 2023		Jan 2024		Feb 2024		Mar
Ward	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates	Night Rates	Day Rates
FUJI													
REGISTERED	97.8%	92.1%	110.8%	100.7%	95.4%	88.7%	95.8%	85.4%	106.0%	92.6%	115.5%	95.1%	104.4%
UNREGISTERED	158.1%	137.8%	180.9%	155.3%	177.7%	154.1%	154.7%	134.7%	147.4%	133.3%	132.0%	113.4%	110.0%
LAGOON													
REGISTERED	93.6%	87.2%	86.1%	98.4%	107.2%	88.3%	107.1%	100.0%	105.5%	98.7%	99.1%	98.1%	109.1%
UNREGISTERED	170.0%	190.4%	187.1%	170.3%	152.2%	150.7%	149.0%	155.5%	129.8%	140.6%	106.8%	104.5%	108.7%
LARKWOOD													
REGISTERED	82.4%	89.5%	94.7%	67.4%	97.3%	68.1%	93.5%	67.5%	100.2%	69.0%	93.7%	67.1%	74.2%
UNREGISTERED	158.4%	136.9%	153.6%	121.8%	143.3%	111.5%	170.5%	124.7%	125.3%	110.8%	126.9%	100.6%	157.3%
LONGVIEW													
REGISTERED	55.2%	58.6%	58.3%	66.0%	95.2%	96.7%	68.1%	57.6%	68.3%	65.5%	84.0%	63.3%	101.5%
UNREGISTERED	140.8%	196.9%	165.1%	223.2%	148.3%	215.3%	120.8%	194.7%	161.4%	240.0%	145.8%	191.1%	153.6%
POPLAR													
REGISTERED	105.9%	96.8%	118.3%	98.1%	139.2%	102.2%	123.9%	101.9%	90.1%	102.0%	94.3%	99.8%	88.3%
UNREGISTERED	110.7%	196.4%	89.8%	142.5%	123.5%	190.1%	91.7%	154.6%	94.3%	176.5%	70.8%	125.0%	73.7%
RAINBOW UNIT													
REGISTERED	89.7%	50.0%	91.6%	51.5%	97.0%	49.9%	89.6%	50.2%	99.4%	104.5%	103.3%	99.9%	109.1%
UNREGISTERED	77.4%	118.5%	67.4%	91.3%	51.3%	67.6%	54.6%	73.1%	123.3%	140.6%	123.8%	122.5%	140.9%
ROBIN PINTO UNIT													
REGISTERED	135.5%	76.7%	122.1%	91.9%	128.9%	100.0%	143.3%	95.2%	151.2%	100.6%	153.1%	97.5%	156.1%
UNREGISTERED	115.2%	246.7%	126.1%	271.0%	109.5%	220.0%	111.6%	266.8%	139.5%	300.0%	149.7%	309.2%	182.2%
WOODLEA CLINIC													
REGISTERED	130.2%	211.1%	142.7%	257.2%	174.9%	223.1%	163.8%	183.9%	135.7%	210.3%	143.5%	208.1%	107.0%
UNREGISTERED	121.8%	105.4%	126.3%	184.6%	115.8%	129.8%	116.7%	112.2%	109.5%	112.2%	116.7%	120.0%	122.4%

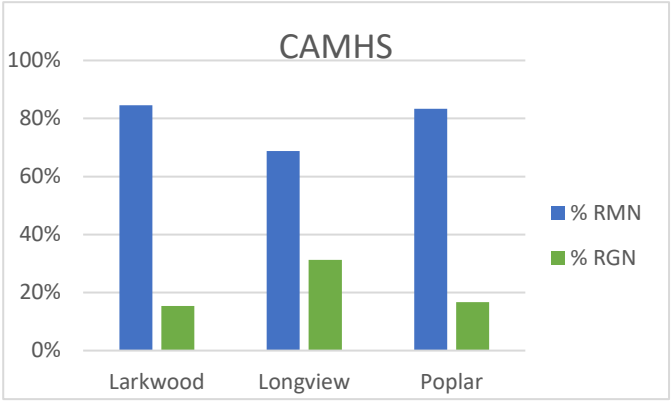
The fill rates for 2023/24 are shown in the Tables above. Fill rates guide the need for escalation if the fill rates fall below 90%, so that mitigation can be provided in accordance with the safe staffing escalation protocols. There have been significant periods where the fill rate has exceeded 100%, the primary reasons are that the funded establishments to not reflect the current patient acuity and dependency. During the periods of fill over 100% some of the people we care for in our in-patient wards have experienced dynamic changes in acuity of their presenting conditions which has been assessed to confirm if additional staff are required to ensure their care needs are met. The process for this is managed within the care units SitRep calls chaired by clinical service managers. From 2024 the Time to Care funding is secured to recruit to the increased registered ward staff, which will reset funded establishment to be more reflective of the care needs and reduce the need to over fill shifts.

Skill mix ratio RMN/RGN January 2024

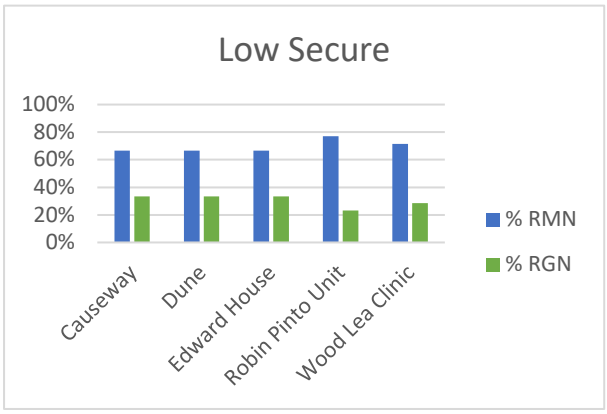


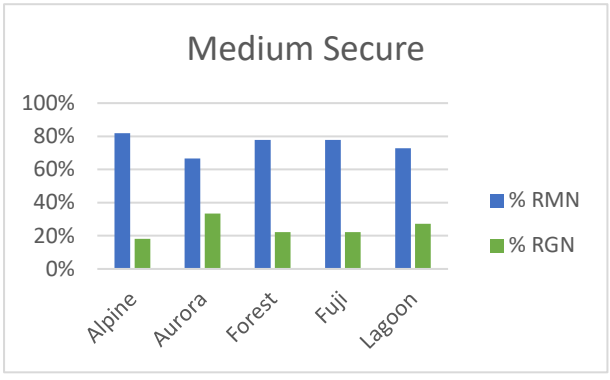






The skill mix ratios shown illustrate the breakdown of Registered Mental Health Nurses (RMN) and Registered General Nurses (RGN) across the mental health inpatient areas. Welcoming the skills and experiences of RGNs to the mental health wards benefits the holistic care of our patients in a mental health setting and is part of our Time to Care philosophy. Benefits of having RGN's within the ward establishments include physical health assessment, recognition and treatment of physical health deterioration to improve physical health outcomes. There is also an opportunity of not only our RMNs upskilling their RGN colleagues in mental Health care practices but also the benefit of RGNs upskilling our existing mental health nurses with physical health skills. Supporting the importance of holistic care and parity of esteem.





4. MHOST Review of ward establishments needs

4.1 Mental Health Optimal Staffing Tool

During 2023, EPUT undertook its first review of the inpatient mental health ward nursing staff establishments. The Mental Health Optimal Staffing Tool (MHOST) is a National Institute of Clinical Excellence endorsed evidence-based tool that uses acuity and dependency, professional judgement and quality indicators to support workforce planning. The tool uses an evidenced based calculation system of identifying patients according to acuity (how ill the patient is) or dependency (how dependent the patient is on care from the ward staff) to calculate **Care Hours per Patient Day (CHPPD).**

Whilst the establishment reviews focus on the acuity/dependency results, guidance narrates that these are not to be reviewed in isolation. Experience and best practice identifies that a wider suite of quality indicators must be considered. This allows a more informed approach in respect of assuring that staff are in place to provide high quality, safe and compassionate care. This approach to establishment reviews allows for open discussion, for professional judgement to be applied alongside the triangulation of quality data with acuity/dependency data.

Professional judgement considers particular local workforce needs within wards to mitigate environmental factors, e.g. if garden areas and food serveries are not directly within the ward footprint. Additionally, if the ward area is geographically isolated, or if the number of beds is higher than national recommendations for the patient group. This requires consideration of additional staff to mitigate environmental factors by care unit leadership team for board approval.

Quality indicators include high numbers of patient safety incidents, complaints and workforce instability such as vacancies, recruitment/retention concerns or skills mix variance. In addition, flow and capacity concerns including system delayed discharges or extended length of stay need to be taken into consideration. It is recommended that if the ward has quality indicator flags, then the **advisory MHOST headroom** be applied.

MHOST discussions with ward managers and Matrons for each area provide local professional judgement and quality indicator considerations, these are detailed in the MHOST results.

It is recommended that at least two MHOST exercises take place per year. This increases the richness of analysis and allows for the influence of seasonal variances to be considered in safe staffing level recommendations. It is also noted that wards that have under eight patients will require local review, as they will fall outside of the calculations built into the evidenced based calculation tool.

MHOST headroom (cover for maternity, study, sickness, leave etc.), has been advised at a minimum of 22%. Nationally, the recommendation may be higher dependant on speciality in recognition of specific staff development needs to care for patient groups, restorative supervision and focus on quality management and improvement. EPUT headroom for the first year of collection for inpatient services was 19%. It is important to note that it has been recognised that the Board, through the Time to Care programme, for future inpatient budgets headroom has agreed the 22% minimum recommendation.

The data collection exercises detailed the following:

- 37/38 of the eligible wards participated in MHOST and collected data (one ward, Hadleigh, had reduced beds in the first cycle and closed during the second cycle for refurbishment)

The results from the use of MHOST bi-annually along with the review of staff usage across the previous year will be presented to the board to support recommendations for future workforce planning it is important that 2 years of data is available to the Trust to support future workforce planning.

The tables below reflect the highest dependency data reported from the two collection periods and demonstrates the outcome at 22% headroom.

The Care Hours per Patient Day (CHPPD) calculations using the MHOST calculation tool exclude the band 7 ward manager due to their supernumerary role. However, this post has been included in the MHOST totals for WTE staff requirements. The supernumerary status of the ward manager is a key role to support quality of care delivery for the ward. Additionally, where evidence of increase quality indicator concerns, it is recommended that an increase to maximum headroom is considered to progress local quality management and improvements.

4.2 MHOST Results

4.2.1 Inpatient Mental Health Older Adult and Acute Wards

The Tables below compare the current whole time equivalent (WTE) ward staff who work in core 24/7 care teams (Nurses and HCAs).

Comparison shown with current establishment on Wards (A) in total Whole Time Equivalent (WTE) for 23/24 (B), total WTE funded through Time to Care (C), the guided MHOST results total WTE (D), the total MHOST guided WTE using recommended headroom (E).

Columns (F) and (G) compares the specific registered WTE funding through Time to Care and the MHOST guided registered WTE. This is important when noting the MHOST guided ratio % of registered and unregistered staff.

Columns (B, C, D, E) *Total = registered and unregistered staff with additional 1 WTE Ward manager supervisory 5/7.

Older adult wards

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Beech	28.36	36.08	33.3		34.4		15.71	15.65
Gloucester	26.82	33.54	30.3		31.4		15.71	14.24
Hennage	23.86	31.13	35.8		37.0		15.71	16.83
Kitwood	20.74	28.44	31.5		32.6		15.71	14.81
Meadowview	31.16	37.88	43.0		44.5		15.71	20.21
Roding	20.27	28.94	18.8		19.4		15.71	9.31
Ruby	18.91	28.17	34.7		35.8		15.71	16.31
Tower	22.14	29.84	27.3		28.2		15.71	12.83

Note MHOST ratio of registered to unregistered = 47% for older adult wards

Professional judgement and Quality indicators for consideration to WTE requirement – older adult:

Tower ward is an older adult organic ward that provides care to patients with both mental health and physical health needs. It also provides end of life care. It is a **standalone unit** and therefore additional support and cover not readily accessible.

Beech ward and Gloucester ward are both older adult wards. **Highest bed base** in the Trust at 24 each and reported high levels of acuity during the data collection periods.

Ruby ward had a high level of **delayed discharge** reported during the data collection periods, which is reflected in the data.

Acute adults

A Ward	B 23/24 Total * WTE (19%)	C 24/25 Time to Care WTE Total* (22%)	D MHOST guided Total* WTE (22%)		E MHOST guided total* with Recommended headroom WTE (27.3%)		F 24/25 Time to Care WTE registered (22%)	G MHOST guided Registered WTE (22%)
Ardleigh	22.02	29.81	46.6		48.7		15.71	25.16
Cedar	25.81	32.54	41.4		43.3		15.71	22.34
Chelmer	20.74	28.44	31.4		32.8		15.71	16.96
Cherrydown	25.82	33.54	35.4		36.0		15.71	19.11
Finchingfield	19.47	29.73	31.0		32.4		15.71	16.74
Galleywood	20.74	26.44	37.0		38.6		15.71	19.98
Gosfield	22.78	29.48	32.9		34.4		15.71	17.77
Ipswich Road	15.86	15.86	12.8		13.3		5.53	6.91
Kelvedon	25.81	32.54	28.8		30.1		15.71	15.55
MHAU	30.97	41.35	33.0		34.3		20.95	17.82
Peter Bruff	31.73	40.68	39.6		41.4		20.95	21.38
Stort	22.2	28.90	26.2		27.4		15.71	14.15
Topaz	19.07	26.77	37.9		39.7		15.71	20.47
Willow	25.82	34.54	30.7		32.1		15.71	16.58

Note MHOST ratio of registered to unregistered = 54% for acute adult wards.

Professional judgement and Quality indicators for consideration to WTE requirement - acute:

During the data collection 15/22 wards had a near to full bed occupancy. This is a result of the demands on the service and the pressure on beds for this care group.

The substantive workforce recruitment has resulted in a large cohort of preceptee nurses requiring support and development for the minimum 1 year preceptorship period.

The suggested increase in WTE is significant for Ardleigh ward and Cedar ward shown in red, both had significantly higher MHOST outcomes in comparison to their funded WTE. Both had high level of acuity reported during the data collection periods. Whilst it is acknowledged this reflects the clinical demand and complexity of the patient group, it may also reflect in the first year use of MHOST tool and potential unfamiliarity with its use. Therefore, the validity of the data may be improved by collecting an additional data sets with enhanced support and training

if necessary. **The recommendation would be to increase the data collection for Ardleigh and Cedar wards to 3 collections over 2024 due to the significant variation in comparison with similar wards in the Trust.**

439 Ipswich Road is an adult rehab unit. MHOST suggests a decrease however; the recommendation is for no change to be made to WTE. Rationale for this – **standalone unit** and therefore additional support and cover not readily accessible.

Topaz ward is a mixed adult acute ward with detox beds (additional staff rostered as required to accommodate this). During the data collection periods high number of **reported patient safety incidents** reflecting the complexity of the client group.

Willow, MHAU Basildon, Chelmer and Willow report also **high sickness** for the second census.

Cherrydown, Chelmer, Galleywood and Ardleigh wards also reported a high number of patient safety **incidents**.

Grangewaters and Peterbruff assessment units have significant increase in patients' **length of stay** over 3-7 days

Ardleigh, Cedar, Cherrydown, Finchingfield, Gosfield, Kelvedon, Willow and Stort wards all had 2 or more patients who had a **system delayed discharges** for patients during both census periods. With Finchingfield, Kelvedon and Willow having an average of 4 or more patients during both census periods.

Basildon Mental Health unit- all area have Gardens and Serveries away from the ward.

Finchingfield and Galleywood- food servery away from the ward

4.2.2 PICU MHOST data

PICU

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Christopher unit	25.86	37.8	30.9		32.6		20.95	14.83
Hadleigh unit								

Note MHOST ratio of registered to unregistered = 48% for PICU

Professional judgement and Quality indicators for consideration to WTE requirement – PICU:

Christopher unit reported a high number of patient related **incidents** during the second data collection. Additional **staff sickness** was above the trust target

Both the PICU units had closed beds during the first data collection due to building works. Hadleigh was then closed for refurbishment during the second data collection that extended beyond the intended completion date. Therefore, Hadleigh did not participate in the November data collection. Due to the reduced beds in March for both units, the data outcome is not a

true reflection compared to the wards being at full occupancy. **The recommendation would be to repeat the data collection to 3 collections over 2024.**

4.2.3 Specialist Services MHOST data

Low secure

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Causeway	23.99	24.25	16.3		16.5		10.48	8.64
Dune	21.44	21.70	14.9		15.1		10.48	7.90
Edward House	36.44	39.82	20.0		20.2		18.34	10.8
Robin Pinto	23.24	20.67	22.3		22.6		10.48	12.04
Woodlea clinic	23.24	23.52	13.8		13.9		10.42	7.45

Note the ratio of registered to unregistered = 53% for low secure wards

Professional judgement and Quality indicators for consideration to WTE requirement – low secure:

Dune ward had **closed beds** due to refurbishment. Data does not reflect full occupancy.

Woodlea Clinic and Robin Pinto Unit are a Learning Disability service. Both are **standalone** units based in Bedford and therefore additional support and cover not readily accessible.

Causeway ward have a high level of **international recruits** requiring support and development in the first year of preceptorship.

Edward House reported a high number of patient reported **incidents**. Has 2 separate wings which function with separate staff rotas.

Medium secure

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Alpine	27.8	29.88	20.2		21.2		10.48	10.6
Aurora	13.77	19.14	13.4		14.0		10.48	6.7
Forest	21.45	24.25	26.6		28.0		10.48	13.3
Fuji	31.38	31.64	26.2		27.5		10.48	13.1
Lagoon	24.54	29.43	29.5		31.1		10.48	14.75

Note the ratio of registered to unregistered = 50% for medium secure wards

Professional judgement and Quality indicators for consideration to WTE requirement – medium secure:

Aurora ward during data collection high level of patient **stepdown ready/discharge**. The patient acuity was not a true reflection of a medium secure service.

Fuji ward high number of reported **incidents** during data collection periods.

Lagoon and Forest reported **high acuity** during the data collection that was above the national averages for similar wards.

Brockfield House – has multiple outside areas such as gym, sports pitch, court yard and gardens that are not directly accessed from the wards

CAMHS

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Larkwood	38.78	42.56	20.6		21.7		15.71	9.89
Longview	39.17	39.87	37.2		39.3		15.71	17.86
Poplar	40.33	42.24	32.0		32.8		15.71	15.36

Note MHOST ratio of registered to unregistered = 48% for CAMHS wards

Professional judgement and Quality indicators for consideration to WTE requirement - CAMHS:

Longview reported a high number of i**ncidents** during the data collection. The ward also received one **formal complaint**. **Staff sickness** has also been recorded as above the trust target

Poplar- is on the first floor and therefore outside garden is accessed via a secure walkway linking the ward to the garden

There was a 50% **bed occupancy** for CAMHS during the data collection with the outcome not providing true reflection of normal ward activity. Beds managed for this care group are in collaboration with the East of England Provider Collaborative (PC) and have specific criteria for admission. The East of England PC consists of six providers across the region, with EPUT providing a majority of the beds for inpatient mental health care across its two sites Poplar Adolescent Unit at Rochford Hospital and the St Aubyn Centre, Longview and Larkwood wards. Larkwood, a 10 bedded PICU unit, is the only in PICU in region accepting referrals from all six providers, as well as out of area referrals. **The recommendation would be to repeat the data collection to 3 collections over 2024**

Perinatal services

A	B	C	D		E		F	G
Ward	23/24 total* WTE (19%)	24/25 Time to Care total* WTE (22%)	MHOST guided total* WTE (22%)		MHOST Guided total* with Recommended headroom WTE (25.9%)		24/25 Time to Care WTE registered (22%)	MHOST guided Registered WTE (22%)
Rainbow unit	17.4	21.66	15.8		16.6		10.48	8.06

Note the ratio of registered to unregistered = 51% for perinatal wards

Professional judgement and Quality indicators for consideration to WTE requirement – perinatal services:

The Royal College of Psychiatry advises on perinatal staffing levels: **Service Standards** for Mother and Baby Units (2014) and states that there is a minimum accepted expectation of staffing levels in regards to units meeting accreditation standards.

Rainbow unit is the **only perinatal ward** in EPUT staffed by staff with clinical skills unique to the service. However, there is cross cover from other site teams at The Linden and Crystal centres. During the data collection, the unit was **not at full bed occupancy**.

4.3 Safer Nursing Care Tool (SNCT)

The Safer Nursing Care Tool is a tool that has been developed to support physical health wards measure patient acuity and / or dependency to inform evidence-based decision making on staffing and workforce. The decision matrix allows staff to measure the acuity (how ill a patient is) and dependency (how dependent a patient is on nursing staff to have their normal needs met, such as moving, going to the toilet, eating and drinking) of patients in a ward. It incorporates the rules to follow to ensure that data is captured accurately and how to use this information to calculate the optimal level of staff needed in a particular ward using nursing multipliers to ensure the delivery of safe patient care.

The tool has been recently updated by NHSE to incorporate additional indicators that reflect patient who have care needs requiring additional staff. Consequently, with these changes coupled with new appointments in the senior clinical leaders (Matron and ward manager) for our physical health wards, arrangements are currently in progress for some further training to be delivered by NHSE. Following this data will start to be collected to inform future establishment reviews for our five wards.

5. Next Steps

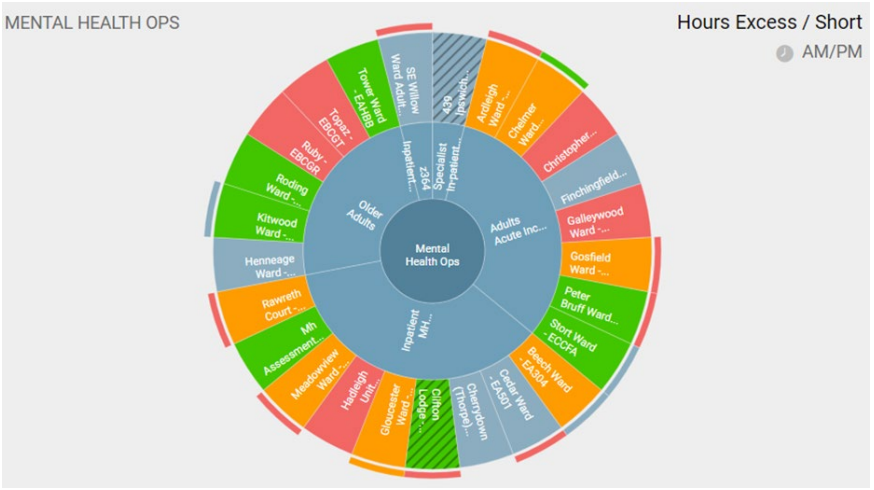
- Continue to work with the care unit leadership teams to share the outcomes of the MHOST
- Continue MHOST data collection twice yearly in line with NQB recommendations
- Ensure there is a formalised approach to the collection of relevant quality indicator information
- Ensure there is a formalised approach to gaining professional judgement to support workforce considerations

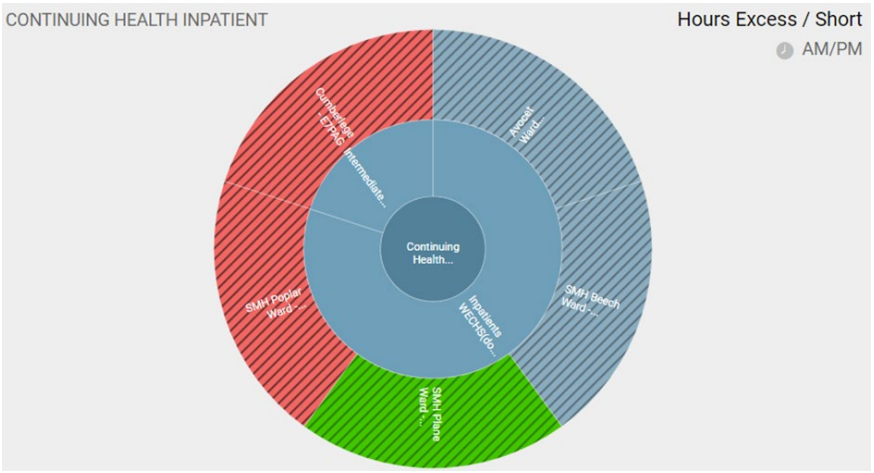
- Continue to provide training including refresher training, concerning the data collection process in preparation for future data collections. Training suggested to be a role requirement for Band 6 , Band 7 and Matrons within Mental Health Inpatient services
- Review the approach to recommended headroom for the organisation, where quality of care indicators highlight concern.
- Monitor the impact of Time to Care innovative roles to enhance Quality of Care whilst we implement the inpatient care operating model.
- Formalise professional judgement decision making process during daily staffing reviews in relation to booking bank and agency staff
- Review any outlier wards and repeat MHOST outside the data collection cycle
- Continue with recruitment approaches to fill vacant clinical posts in line with the implementation of Time to Care
- Support opportunities to develop new roles within the mental health inpatient services in line with Time To Care
- Embed establishment review methodologies into EPUT community wards, learning disabilities, community nursing services and care homes.

Appendices

Safer staffing resources

Examples of the Safecare Sunburst (1st March 2024)





Safe staffing escalation tool.

Supporting literature

How to Ensure the Right People with the Right Skills are in the Right Place at the Right Time: A guide to Nursing, Midwifery and Care Staffing Capacity and Capability (National Quality Board 2013)

Mental Health Staffing Frame work https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf

Mental Health Optimal Staffing Tool (MHOST) https://www.pslhub.org/learn/patient-safety-in-health-and-care/mental-health/shelford-groupmental-health-optimal-staffing-tool-mhost-10-may-2019-r2303/

Royal College Nursing: guidance on safe nurse staffing levels in the UK https://www.bing.com/ck/a?!&&p=1822da2f9849462dJmltdHM9MTcxMDQ2MDgwMCZpZ3VpZD0xM2I5ZWI5MS1iMmUyLTY3M2UtMzUxMy1mOGFjYjNkMTY2ZTgmaW5zaWQ9NTIxMQ&ptn=3&ver=2&hsh=3&fclid=13b9eb91-b2e2-673e-3513-f8acb3d166e8&psq=royal+college+nursing+staffing+levels&u=a1aHR0cHM6Ly93d3cucmNuLm9yZy51ay8tL21lZGlhL3JveWFsLWNvbGxlZ2Utb2YtbnVyc2luZy9kb2N1bWVudHMvcHVibGljYXRpb25zL29ic2VsZXRlL3B1Yi0wMDM4NjAucGRmP2xhPWVu&ntb=1

Safe, sustainable and productive staffing in district nursing services (National Quality Board 2018)

8. ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL

8.1 BOARD ASSURANCE FRAMEWORK

Decision Item | PS | 10

REFERENCES

Only PDFs are attached

Board Assurance Framework Report August 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Board Assurance Framework Report**					
Executive/ Non-Executive Lead:	Denver Greenhalgh Senior Director of Governance & Corporate Affairs					
Report Author(s):	Denver Greenhalgh Senior Director of Governance & Corporate Affairs					
Report discussed previously at:	Executive Team					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

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

Purpose of the Report		
This report provides a high-level summary of the strategic risks and high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Note the de-escalation of CRR99 Safeguarding Referrals.
3 Note the reset of risk SR5 Lampard Inquiry
4 Request any further information or action

Summary of Key Issues

This report provides a high-level summary of the strategic risks and high-level operational risks (corporate risk register) and progress against actions designed to moderate the risk.

These risks have significant programmes of work underpinning them with longer term actions to both reduce the likelihood and consequence of risks and to have in place mitigations should these risks be realised.

The Board is asked to note:

- Section 1 – Board Assurance Framework dashboard providing an oversight.

  SR5 Lampard Inquiry – reset of risk following publication of the terms of reference for the inquiry and establishment of the Lampard Oversight Committee.

  SR2 People – note the proposed move to split out this strategic risk into its component parts for greater oversight. The proposed set of risks has been socialised with the People Equality and Culture Committee. These being:

  1. **Organisational Development** - The Trust does not currently have effective OD support to address cultural development and management of change. Therefore, change programmes do not have the positive impact on staff and patient care we would have expected. This impacts staff development/morale and patient care outcomes.

  2. **Staff Retention -** The Trust does not currently have a coherent staff retention strategy. This is having an effect on continued staff shortages and skill shortages in certain professions. This impacts patient care as well as staff morale with increased costs due to temporary staffing.

  3. **Workforce Sustainability -**There are limited workforce plans that support recruitment and development leading to limitations in workforce sustainability. Therefore the effect are gaps in workforce and inefficient use of high cost temporary staff. Resulting in an impact on staff morale, skills gaps and quality of care.

  SR1 Safety – note the link through to the year 3 report on our Safety First Safety Always strategy as we transition formally over to Quality of Care Strategy and the proposed review of this risk.

- Section 2 – Risks that have changed in risk score

  CRR99 Safeguarding Referrals – Assessment has confirmed that the target score has been met (risk score 8) and the risk has been de-escalated from the corporate risk register. It will continue to be reviewed through the Nursing and Quality risk register due to continued high numbers of referrals.

- Section 3 – Strategic Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Executive Responsible Officer

- Section 4 – Corporate Risk Register at a glance for each individual risk with updates against each action being taken to increase risk controls provided by each Responsible Officer

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

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

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

Acronyms/Terms Used in the Report			
IG	Information Governance	TSG	Transformation Steering Group
DSPT	Data Security Protection Toolkit	CQC	Care Quality Committee
DR / BCP	Disaster Recovery / Business Continuity Plan		
ESOG	Executive Safety Oversight Group		

Supporting Reports/ Appendices /or further reading

- Board Assurance Framework Dashboard
- Strategic Risk Register
- Corporate Risk Register

Lead

Denver Greenhalgh
Senior Director of Governance & Corporate Affairs

NHS
Essex Partnership University
NHS Foundation Trust

Board Assurance Framework

30 June 2024

Denver Greenhalgh
Senior Director of Corporate Governance

EPUT

Risk Dashboard

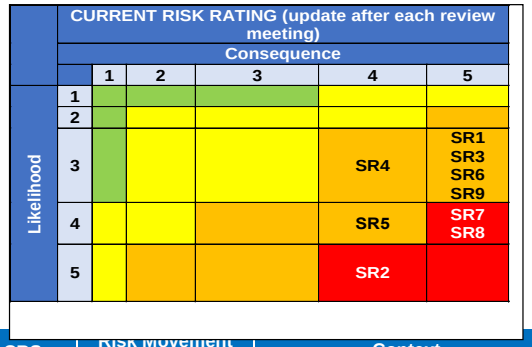
June 2024

EPUT

Strategic Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
9	0	0	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	1	8	8



% Risks with Controls Identified	% Risks with Assurance Identified	Actions Overdue	Risk Reviewed by Risk Owner
100%	100%	2	9

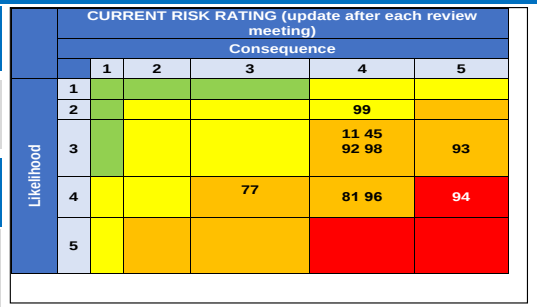
ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR2	2	People	MR	Safety Experience Regulatory Service Delivery Reputation	5x4=20	20 20 20	National challenge for recruitment and retention	As discussed this risk is being reviewed with the aim of breaking it down into component parts for greater oversight. This has been socialised with the People Equality and Culture Committee in July 2024 and will be progress. See appendix for high level risk descriptors. The new Executive Chief People Officer is reviewing the operating model and structure of the People and Culture Directorate to support the organisation to meets its strategic and operational needs.
SR7	All	Capital	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	20 20 20	Need to ensure sufficient capital for essential works and transformation programmes in order to maintain and modernise	Continuing to horizon scan to maximise opportunities both regional and national to source capital investment (noting the Trust secured an additional £0.4m following mental health applications). Capital plan agreed by Board for 2024/25. Progress with the procurement of new electronic patient record continues and awaiting formal notification of decision following review of the full business case.
SR8	All	Use of Resources	TS	Safety, Compliance, Service Delivery, Experience, Reputation	5x4=20	20 20 20	The need to effectively and efficiently manage its use of resources in order to meet its financial control total targets and its statutory financial duty	Continued enhanced controls, efficiency and productivity improvement and transformation / restructure activities. As part of MSE system participating in an investigation and intention programme of work to support the system performance.
SR4	All	Demand and Capacity	AG	Safety, Experience, Regulatory, Service Delivery, Reputation	5x4=20	15 15 15	Long-term plan. White Paper. Transformation and innovation. National increase in demand. Need for expert areas and centres of excellence. Need for inpatient clinical model linked to community. Socioeconomic context & impact. Links to health inequalities.	Finance and Performance Committee undertook a deep dive of this risk at its meeting held July 2024, noting the causative factors leading to the pressures on capacity with the EPUT footprint. The Committee was assured that the work programme will control the risk as it reduces variation across our services and impact from the delivery of the new staffing and operating model provided for through the Time to Care Programme.
SR5	1	Lampard Inquiry	NL	Regulatory Reputation	4x4=16	16 16 16	Government led public inquiry in to Mental Health services in Essex	The risk has reset following the publication of the terms of reference for the Lampard Inquiry in April 2024. Governance has been established to oversee the Trust response - Lampard Oversight Committee co-chaired by Dr Mateen Jiwani and Elena Lokteva.

ID	SO	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
SR1	1	Safety	FB	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS & complexities; Systemic workforce issues in the NHS	To conclude the transition from the programme of activity taken place across the Trust to support the implementation of the Safety First Safety Always strategy to the new Quality of Care strategy approved by the Board - we have undertaken a year 3 review and this is to be presented to the Board at its meeting in August 2024. Delivery of the Patient Safety Incident Response Plan 2023-25 and particularly the Safety Improvement Plans continues and is now aligned within the new Quality of Care governance. The integration of IWGC data with the Patient Safety Dashboard has been completed. Additional functionality is being added to the incident reporting module on Datix to further support the Care Units.
SR3	All	Infrastructure	TS	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	Capacity and adaptability of support service infrastructure including Estates & Facilities, Finance, Procurement & Business Development/ Contracting to support frontline services.	The development of the Estates Strategy was the focus of a Board seminar held in July 2024 and draft socialised via the Finance and Performance Committee, where it was agreed to do further socialisation with the Board ahead of formal approval at the Board meeting in October '24.
SR6	All	Cyber Attack	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Finance and Performance Committee undertook a deep dive of this risk at its meeting held June 2024. The Business Continuity and Disaster Recovery Policy has been approved by CPPG. All in scope systems (following IT Security Health Check and Penetration Testing) have now been decommissioned (Serve 2008 legacy systems).
SR9	1	Digital and Data Strategy	ZT	Safety, Experience, Regulatory, Service Delivery, Reputation	5x3=15	15 15 15	The risk of not being a digitally and data enabled. Resulting in poor and/or limited implementation of systems and technologies, with reduced quality and safety of care and lack of data intelligence to inform change / transformation.	The Digital transformation plan is being reviewed to ensure it reflects the Trust efficiency targets and prioritise areas of greatest need for lifetime of the strategy. Target operating model approved May '24 with implementation commencing July '24. To be fully implemented by the end of the 2024/25 year.

Corporate Risk Register at a Glance

Existing Risks	New Risks	Change in Rating	Closed
10	0	1	0

Risk Score Increase	Risk Score Decrease	Risk Score No Change	On Risk Register >12 months
0	1	9	8



% Risks with Controls Identified	% Risks with Assurance Identified	Extended Actions	Risk Reviewed by Risk Owner
100%	100%	0	100%

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR94	Engagement & Supportive Observation	AG	Safety Regulatory	5x4=20	20 20 20	CQC found observation learning not embedded	Following completion of Safe Wards training now moved into implementation phase of Safe Wards interventions. Safewards interventions seek to reduce rates of behaviours that threaten patient safety or the safety of others (violence, suicide, self-harm, absconding etc.) and seeks to minimise harmful outcomes (e.g. PRN medication, special observations, seclusion, etc.). Safe Wards has been very well received with each ward in implementation phase with some innovative ideas and initiatives. These include painting of discharge trees/mountains on the walls of our wards which have included staff and patients working together. Mutual expectations being generated at community meetings where patients and staff agree together what they expect of each other and boards on the wards that detail getting to know you information about staff members with pictures that bring a more personal side to our staff teams. These are just some of the areas of work. We have agreed to include a focus on safe wards as part of our reducing restrictive practice quality priority for 23/24. This involves all inpatient areas across adult inpatient and specialist services each month sharing areas of good practice across the wards in relation to safe wards and monitoring impact. As part of reviewing the risk assessment undertaking themative review of trend over time to assess the impact of our actions on sleeping on duty and incidents involving observation and engagement.
CRR98	Pharmacy Resource	FB	Safety	4x3=12	12 12 12	Continuous state of business continuity plan	Recruitment campaign ongoing and continuing to see recruitment with clear pipeline running throughout 2024. 24.3 WTE vacancies (which includes the 9 new post within Time to Care). To note: due to demand for pharmacy staff being high we have experienced leavers to promotions or posts closer to home for the individuals.
CRR11	Suicide Prevention	MK	Safety	4x3=12	12 12 12	Implementation of suicide prevention strategy	The framework approved by Executive Team 7 May '24 ad the work programme aligned with the new Quality of Care strategy priority grouping with leadership through the Effectiveness of Care Group (Chaired by Executive Medical Director) and reporting through to Quality Committee for assurance on programme delivery. All actions associated with CRR34 have now been completed and therefore the reference removed in future reporting.
CRR45	Mandatory Training	MR	Safety Regulatory	4x3=12	12 12 12	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Compliance with mandatory training trust-wide has met its recovery trajectory and therefore the risk score reduced. 59% of bank staff have completed TASI training to date.
CRR77	Medical Devices	FB	Safety Financial Service Delivery	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	Continue to progress partnership with MSEFT for the provision of quality assurance programme for Point of Care Testing equipment and in process of procuring new devices to support the transition. The tender contract for medical devices management programme will commence in April '24 to replace the current contract as it comes to end of term in December '24. A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with the potential to reduce the risk.

ID	Title	Lead	Impact	CRS	Risk Movement (last 3 months)	Context	Key Progress
CRR81	Ligature	AG/TS	Safety Regulatory Reputation	4x3=12	12 12 12	Patient safety incidents	There has been a marked reduction in fixed point ligature incidents and therefore the risk has been reassessed based on latest patient safety incident data (to include no harm incidents). Following work of the Safety First Safety Always Strategy - Ligature reduction programme (including significant investment into improving our clinical environments and the introduction of a greater focus on therapeutic engagement) the outcomes are more likely to be low or no harm from incidents for both fixed and non-fixed incidents. There is also a decreasing and plateauing trend in the likelihood of a severe outcomes for non-fixed and fixed incidents respectively. The risk likelihood has therefore been reduced to a 3 (possible) from a 4 (likely). We continue to invest in staff training and the Safe Wards programme to continuously focus on reduction of harms for our service users.
CRR92	Addressing Inequalities	MR	Experience	4x3=12	12 12 12	Staff Experience	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee at the end of March '24. The Leadership Behaviour Toolkit has been developed and is being socialised. Sexual safety phone line now operational 24 hours a day, seven days a week. Managers have also been reminded of their role in supporting staff who have reported any issues of this nature and on call directors are enrolled into Level 2 Safeguarding Training. We are working with staff to co-design a road map on how the Trust should respond to all incidents of violence and abuse. In addition we are working with Peer Support Workers and patients to gain an understanding as to why violence and abuse may occur on wards and what can be done to reduce incidents.
CRR93	Continuous Learning	FB	Safety Regulatory	5x315	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	All actions have been completed and a confirmation of the risk reduction target score is undergoing a review at the time of writing this report.
CRR96	Loggists	NL	Regulatory	4x4=16	16 16 16	Major incident management	Trained loggist continue to increase (with 21 in place) which is assessed to meet the threshold for delivery of a 24/7 response should it be needed. Risk assessment being reviewed for closure. We will continue a programme of Loggist training as both a refresher and to continue to bolster our numbers.
CRR99	Safeguarding Referrals	FB	Safety	4x2=8	12 12 8	Escalation from operations and high increase in referrals	Assessment has confirmed that the target score has been met following the completion of all actions and improving the controls for the management of safeguarding demand. The risk has been de-escalated from the CRR and will be monitored through the Nursing and Quality Risk Register going forward. Included in reporting for note.

Strategic Risk Register

June 2024

EPUT

SR1- Safety (At a Glance)

Risk Description: If EPUT does not invest in safety or effectively learn lessons from the past, then we may not meet our safety ambitions, resulting in a possibility of experiencing avoidable harm, loss of confidence and not meeting regulatory requirements.

Likelihood based on: Incidence of incidents, non-compliance with standards (clinical audit outcomes) and regulatory sanctions imposed historically.

Consequence based on: Avoidable harm incident impact and extent of regulatory actions.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C5 x L2 = 10*	**Note:** Action 4 and 5 previously removed as integral part of action 1**.**

Executive Responsible Office: Interim Chief Nurse
Board Committee: BSOG and Quality Committee

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Patient Safety Incident Management Team	Team Established (note vacancies and some team members undertaking skills development).	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	PSIRF Yr1 early adopter review
EPUT Lessons Team	Team Established	Patient Safety First Safety Always - Leadership Pillar Report end of Yr. 2	
Learning Collaborative Partnership	Forum - live		
Quality and Safety Champions Network	Network - live		
Information sharing communication strategy (lessons learned)	Lessons identified Newsletter Induction Videos Mandatory Training (name)		IA - Safeguarding Arrangements opinion reasonable assurance
Capital Investment	Delivery of essential safety improvements		CQC CAMHS inspection report (safety improvements)
Patient Incident Response Plan	Incident Response Plan - live and being used	Refreshed Incident Response Plan (2023-25)- approved and published on the Website	Refreshed Incident Response Plan (2023-25)- approved by ICB
Culture of Learning Programme		BSOG reviews on progress	
Patient Safety Dashboard	Safety Dashboard - live (Note: additional development see actions)		

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Deliver the Patient Safety Incident Response Plan	Mar '25	MA	Control	The Patient Safety Incident Response Plan (PSIRP) 2023-25 has been approved and is live on EPUT website. The undertaking of thematic analysis of the key areas to inform Safety Improvement Plans is in progress. With a Safety Improvement Plan Oversight Group being established by the Executive Nurse to oversee their development and programmes of work. Reporting monthly into the Safety of Care Group.

2	Deliver Yr3 - Patient Safety Strategy (Safety First Safety Always	Complete	AS	Control (Road Map)	To conclude the transition from the programme of activity taken place across the Trust to support the implementation of the Safety First, Safety Always strategy to the new Quality of Care Strategy (approved by Board) we have undertaken a year 3 review and is to be reported to Board at its meeting in August 2024.
3	Complete automation of two dashboard elements	Complete	MS	Control	The programme work to integrate IWGC data into the Patient Safety Dashboard has been completed (June 2024).
6	Implement EPUT Lessons Identified Management System (ESLMS)	Complete	MA	Control	ESLMS has been successfully reviewed within the test environment and is now functional in the live environment and action is complete. Next steps (see action 7 below) is to put in place governance controls within care units for its use.
7	Ensure good governance controls for monitoring to progress towards action closures and achievement of additional controls	Extended July '24	SY	Assurance	PSIRF Oversight Groups established. Further work added to this action to enhance some aspects of Datix system to improved reporting functionality of the incident management module within the care units.

SR2- People (At a Glance)

Risk Description: If EPUT does not effectively address and manage staff supply and demand, then we may not have the right staff, with the right competencies, in the right place at the right time to deliver services, resulting in potential failure to provide optimal patient care / treatment and the resultant impact on quality of care (safety, effectiveness and experience).

Likelihood based on: Establishment of existing and new roles verses the vacancy factor and shift fill rate.

Consequence based on: Impact of staffing levels on service objectives; length of unsafe staffing (days) through the Sit Rep Return; staff morale; availability of key staff; attendance at key training.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 = 15*	**Note:** Previous reported completed actions 1 to 3 and 9 have been removed from the report. **Note**: Action 6 and 7 are complete and will not feature on future reports. **Note**: As previously discussed this risk is being review with the aim of breaking down into component parts for greater oversight. This was socialised with People Equality and Culture Committee in July '24 and will progressed.

Executive Responsible Office: Interim Chief People Officer
Board Committee: PECC

Key Controls	Controls Assurance		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
People & Culture Team / Hr Policies	Leadership Team Established Interim Chief People Office - awaiting appt. of substantive CPO		
Care Unit Staffing Plans	Workforce plans in place Safer staffing reports	Quality and Performance Scorecard	CQC Inspection - regularity of temporary staffing on inpatient wards (negative assurance)
Recruitment and Retention Programme	Vacancy rate 9%, with mental health nursing in Inpatient and Specialist Services approaching full establishment	PECC reports	IA - Recruitment Processes opinion limited assurance.
Workforce Plans and Strategies	Establishment reviews Framework for health and wellbeing	PECC reports	NHSE & System Workforce returns / benchmarks
Training and Development	Training Tracker in place RISE Programme (completed)	Training and Development report to PECC	Staff Survey / OoAPT successful June '23 / Ofsted Inspection July '22 - Good
Staff Wellbeing Offer	Engagement Champions Employee Experience Managers	Employee Experience reports to PECCC	Staff Survey / Quarterly Pulse
Just Learning Culture	Behaviour Framework FTSU Guardian	Employee Experience reports to PECCC	Staff Survey
Equality and Inclusion Framework	Executive led sponsors for networks ED&I objectives in appraisal Racial abuse guidance for staff and debriefs		WRES / WDES Data

	Actions (to modify risks)	By When	By Who	Gap	Update
4	Review long-term strategy for smart working	Extended Oct '24	FW	Control	Flexible working policy has been revised and is going through the approval process. The Smart Working Group is considering a proposal for agile working for the Lodge and continues to link into the development of the Estates Strategic Plan. Note extension of action to align with revised timing of the Estates Strategy to Board for approval in October '24.

5	Recovery plan for delayed HR policies	Extended July '24	DP	Control	There is a co-dependency on any changes being agreed with Staff Side. Current documents have been assessed as fit to continue in use by subject matter experts. All documents are progressing through approvals in July 2024. Timeline extended for the final set of documents. RAG rated red due to sequence of extensions to the action.

SR2 Continued Actions (to modify risks)		By When	By Who	Gap	Update
6	Produce new programme on improving inclusion, particularly for those with worst experiences, and brief Board, as the next phase of EDI plan	Complete	LH	Control	A series of meetings held with the Executive Team/Chair and set EDI objectives through the Remuneration and Nominations Committee. These are part of the NHS England EDI Improvement Plan with a requirement which is now in place for EPUT.
7	Deliver agreed objectives with MSE ICB to reduce vacancies and temporary staffing	Complete	PT	Control	Agreed temporary staffing reduction plan with ICB. Savings targets and trajectories being finalised. Focus on rostering, reducing HCA use and exiting long term agency arrangements in particular.
8	Review of Operating Model and Structure of P&C Directorate to support organisation to meet its strategic objectives	Extended Sept '24	MR	Control	New CPO commenced in post May 2024 and is reviewing the operating model and structure of the P&C Directorate in line with the People and Education Strategy. Extension of timeline RAG rated green as alignment with the AM's workflow.
10	Ensure robust plans are in place to mitigate the impact of strike action	Ongoing	DP	Control	Update: Successfully managed the last strike and note that there is no further planned action at the time of updating the risk actions.

SR3- Finance and Resources Infrastructure (At a Glance)

Risk Description: If EPUT does not adapt its infrastructure to support service delivery then it may not have the right estate and facilities to deliver safe, high quality care resulting in not attaining our safety, quality and compliance ambitions.

Likelihood based on: The possibility of not having the right estate and facilities to deliver safe high quality care

Consequence based on: The potential failure to meet our safety, quality and compliance ambitions

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x L3 = 15	*C5 x L3 =15*	*C5 x L2 = 10*	**Note:** Previous reported completed actions 1, 3, 4 and have been removed from the report. **Note**: Action 5 is complete and will not feature on future reports. **Note:** Re-assessment of risk on completion of Estates Strategy.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P and Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
EPUT Strategy	EPUT Strategy (approved Jan '23)	Board Report (3 per year)	
Operational Target Operating Model	Care Unit Leadership in place Procurement Team restructured to align with TOM	Accountability Framework	
Estates and Facilities, Contracting and Business Development, Finance Teams	Established Support services	PMO support in place reporting to ESOG Restructure fully recruited to	IA Estates & Facilities Performance (Moderate/Moderate Opinion)
Range of corporate, finance policies	Policy Register and procedures in place	Accountability Framework	
PMO, Capital Programme, E-expenses system,	Capital Steering Group	Capital Planning Group	
Audit Programme and ISO		Audit Committee	
Premises Assurance	Operational meetings for PFIs	Premises Assurance Model in place with assessment	
6-Facet Survey			6-Facet Survey
Business Continuity Plans	Business continuity plan in place		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
2	Develop Estates Strategy & Development Plan (as informed by the 6-facet survey)	Extended Oct '24	MM	Roadmap	Phase 1 - current status complete. Internal delivery and steering groups in place. External support in place. Board seminar held July 2024 and draft was socialised via Finance & Performance Committee, where it was agreed to do further socialisation with the Board and link to ICB infrastructure. Then for approval at Board meeting in October 2024. (Note extended timeline)
5	Business case related to additional estates resource to be prepared prior to budget setting round 2024/25	Complete	MM	Control	Estates establishment has been approved with required resources identified. This is now closed, further review and refresh will be linked to the corporate services review scheduled for the latter part of this year.

SR4- Demand and Capacity (At a Glance)

Risk Description: If we do not effectively address demands, then our resources may be over stretched, resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions.

Likelihood based on: Mismanagement of patient care and length of the effects (both inpatient and community)

Consequence based on: Length of stay, occupancy, our of area placements etc.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed actions 1, 2, 3, 4, 4.1,4.3, 4.4, 4.5, 4.8 and 5 have been removed from the report. **Note**: Action 4.3 is complete and will not feature on future reports.
C5x 4L = 20	*C5 x L3 =15*	*C5 x L3 = 15*	

Executive Responsible Office: Executive Chief Operating Officer Board Committee: BSOG and F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Operational staff (including skilled flexible workforce via Trust Bank) Discharge Co-ordinator Teams	Establishment and Fill Rate Director of Operational Performance Agency Framework in place New roles: Activity Coordinators Clinical Flow Lead (TTC) and CD Flow	Performance Reporting Accountability Framework Meetings	
Care Unit Leadership	Establishment Integrated Director posts		
Target Operating Model / Accountability Framework / Flow and Capacity Policy. MAST roll out / Safety First Safety Always Strategy	Dedicated discharge coordinators CPA Review performance UEC in place	Accountability Framework Meetings Safety First Safety Always Yr2 Report to Board (Mar '23)	
MH UEC Project, MSE Connect Programme. Partnerships, Mutual Aid	Flow and Capacity Project MH Urgent Care Emergency Department opened 20 March 23	Purposeful admission steering group Monthly inpatient quality and safety group	Provider Collaborative(s) MH Collaborative Whole Essex system flow and capacity group
Service Dashboards / Daily SitReps/ Performance Reporting	Updated OPEL framework Essex wide daily sit reps Joint inpatient and community review meets EDD and CRFD reporting in ward review template on EPR, with daily reports providing status	Performance and Quality Report to Accountability Meetings and F&PC Safety KPI dashboard live and accessible	System oversight and assurance groups
Business Continuity Plans	EPRR planning Business Continuity Plan in place		
Care Unit Strategies / Operational Plan 2023/24	Developed including out of area plan	Performance Reporting Published alongside EPUT Strategy One year touch points and monitoring through accountability	
Pan Essex System Flow and Capacity Group	Established Review of bed modelling (supported by KPMG)		System Escalation in place
Bed Stock	157 North Adult beds; 44 North Older Adult beds; 89 South Adult beds; 66 South Older Adult beds; 24 Contracted appropriate OoAP beds		

Actions (to modify risks)		By When	By Who	Gap	Update
4.2	Reclassification of OoAP contracted beds	Complete	LB	Control	Reclassification has been agreed and existing contacts renewed to support delivery of OoAPs trajectory.
4.6	Reducing variations across wards	Aug-24	LW	Control	Stakeholder engagement including systems and people with lived experience has been completed and now progressing through EPUT governance. Action delayed as consequence of scheduling stakeholder engagement session and is RAG rated amber due to extension. Engagement session booked 19 July 2024 and will then be reviewed by Executive Team , with a communications plan to support.
6	New Action: Demand and Capacity module to be procured and fully implement	Oct '24	JL	Control	Demand and capacity module is complete and in proof of concept phase Procurement underway to licence product for use in “live” Next steps following procurement will be to bring into live aim for completion Q2
7	Conclude new risk share arrangement for Out of Area bed capacity with ICB leads.	Oct '24	AG	Control	Discussions are ongoing with ICB colleagues to review and renew the risk share arrangements across our three systems.

SR5 - Lampard Inquiry (At a Glance)

Risk Description: If EPUT does not have the correct governance arrangements in place then it will not serve the Lampard Inquiry effectively, potentially resulting in a lack of confidence from the public and reputational damage for the organisation.

Likelihood based on: the possibility that the Trust cannot effectively meet the requests of the Inquiry both in terms of completeness and response times.

Consequence based on: National media coverage, parliamentary coverage and a loss of public and partner confidence

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Reset of Risk and actions as the Lampard Inquiry terms of reference announced 10 April 2024 and Trust now has clarity on the scope.
C4x 4L = 16	*C4 x L4 =16*	*C4 x L3 = 12*	

Executive Responsible Office: Executive Director Major Projects Board Committee: Audit Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Inquiry Team (Resource with skills and capacity to meet the needs of EPUT response to the Inquiry).	Executive SRO (Nigel Leonard) Project Director Browne Jacobson Essex Chambers	Lampard Oversight Committee	Internal Audit
Financial Resource (To meet the needs of the EPUT response to the Inquiry)	Financial Allocation, budget held by Project Director.	Finance reporting F&P Committee	External Audit of Provision
Inquiry Response Governance	Inquiry Team Chaired by SRO Inquiry Project Team Multi-Disciplinary Working Group	Lampard Oversight Committee	Internal Audit
Learning Log (this is learning noted by the Project Team during searches not in relation to themes from specific incidents. Historic learning of past events within the Inquiry is led by the Quality Committee)	Inquiry Project Team Multi-Disciplinary Working Group	Executive Operational Sub Committee	Internal Audit
Support for staff	Resources from Psychology. Project Working Group	Lampard Oversight Committee	Internal Audit
Support for families	Report from HPT to Project Working Group	Lampard Oversight Committee	Internal Audit
Communications Plan	Multi-disciplinary Project Working Group Multi-disciplinary Communications Group	Lampard Oversight Committee	Internal Audit

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Management Development Programme module in place	Complete	GW	Control	First session took place on 25 April 2024 and action complete.
2	Support re-secured for families	June '24	GB	Assurance	EPUT Contracting Team have developed the agreement which has been shared with HPFT. The Trust awaits the signed contract.
3	Protocols in place for support for current and former staff	July '24	GW	Assurance	DPIA submitted, SIRO requested further information and legal advice prior to sign off. This has been received and DPIA changes being made for submission week of 5 August 2024.

SR5 Continued Actions (to modify risks)		By When	By Who	Gap	Update
5	Schedule meetings for Care Units and Wards in place	Complete	GW	Control	Completed. Attending Care Unit Meetings and completing staff visits.
6	Review data (C1, 2, 3, 4): A -Extraction of data from incidents resulting in SI/PSIRF investigations. B - Review of board and committee papers from 2000 to 2023. C - Cataloguing of information and running patient searches D - Learning themes from SI/PSIRF reports, including PFDs, to establish what action has been taken and what may be outstanding E - Review of thematic reviews. F- Completion of Rule9(1) request	Sept '24	GB/GW	Assurance	B- E - Working progressing in all areas. F - This is a final date and if missed the Trust may face a S21 notice. Mitigated by increasing the number of staff trained and available to roster to over 90.
7	Information system procured and in place	Nov '24	GB/AW	Control	Procurement discussions being held DPIA being completed.

SR6- Cyber Security (At a Glance)

Risk Description: If we experience a cyber-attack, then we may encounter system failures and downtime, resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage.

Likelihood based on: Prevalence of cyber alerts that are relevant to EPUT systems.

Consequence based on: assessed impact and length of downtime of our systems

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L3 =15*	*C4 x L3= 12*	**Note:** Previous reported completed actions 1 and 4 have been removed from the report. **Note**: Actions 2 and 3 are complete and will not feature on future reports.

Executive Responsible Office: Executive Director Strategy Transformation and Digital Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Scanning systems for assessing vulnerabilities, both internal and through NHS Digital and NHS mail		Reporting into IGSSC with exception reporting to Digital Strategy Group	
Cyber Team in place	Substantive post holder (Aug '23)	IGSSC	NHS Digital Data Security Protection Toolkit (DSPT) IA - Data Security and Protection Toolkit opinion substantial assurance (2023/24) Cyber Essentials Accreditation
Range of policies and frameworks in place	Virtual and site audits Compliance with mandatory training – Cyber Assurance Framework	IGSSC; IA - Data Security and Protection Toolkit opinion substantial assurance (2023/24)	As above MSE ICS IG & Cyber Levelling Up Project (annual) IA - Data Security and Protection Toolkit opinion substantial assurance (2023/24)
Investment in prioritisation of projects to ensure support for operating systems and licenses	Prioritisation of digital capital allocation	CPPG – with priority decisions made at DSG	
IG & Cyber risk log	Risk working group reporting into IGSSC – owing and tracking actions from audits and assessments	IGSSC and Digital Strategy Group	DSPT IA - Data Security and Protection Toolkit opinion substantial assurance (2023/24)
Business Continuity Plans and National Cyber Team processes	Business Continuity and Disaster Recovery Plan	Successfully managed Cyber incident	Annual Testing as part of DSPT NHS Digital Data Security Centre, Penetration Testing, Cyber Essentials+
CareCert notifications from NHS Digital	Monitored and acted upon within 24 hours of their announcement	Reported to IGSSC	NHS Digital
Cyber Essentials Accreditation	Certification achieved	Monitor controls through IGSSC	Accreditation certified
MSE ICS DSPT & Cyber Maturity Baseline	Completed	F&P Committee Oversight	IA - Data Security and Protection Toolkit opinion substantial assurance (2023/24)

SR6 Continued Actions (to modify risks)		By When	By Who	Gap	Update
2	Develop business continuity plan and disaster recovery for each system (using third party)	Complete	AW	Control / Assurance	The Business Continuity and Disaster Recovery Policy was approved by CPPG with evidence supplied to our auditors to close the management action.
3	Complete actions from IT Security Health Check and Penetration Testing	Complete	AW	Control	All of the in scope systems have now been decommissioned (Server 2008 legacy systems).
5	Systems that are running unsupported software identified by the latest penetration test and internal cyber audit require upgrade or replacement.	Jul-24	AW	Control	Further systems requiring security remediation - Progress against mitigation is reported and tracked through the cyber assurance report to the Finance and Performance Committee - on track.

SR7- Capital (At a Glance)

Risk Description: If EPUT does not have sufficient capital resource, e.g. digital and EPR, then we will be unable to undertake essential works or capital dependent transformation programmes, resulting in non achievement of some of our strategic and safety ambitions.

Likelihood based on: Percentage of capital programme unable to deliver / deferred

Consequence based on: What not delivered and the impact on the strategic plans.

Initial Risk Score C5x 4L = 20	*Current Risk Score* C5 x L4 = 20	*Target Score* C5 x L3 = 15	**Note:** Action 2 is complete and will not feature on future reports.

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team in place	Decision making group in place and making recommendations to ET, FPC and BOD	
Purchasing / tendering policies	Policy Register		Internal Audit
Estates & Digital Team (Response to new resource bids)	Team in place		
Capital money allocation 2023/24	Capital Project Group forecasting	Capital Resource reporting to Finance & Performance Committee	
Horizon scanning for investment / new resource opportunities	£0.4m new resources secured (reported at month 3)	Capital Resource reporting to Finance & Performance Committee	
ICS representation re: financial allocations and MH/Community Services	EPR convergence business case developed with additional capital resources identified	ECFO or Deputy Attendance at ICS Meetings; CEO or Deputy membership of ICB;	
Prioritised capital plan to maximise the use of available capital resources	Capital Plan 2023/24 in place		
EPR Programme	EPR Joint Committee Reporting established.	EPR Joint Oversight Committee EPR Programme Board Convergence and Delivery Board EPR FBC approved by Board	OBC Agreed

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Horizon scan to maximize opportunities both regional and national to source capital investment	Ongoing	JD	Control	Currently over committed the programme which is planned to be covered by system resources. We have been successful to date in securing an additional £0.4m following mental health applications.

SR7 Continued Actions (to modify risks)		By When	By Who	Gap	Update
2	Capital Plan for financial year 2024/25	Complete	JD	Control	Capital plan agreed by Board March 2024.
3	Track key strategic investments i.e. EPR to be monitored for impact on Capital Programme	Mar '25	JD	Control	Electronic Patient Record Full Business Case approved by Board and submitted to NHSE (8 March '24). Awaiting formal notification of decision following review.

SR8- Use of Resources (At a Glance)

Risk Description: If EPUT (as part of MSE ICS) does not effectively and efficiently manage its use of resources, then it may not meet its financial controls total, Resulting in potential failure to sustain and improve services

Likelihood based on: Likelihood based on: EPUT financial risk and opportunities profile

Consequence based on: Consequence based on: assessed impact on long financial model for EPUT and the System

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previous reported completed action 1 has been removed from the report. **Note**: Actions 3,4,5 and 7 are complete and will not feature in future reports.
C5x 4L = 20	*C5 x L4 =20*	*C5 x L3 =15*	

Executive Responsible Office: Executive Chief Finance & Resources Director Board Committee: F&P	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Finance Team (Response to new resource bids and financial control oversight)	Team Establishment	Use of Resources Assessment	Use of Resources NHSE Assessment
Standing Financial Instructions Scheme of reservation and delegation Accountability Framework	Standing Financial Instructions in place Scheme of Delegation in place Accountability Framework in place	Financial Management KPIs Audit Committee F&PC Accountability Framework	IA Key Financial Systems – Budget Management (2022) Substantial opinion and Costing (2023). IA Core Financial Assurance excluding payroll controls opinion reasonable assurance (2023/24)
Estates & Digital Team (Response to new resource bids)	Team in place		
Deliver efficiency savings and targets 23/24		Finance Report	IA - Efficiency Savings opinion reasonable assurance (2023/24)
Finance reporting	Finance Reports AF Reports		NOF3 Rating External Audit of Accounts (2023/24 unmodified opinion).
Budget setting	Completed mid year financial review. Key risk and opportunities assessments performed	Accountability framework reporting; Finance reporting to F&PC; National HFMA Checklist Audit	Annual VFM through external auditors identified no significant weaknesses
Operational Plan 2024/25		Oversight by F&P Committee	External Audit (Planned year end 2024/25)
Forecast Outturn and risk/ opportunities assessments 24/25		Oversight by F&P Committee	

Actions (to modify risks)		By When	By Who	Gap	Update
2	Deliver Financial Efficiency Target	31 Mar '25	TS	Control	Action rolled forward for 2024/25. £28.6m (5.2%) by 31 March 2025 - schemes identified but with high risk of full delivery. YTD efficiency (reported to F&P Committee - month 3) £2.2m (£1.8m in month 2) with shortfalls relating to bank reductions linked to Time to Care implementation i.e. recruitment and changes in clinical and operational practice and underperformance against out of area placements due to demand. These shortfalls are partially offset by vacancy position.
3	In year forecast outturn (FOT) and associated risk and opportunities assessment	Complete	SC	Assurance	Delivered to forecast outturn.
4	Deliver Operational Plan 2023/24	Complete	AG/TS	Control	Delivered operational plan 2024/24.
5	New Action - Submit Operational Plan 2024/25	Complete	AG/TS	Control	As approved by Board March 2024.
6	New Action - Deliver Financial plan for 24/25	Mar '25	TS	Control	Continued enhanced controls, efficiency and productivity improvement and transformation/restructure activities. YTD £1.3m adverse to plan (reported to F&P Committee - month 3).
7	Ensure the finance impact of the Lampard Inquiry is articulated in the financial plan	Complete	SC	Control	Impact assessed as part of year end processes.

SR9- Digital and Data Strategy (At a Glance)

Risk Description: If we do not have the required capability and expert knowledge to deliver the digital and data strategy, then the trust may fail to achieve strategic ambitions, specifically: embedding a digital mindset and culture, which may result in limitations in our ability to procure and implement the appropriate technology to support the integration of care closer to where our service users live, and support staff to carry out their duties effectively; Threaten the development of our patient facing technologies to support our service users, families and carers; and stall our capability and agility to use data to inform both direct care and insight driven decision making.

Likelihood based on: The likelihood of conditions that place constraints on the ambitions of both the digital and data strategy, e.g. capability, resource availability and transformation programme prioritisation

Consequence based on: The inability to realise the wider organisations strategic ambitions as well as the inability to maintain regulatory and compliance data security and cyber assurance.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Previously reported complete action 2,3, 6 and 8 have been removed from the report.
C5x 3L = 15	*C5 x L3 =15*	*C5 x L2 =10*	**Note**: Action 7 is complete and will not feature on future reports.

Executive Responsible Office: Executive Director of Strategy, Transformation and Digital
Board Committee: F&P

Key Controls	**Controls Assurance**		
	Level 1 (Management)	**Level 2 (Oversight)**	**Level 3 (Independent)**
Resources			
IT/Digital team Resource and skill set is appropriate and sustainable	Education and training in specific technology Target operating model - modernise digital services	Digital strategy resource management (RAID Log)	
Clinical Digital leadership are engaged with dedicated leads responsibilities defined.	CCIO/CNIO oversight		
Strategies & Policies			
Information Governance policies and controls are in place to provide secure and appropriately governed processes and procedures	Information governance controls processes	Information Governance Steering Sub-Committee reporting and assurance	Data Security and Protection toolkit assessment (Standards Met)
Data quality is of a standard that assures national standards.	Data quality group reporting and assurance	Internal Audit	National data quality framework
DSPT “standards met” can be achieved		Internal Audit	DSPT submission and Cyber assurance framework
Investment			
Capital allocation to digital and data initiatives secured	Approved Digital capital plan		CDEL allocation from system for 23/24 schemes
External funding is obtained for schemes that are supported by national envelopes	Cost modelling of the digital strategy programme	Digital, data and technology group assurance report	
Innovation			
The space and governance exists to support innovation	CIO discover opportunities from national forums and partners (inl. Academic)	Innovation strategy governance - Strategy Steering Group	
Academic partnerships promote innovation	CIO engagement with academic partners on digital innovation opportunities		

Actions (to modify risks)		By When	By Who	Gap	Update
1	Digital Transformation programme Plan	Extension Sept '24	JL	Road Map	The Digital transformation plan is undergoing further review to ensure it reflects the Trust efficiency targets and prioritises areas of greatest need for lifetime of the strategy.
4	Digital target operating model implementation	Mar '25	AW	Control	Target operating model approved May '24 with implementation commencing July '24 and will be fully implemented by the end of the 2024/25 year. Action timeline amended to align with the programme of work.
7	Clinical safety Officer framework development	Complete	RP	Control	Clinical Safety Framework presented at the Digital Strategy Group in March '24. Proposals for enhanced governance for the safe deployment and maintenance of clinical systems agreed in principle subject to final approvals. The first Digital Clinical Safety Steering Group met in April '24.
9	Implementation of the new service desk management system.	Sept '24	AW	Control	New service desk platform (Hornbill) has been procured through a competitive tender process. A capital bid is being taken to CPPG in May '24 to support digital capital expenditure to develop the system. On track.

Corporate Risk Register

June 2024

EPUT

CRR94 - Observation and Engagement

Risk Description: If EPUT does not manage supportive observation and engagement then patients may not receive the prescribed levels resulting in undermining our Safety First Safety Always Strategy.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5x 4L = 20	*C5 x L4 = 20*	*C5 x L2= 10*	**Note 1**: Previous reported completed actions 1-9 have been removed from the report. **Note 2**: Action 10 and 11 are complete and will not feature on future reports. **Note 3**: Risk assessment has been reviewed and assessing the evidence to support a risk reduction based on likelihood reducing. **Note 4**: Risk description being review to align with transition of work flow to the new Quality of Care Strategy.

Executive Responsible Office: Executive Nurse Director Lead: Director of Nursing and IPC Leads: Deputy Directors of Quality & Safety (Inpatients and Specialist Services) Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Weekly Ward Huddles	AD's undertaking 15 leadership steps Local oversight of roster quality checks		
Electronic observations recording tool	e-observations in wards (with exception of 7 wards)		
Tendable Audits (quality control)	Audit results reviewed at weekly huddles		
Observation and Engagement e-learning and training videos			
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		
Deep dive into unexpected deaths in inpatient services or within 3 months of inpatient admission between 2000 - 2022		Analysis of 1500 unique recommendations with identification of 31 themes. Validation with stakeholders. Mapping exercise and assurance report to ET Apr'22	
Safe Wards Interventions			
Ward Improvements	Planning supported by patients Grab Therapy Resources available		

CRR94 Continued Actions (to modify risks)		By When	By Who	Gap	Update
10	Implement Safe Wards Interventions	Complete	LJ	Control	Following completion of Safe Wards training is now in place. Safe Wards has been very well received by our staff teams and each ward is in implementation phase with some innovative ideas and initiatives. These include painting of discharge trees/mountains on the walls of our wards which have included staff and patients working together. Mutual expectations being generated at community meetings where patients and staff agree together what they expect of each other and boards on the wards that detail getting to know you information about staff members with pictures that bring a more personal side to our staff teams. These are just some examples of the areas of work. The focus on safe wards is included within the reducing restrictive practice quality priority for 23/24. This involves all inpatient areas across adult inpatient and specialist services each month sharing areas of good practice across the wards in relation to safe wards and monitoring impact. The action is now complete as safe wards has moved into business as usual.
11	Deep Dive into Staff Sleeping	Complete	LJ	Assurance	Deep dive now complete in Adult Inpatient areas. Plan of action being reviewed with oversight through the Safety of Care Group. The Executive has agreed that this should be assessed and entered on the risk register as a stand alone risk and dependent on the risk exposure score escalated in line with the Risk Management Assurance Framework.
12	Thematic review into incidents across all units	Jun-24	LJ	Assurance	To review controls and assurances have made an impact in the incidents over time. Risk aligned to the Reducing Restrictive Practice Group and two DDQS are taking forward the thematic analysis looking into the comparison of levels of incidents for now vs 2 years ago.
13	**New Action** Monitor Safe Wards Interventions	Oct-24	LJ	Assurance	To establish a baseline to see how this is having an impact on conflict on the wards. To identify how do we monitor movement from baseline to safer wards. To be reviewed by the Safety of Care Committee.

CRR11 - Suicide Prevention

Risk Description: If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services, then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4x 4L = 16	*C4 x L3 = 12*	*C4 x L2= 8*	**Note:** CRR34 Suicide Prevention Training has been amalgamated into this risk as part of delivery of overall Suicide Prevention Framework, with CRR34 being closed on the risk register. **Note:** Previous reported completed actions 1 to 4 have removed from the report for CRR11. **Note:** Previous reported completed actions 1, and 3 have been removed from the report for CRR34.

Executive Responsible Office: Executive Medical Director Director Lead: Dr Nuruz Zaman Deputy Medical Director Leads: Glenn Westrop, Deputy Director of Quality and Safety Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Observation and Engagement Policy	Policy in place Personalised Engagement Boards		
Electronic observations recording tool	eObservations		
Ward level oversight	Tendale Audit results reviewed at weekly huddles	Patient led safety huddles (Basildon)	
Observation and Engagement e-learning and training videos	STORM training		
Engagement resources	Purchased equipment e.g. games / newspapers etc. Garden Protocol (with spots checks)		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
1	Development of revised framework in line with national guidance	Complete	NZ	Roadmap	The framework was reviewed and approved by Executive Team 7 May '24 and the work programme is embedded within the Quality of Care Strategy priority grouping with leadership from the Effectiveness of Care Group (Chaired by Executive Medical Director). Note: DDQS lead change to Lianne Joyce / Alan Hewitt in line with the new Quality of Care Strategy priorities.
5	Review approach to ligature risk management training (through the introduction of effective self-harm and suicide prevention training).	July '24	GW	Control	STORM (Effective self-harm and suicide prevention) training rolling out which will have a greater focus on neuro diverse services users and be an extended training package. Training is available and being tracked, with continued promotion. Further work being taken forward to update safety plans and fit to leave plans.

CRR11 Continued Actions (to modify risks)		By When	By Who	Gap	Update
6	Implementation of the Suicide Prevention Framework (as aligned to the Quality of Care Strategy	Dec '26	GW	Control	Next steps following approval of the framework (action 1) is to work with our Lived Experience Ambassadors and our communities to take forward actions. Oversight of this programme of work is through the new Effectiveness of Care Group chaired by the Executive Medical Director.
CRR342	Business case to be developed to create sustainable training capacity (trainers).	Complete	PT	Control	*Note: action transferred from CRR34* ILS and mandatory training across the Trust has been reviewed and a business case was presented to the Executive Team, with agreement to expand the training team to meet the requirements. Roles being advertised with the ambition of having people in post from September 2024.

CRR45: Mandatory Training

Risk Description: If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4= 16	*C4 x L3 = 12*	*C4 x L2 = 8*	**Note:** Previously reported completed actions 1, 2 and 3 have been removed from the report. **Note:** Compliance with mandatory training trust-wide has met its recovery plan and therefore risk score reduced (driven by likelihood of staff to having the required training. Likelihood reduced to a 3, in recognition that there remains a risk to sustained compliance as we transition TASI training back to an annual update for staff and we provide training for new staff both substantive and bank (new actions).

Executive Responsible Office: Executive Director People and Culture Director Lead: Paul Taylor Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Training Team	Established – current resource 8.5WTE TASI trainers increased		12 month TASI accreditation from BILD
Induction and Training Policy	Policy and Procedure in Place		
Training Tracker	Management Check	Accountability. F&PC and PECC, SMT and TB	
Training Recovery Plan	Team switching staff incrementally to an amber rating giving 3 months to complete training Recovery plan on TASI	Training venues Executive team approval to incremental approach to annual updates Task and Finish Group	BILD
Flexible workers	Equal priority on mandatory training		
Training Venues	Training room identified at The Lodge		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
4	New Action: Monitor transition of TASI training back to yearly update arrangements and that all new starters have successfully completed the full suite of mandatory training.	Mar '25	PT	Assurance	Monitoring through Accountability Framework meetings. Transition complete back to annual update, current TASI compliance is 91% Progress with new starters to complete suite of mandatory training, including additional training added, compulsory booking and communications strategy.
5	Provide TASI training to bank who have joined EPUT temporary workforce.	Sept '24	PT	Control	All bank staff compulsory booked to attend by the end of May '24. Any 'did not attends' will be picked up in arranged training prior to target date of Sept '24. 1071 (59%) trained for TASI (Bank)

CRR77: Medical Devices

Risk Description: If EPUT does not fund resources and the deep dive to address the clinical rationale/ pathway for medical devices, then unsafe, non-serviced, non-calibrated and inappropriate devices remain in use, resulting in a failure to achieve our safety first, safety always strategy, and reputational damage

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L4 = 16*	*C4 x L2 = 8*	**Note:** Previous reported completed actions 1, 6-8 have been removed from the report. **Note:** A reassessment of the risk is underway to assess the impact of the improved asset register function and service records with potential to reduce the risk score.

Executive Responsible Office: Executive Nurse
Director Lead: Angela Wade
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Corporate Nursing Team and Datix Team including Head of Deteriorating Patient and Clinical Governance.	Established Nominated Central Alert System person MDSO in post with dedication administrative support		
Medical Devices Group	Established	Overseen by Physical Health Sub-Committee	
Ergea contract for device maintenance	Medical Devices Group oversight of Monthly KPI Report		
Procurement process in place Medical Devices Policy	eQUIP Asset Register	Tendable audits – medical device safety / management	Internal Audit Report 2021/22 (Moderate / Limited Assurance)
Incident Reporting	In place		
Business Continuity Plans	Ergea BCP		

	Actions (to modify risks)	By When	By Who	Gap	Update
1a	Implement the solutions from the outcomes of the deep dive	Extended Aug '24	NA	Control	Management actions concluding. Remaining action associated with actions detailed below.
2	Options appraisal for Capital replacement programme and Medical device replacement strategy	Complete	NA	Control	Medical device replacement strategy approved by Executive team 15 Jan '24. All medical devices now have an 'end of life' time stamp and for each annual planning cycle will feed into Capital programme for prioritisation. Medical Devices equipment that is marked 'end of life' on the asset register is subject to risk assessment for approval of its continued use or removal for the clinical areas. Action complete and now in business as usual processes for capital planning on an annual basis.
4	Medical Device Management training ensuring staff know that they have a responsibility to ensure pieces of kit are calibrated	Extended Sept '24	NA	Control	Ongoing and part of the training - Responsibilities of staff groups on training will be stated in new SOP

Actions (to modify risks)		By When	By Who	Gap	Update
CRR77 Continued Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
5	Introduce point of care testing quality assurance process to avoid use of equipment that is not calibrated or serviced	Extended Aug '24	NA	Control	Exploring working in partnership with MSEFT for the provision for quality assurance programme. In process of procuring new devices to support the programme.
9	Tender contract for medical devices programme.	Sept '24	NA	Control	Tender for contract will commenced April '24, with timeline for completion Sep '24. The current contract runs to the 31 Dec '24.
10	To enhance the Medical Devices Policy with detail of risk assessment for equipment marked as 'end of life' to support continued use in a clinical area.	Extended Aug '24	AB	Control	Policy scheduled for review and technical approval through the Physical Health Steering Group and then for final ratification at Policy Oversight and Ratification Group in the first week of August 2024. RAG rated amber due to delays in approvals process as a consequence of delay in consultation on the revised document.
11	To deliver management actions from the IA of medical devices management at ward / service level (2023/24)	Jan '25	NA	Control	Management actions being progressed.

CRR81: Ligature

Risk Description: If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions

Initial Risk Score C4 x L4 = 16	*Current Risk Score* C4 x L3 = 12	*Target Score* C4 x L2 = 8	**Note:** Previous reported completed actions 2, 3, 5 and 6 have been removed for the report.

Executive Responsible Office: Executive Director Operations Director Lead: Nicola Jones / Moriam Adekunle Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Estates Ligature/ Patient Safety Co-ordinator H&S Team and Compliance Team LRRG / EERG Ligature Project Group	Teams established LRRG in place	LRRG reports Escalations via Accountability framework	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Policy and Procedure including environmental Standards	Ligature wallet audits / ligature inspections. Policy review and approval March 2023	Annual Report	BDO Audit November 2022 (Patient Safety) Design: Substantial; Effectiveness: Moderate
Ligature Training (target 85%) and Tidal training	TIDAL training. OLM prevention of suicide by ligature training – August 2023 – 88% compliance	Reporting to LRRG	
Trend Analysis	Benchmark 42 per 1000 bed days. EPUT Trend analysis April 21 – March 23 remain on average slightly above benchmark. Ligature analysis 2022-23 Report	Reporting to LRRG and BSOG	
Reduced ligature environment	Range of innovations in place including DTAs and Oxevision. Estates safety/ligature annual programme	Annual ligature inspection for all MH wards	
Learning from incidents and safety alerts via Lessons Team/ ECOL/ 5 key messages	Enhanced learning within annual reporting utilising deep dive data		Actions completed from the CQC Brief Guide
Local Area Ligature Network and Awareness and ownership of ligature reduction work	Network Established		
Support for staff	Support package developed – debriefing facilitated by Nursing in Charge/ Ward Manager/ Matron/ Service Manager/ Clinical Lead/ Consultant (or other member of Senior Medical Team)	Here for You – signposting for individual follow up Input from Psychological Services Patient Safety Team facilitates 'cold' debrief in the form of after action review for staff support	

Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**

1	Identify new system for recording ligature actions (overseen by Project Group)	Complete	SP	Control	LRRG agreed to new Environmental standards with new ways of recording. Proposal agreed and action complete. New action to review policy and put new system in place.
Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update**
4	Further roll out of environmental improvements	Complete	MM	Control	Roll out complete for 2023-24.New risk stratification document developed identifying improvements prioritised for 2024-25. this is now a BAU process Recommending to Executive Team/ Lead that action is closed
6	Pilot the project for a year followed by evaluation (in house training)	Complete	Project Group	Control	Action complete with new training proposal approved by Executive Team. New action to roll out training (see action 8).
7	Implement new environmental standards with new way of recording maintenance breaches only on 3i	Jul-24	SP	Control	Ligature policy including new environmental standards and inspection SOP has been updated with new process and following consultation has been approved. New audit tool developed and with pilot with 'go live' July 2024. New capture to distinguish actions which are maintenance requirements has been put in place. Assessment of action for closure is
8	Roll out new ligature training	Jul-24	Project Group	Control	Roll out of new training programme commenced in May 2024 (507 staff trained). Skills drills (following training) are arranged in all inpatient areas from Sept '24 Recruitment of additional trainers to support delivery underway

CRR92: Addressing Inequalities

Risk Description: If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L4 = 20	*C4 x L3 = 12*	*C3 x L2 = 6*	**Note:** Previous reported completed actions 1, 2 and 3 have been removed from the Board report. **Note:** Action 6 is complete and will not feature in future reports.

Executive Responsible Office: Executive Director People and Culture Director Lead: Lorraine Hammond Board Committee: PECC	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Employee Experience Team including Director	Established and 6 Employee Experience Managers in post. Working with VAPR and safety teams		
Equality and Inclusion Policies	Policy and Procedures in place	Governance - Equality & Inclusion Sub-Committee and reporting to PECC	
Range of equality networks and staff engagement methods	Networks Established Executive Sponsors		
Training (inc. RISE Programme)	Workshops on micro-incivilities completed RISE Programme in place	RISE (3 cohorts completed with positive staff feedback)	
WRES and WDES	WRES and WDES plans in place Executive Sponsorship of plans		
EDI Culture	Ongoing programme in place to Nov 24 Supporting staff affected by discriminatory behaviour, abuse and bullying		
Behaviours Framework	Behaviour Framework in place		
EDI Framework RAG system	Framework developed		

	Actions (to modify risks)	**By When**	**By Who**	**Gap**	**Update**
4	Improve the environment of psychological and physical safety for staff. Address racial abuse and sexual safety at EPUT.	Mar '25	LH	Control	Sexual safety phone line now operational 24 hours a day, seven days a week. Managers have also been reminded of their role in supporting staff who have reported any issues of this nature and on call directors are enrolled into Level 2 Safeguarding Training. We are working with staff to co-design a road map on how the Trust should respond to all incidents of violence and abuse. In addition we are working with Peer Support Workers and patients to gain an understanding as to why violence and abuse may occur on wards and what can be done to reduce incidents.

Actions (to modify risks)		By When	By Who	Gap	Update
5	Implement the EDI framework as part of NHS England EDI plan (including new Leadership Behaviour Toolkit)	Extended Dec '25 To align with NHS England EDI Improvement Plan	LH	Control	Executive EDI objectives have been set and agreed through Remuneration and Nominations Committee. The Leadership Behaviour Toolkit has been developed and is being socialised.
6	Update the Equality Inclusion and Human Rights Policy (Reference CP24)	Complete	LH	Control	Equality Inclusion and Human Rights Policy (Reference CP24) has been fully approved.

CRR93: Continuous Learning

Risk Description: If EPUT does not continuously learn, improve and deliver service changes, then patient safety incidents will occur and vital learning lost resulting in failure to achieve our safety strategy ambitions and maintain or improve CQC rating.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C5 x L3 = 15	*C5 x L3 = 15*	*C5 x L2 = 10*	**Note:** Previous reported completed actions1, 3-5 and 7 have been removed from the report. **Note:** The confirmation of the risk reduction to target score is undergoing evidence review at the time of writing this report.

Executive Responsible Office: Executive Nurse
Director Lead: Moriam Adekunle
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Patient Safety Incident Management Team (PSIM)	Established (some vacancies) Deputy Director in post	Governance Structure in place Training in place	
Quality and Safety Champions Network	84 People registered (June '23)		
Learning Collaborative Partnership and Learning Oversight Committee	Forums in place	Safety of Care Group and QC Reporting	Pan Essex CQRG
Adverse Incident Policy incl. PSIRF SOP and People and Culture Policies	Policy and Procedures in place		
Culture of Learning Project	Culture of Learning Programme live	Safety of Care Group and QC reporting	IA - Learning from the Independent Inquiry (Mar '23) Design Moderate and Effectiveness Moderate
Themes allocation to clinical / assurance / transformation groups			
Learning information sharing	Communications Plan Lesson Newsletter Internal Safety Alerts Champions Network		HSE (2021) CQC (2021, 2022) findings
Patient Safety Dashboard	Dashboard Live (Feb '23) Triage and early warning tool Power BI		

	Actions (to modify risks)	By When	By Who	Gap	Update
2	Develop and implement EPUT Safety and Lessons Management System (ESLMS)	Complete	MA	Control	Action complete and final handover from project team in week of 6 May '24.
6	Develop QI methodology	Complete	MA	Control	The model for QI has been reviewed and approved and is supported by a mixture of redeployed staffing resource, and training / development funding. The LifeQI Platform will continue to be available for local teams to document and track local quality improvement projects. The Transformation Team continue to provide QI skills training and coaching to a network of staff that include transformation team members, DDQS's Clinical and ops leads and Quality & Safety Champions.

CRR93 Continued Actions (to modify risks)		By When	By Who	Gap	Update
7	**New action** Assessment of the current Risk	August '24	MA	Assurance	This risk is currently static at 15. An assessment against the original scoping of the risk and comparison to today is being undertaken to identify what further actions will help to reduce the score.

CRR96: Loggists

Risk Description: If EPUT is unable to increase the number of trained loggists and increase hours available for 24/7 then there may not be sufficient loggists available to log a major incident resulting in poor decision / action audit trail in the event of a major incident.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L4 = 16*	*C4 x L1 = 4*	**Note:** Previous reported completed actions 1-2 have been removed from the report. **Note**: Assessing the impact of the new loggists on the risk score and confirming 24/7 access to loggist should this be needed, with assessment for closure of risk.

Executive Responsible Office: Executive Director Major Projects Director Lead: Nicola Jones , Director of Risk and Compliance Leads: Amanda Webb Board Committee: Quality Committee	**Controls Assurance**

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Pool of trained loggists, including EPRR Team and Executive Directors PAs	All EPRR incidents have been logged to date	Command structure	EPRR Core Standards Return and EPRR Annual Report 2022/23 notes number of EPRR events in 2022/23 and that appropriate response was stood up successfully.
Loggist Training	Available from NHS EoE and from in-house provision 21 Loggists available		
Major Incident Policy	Major Incident Policy in place		

	Actions (to modify risks)	By When	By Who	Gap	Update
3	Deliver Loggist training as per training needs analysis for new entrants on the Loggist register	Complete	NJ	Control	Trained loggists continue to increased (21 in place which is assessed to meet the threshold for delivery of a 24/7 response following declaration of an incident. The trained loggists within the Corporate Governance Team are available to cover out of hours if required). The action is now closed and risk assessment being reviewed for closure. We will continue a programme of Loggist training as both a refresher and to continue to bolster our numbers.

CRR98: Pharmacy Resource

Risk Description: If EPUT is unable to fill new and pre-existing positions within Pharmacy Services, then it may not be able to deliver a comprehensive Pharmacy Service to Trust patients, resulting in delayed treatment, poor clinical outcomes and possible patient harm.

Initial Risk Score	*Current Risk Score*	*Target Score*	**Note:** Following a review of business continuity plan as a consequence of new starters in February '24 , the likelihood score driving the change from a 4 (likely) to a 3 (possible) with a revised risk score of 12.
C4 x L4 = 16	*C4 x L3 = 12*	*C4 x L2 = 8*	

Executive Responsible Office: Executive Nurse
Director Lead: Tendayi Musundire
Leads: Tendayi Musundire
Board Committee: Quality Committee

Controls Assurance

Key Controls	Level 1 (Management)	Level 2 (Oversight)	Level 3 (Independent)
Pharmacy Team	Vacancy Factor high New posts to support new registrants	Executive Team - provided additional funding for pharmacy resources.	Collaboration with HEE and HEIs to develop a sustainable pipeline of staff CQC (July 2023) Must Do Action
Use of band and agency staff	Support from ICB secondment of pharmacist part-time		
Support from Patient Experience Team			
Rolling recruitment programme	£300k additional substantive staffing agreed - implementation in progress to fill posts	Performance reporting	
Business Continuity Plan	Using Datix Dashboard for pharmacy related incidents and monitored by pharmacy		

	Actions (to modify risks)	By When	By Who	Gap	Update
1	Continue with recruitment campaign	Ongoing	HS	Control	Recruitment campaign remains ongoing and continuing to see recruitment with clear pipeline running throughout 2024. 24.3 current vacancies (including the 9 WTE Time to Care provision) To note due to our successes over the past two years and the demand for pharmacists and technicians being high we have experienced leavers to promotions or posts closer to home for the individuals. Hence the recruitment campaign will continue on an ongoing basis.

CRR99 Safeguarding Referrals

Risk Description: If EPUT is unable to manage the increase in safeguarding referrals then it may not adequately assess patient needs resulting in compromised patient safety, wellbeing and compliance with safeguarding best practice and regulation.

Initial Risk Score	*Current Risk Score*	*Target Score*	
C4 x L4 = 16	*C4 x L2= 8*	*C4 x L2 = 8*	**Note:** Previous reported completed actions 1-2 have been removed from the report. **Note**: Assessment has confirmed that the target score has been met following the completion of all actions and improving the controls for the management of safeguarding demands. This risk has now been de-escalated from the CRR and will be monitored through the Nursing and Quality Risk Register going forward. And will not feature in future BAF reports.

Executive Responsible Office: Executive Nurse Director Lead: Tendayi Musundire Leads: Tendayi Musundire Board Committee: Quality Committee	**Controls Assurance**		
Key Controls	**Level 1 (Management)**	**Level 2 (Oversight)**	**Level 3 (Independent)**
Trust Safeguarding Team	Gap: Vacancies within Safeguarding Team	Local system to monitor child safeguarding case involvement	IA - Safeguarding Arrangements opinion reasonable assurance (2023/24)
Safeguarding Policies and Procedures	Policy and Procedure in place		CQC Inspection
Prioritisation for oversight of S17, S47, MAPPA and MARAC attendance at appointments and involvement in reports, as well as attendance at statutory meetings on behalf of doctors.	Prioritisation and monitoring in place		
Safeguarding Training	Training in place ad monitored	Accountability Framework Metric Performance Reporting	
Caseload Management	Team Managers monitor caseloads and circulate monthly caseload reports to Operational Teams	Safeguarding Reports	
Datix Reporting	Datix amendments for sign off and categories		
Southend Unitary Reporting Authority Open Referrals Closed	Completed 19 May '23		

Actions (to modify risks)		**By When**	**By Who**	**Gap**	**Update 17/01/24**
3	Incorporate safeguarding forms into patient records	Action on monthly touchpoints pending full introduction of the portal.	TM	Control	Essex County Council changed how all safeguarding adult referrals were to be received. As of 1st May concerns are now raised on the ECC portal directly, printing off the completed form and adding this to patient records. Thurrock and Southend remain on EPUT paper forms. Safeguarding planning forms are now live on Paris. Work is ongoing to get the form on

CRR99 Continued Actions (to modify risks)		By When	By Who	Gap	Update 17/01/24
4	Explore options to establish Associate Safeguarding Practitioners to assist Care Co-Ordinators to facilitate safeguarding (adult patients)	Complete Mar '24	TM	Control	Recruitment into all clinical posts is complete to establishment within the Safeguarding Team. New business support structure has been implemented. From 1st of May we are fully staffed to that structure.
5	Develop action plan to share with Southend UA to ensure all future open referrals are signed off	Complete	TM/ DP	Assurance	Action complete with handover of S75 being achieved and new agreed safeguarding processes in place.

Risk Movement

June 2024

EPUT

Risk Movement and Milestones

Strategic Risk Movement – two year period (July 22 – Jun 24)

Risk ID	Initial Score	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Au 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	
SR1 Safety	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	**15↔**
SR2 People	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	**20↔**
SR3 Infrastructure	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	**15↔**
SR4 Demand	20	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	15↓	15↔	15↔	**15↔**
SR5 Inquiry	20	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	16↓	16↔	16↔	**16↔**
SR6 Cyber	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	**15↔**
SR7 Capital	20			New	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	**20↔**
SR8 Resources	15			New	15↔	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	**15↔**
SR9 Digital	20																			New	20↔	15↓	15↔	15↔	15↔	**15↔**

Risk Movement and Milestones

Corporate Risk Movement and Milestones – two year period (July 22– June 24)

Risk ID	Initial Score	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	
CRR11	16	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12 ↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR34	9	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15 ↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	close					
CRR45	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16 ↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	**12↔**
CRR77	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16 ↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	**16↔**
CRR81	12	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16 ↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	**12↔**
CRR92	20	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12 ↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	**12↔**
CRR93	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15 ↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	**15↔**
CRR94	16	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20 ↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	**20↔**
CRR95	20			15	15↔	15↔	15↔	15↔	12↓	12↓	Close																
CRR96	16						New	16↔	16↔	16↔	16↔	16↔	16 ↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	**16↔**
CRR98	20							New	20	20	20	20	20 ↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	12↓	12↔	12↔	12↔	12↔	**12↔**
CRR99	16						New	16↔	16↔	16↔	16↔	16↔	16 ↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	08↓	8↔	8↔	**8↔**

8.2 EMERGENCY PREPAREDNESS AND RESILIENCE ANNUAL REPORT

Information Item | NL | 5

REFERENCES

Only PDFs are attached

EPRR Annual Report August 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Emergency Preparedness, Resilience And Response Annual Report**					
Executive Lead:	Nigel Leonard Executive Director of Special Projects and EPRR AEO					
Report Author(s):	Amanda Webb Emergency Planning and Compliance Manager					
Report discussed previously at:	HSSC / Safety of Care Committee / Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

✓ **please use this tick on the below**

Risk Assessment of Report			
Summary of risks highlighted in this report	EPRR training availability by NHSE Availability of trained Loggists (currently escalated to Corporate Risk Register)		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~Yes~~/ No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	~~Yes~~/No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with assurance that EPUT has effective organisation resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity issue. The report provides evidence of the Trusts achievements and continued commitment to the organisational resilience during 2023-24 in order to meet the requirements of the Civil Contingency Act 2004 and NHS England's Emergency Preparedness, Resilience and Response Framework 2022.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1. Receive and note the contents of the report
2. Request any further information or action

Summary of Key Points

EPUT is compliant with all of its statutory duties under the Civil Contingencies Act 2004 and associated Cabinet Office Guidance. The Department of Health and Social Care (DHSC) requires all NHS Trusts to be prepared to a category 1 responder and EPUT has systems and processes in place to be prepared to this level and fulfils its civil protection duties.

The Trust has a nominated Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard). The Chief Executive Officer, Paul Scott holds overall responsibility. There is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning supported by Amanda Webb, Emergency Planning and Compliance Manager for day to day actions

Following the “self- assessment” and the “confirm and challenge” for the NHS England EPRR Core Standards 2022-23 that was led and monitored by the Mid and South Essex Integrated Care Board (MSE ICB), the position reported is that of substantial compliance having reached 96.5% against the 2023/24 Core Standards for EPRR.

All Business Continuity Plans for inpatient services and non-critical sites are currently being reviewed and are stored both locally and centrally by the EPRR team.

EPUT has undertaken EPRR exercised in line with National Guidance.

Training has continued in 2023/24 utilising both internal and external courses available. An internal course has been developed and tested in order to meet the Minimum Occupational Standards, aiding the development of EPUT Loggists.

The Emergency Planning and Compliance Manager has successfully passed the Level 4 Diploma in Health Emergency Preparedness, Resilience and Response in March 2024.

The EPRR Workplace has continued to be progressed throughout 2023/24. Outstanding actions will be transferred into the 2024/25 workplan.

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

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	✓

Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed		**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
EPRR	Emergency Preparedness Resilience and Response	BCP	Business Continuity Plans
RAAC	Reinforced Autoclaved Aerated Concrete	NHSE/I	NHS England and NHS Improvement
ICS	Integrated Care Systems	ICB	Integrated Care Boards
LRF	Local Resilience Forum	LHRP	Local Health Resilience Partnership
ICC	Incident Control Centre	BAU	Business as usual

Supporting Reports and/or Appendices

Emergency Preparedness, Resilience And Response Annual Report

Executive Lead:

Nigel Leonard
Executive Director
Major Projects & Programmes

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT 2023-24

EPUT

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL REPORT

24 May 2024


NHS

CONTENTS

INTRODUCTION

PURPOSE

The purpose of this annual report is to provide assurance that EPUT has robust and effective organizational resilience measures in place to respond to a Major Incident, Critical Incident or Business Continuity event.

This report also presents evidence of the Trust's achievements and continued commitment to organisational resilience during 2023-2024.

ACCOUNTABILITY

The NHS Act 2006 (as amended) places a duty on relevant service providers to appoint an individual responsible for discharging their duties under section 252A. This individual is known as the Accountable Emergency Officer (AEO) who is an Executive Director of the Board (Nigel Leonard) and Deputy AEO who is a Non-Executive Director of the Board. However, the Chief Executive Officer, Paul Scott holds overall responsibility.

In addition, there is a dedicated EPRR team, which is led by Comfort Sithole, Head of Compliance and Emergency Planning, supported by Amanda Webb, Emergency Planning and Compliance Manager for day to day actions and duties.

RELEVANT GUIDANCE

This report confirms that the Trust is compliant with all its statutory duties under The Civil Contingencies Act 2004 and associated Cabinet Office Guidance and other relevant legislation and guidance such as:

1. The NHS Act 2006
2. The NHS Constitution
3. The requirements for EPRR as set out in the NHS Standard Contract(s)
4. NHS England EPRR guidance and supporting materials including:
5. NHS England Core Standards for Emergency Preparedness, Resilience and Response
6. NHS England Business Continuity Management Framework (service resilience)
7. Other guidance available at http://www.england.nhs.uk/ourwork/eprr/
8. National Occupational Standards for Civil Contingencies
9. BS ISO 22301 Societal security – Business continuity management systems

NHS ENGLAND EPRR CORE STANDARDS 2023-2024

As part of the NHS Emergency Preparedness Resilience and Response (EPRR) Framework, NHS England seeks annual assurance that NHS funded services are prepared to effectively respond to emergencies and are resilient in relation to continuing to provide safe patient care. The NHS EPRR process concludes with a submission to the NHS England Board and assurance is provided thereafter to the Department of Health and Secretary of State for Health.

NHS England Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR and are split into ten domains:

1. Governance
2. Duty to risk assess

3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN)

A self-assessment of compliance with the national EPRR core standards is required to be submitted on an annual basis providing assurance that the Trust is meeting all standards and supply relevant evidence on request.

Following the "self-assessment" and the "confirm and challenge" that was lead and monitored by the Mid and South Essex Integrated Care Board (MSE ICB), the position reported is that of substantial compliance having reached 96.5% against the 2023/24 Core Standards for EPRR. 56 out of the 58 EPRR Core Standards have been assessed as compliant, with 2 having been assessed as partially compliant (meaning the Trust aims to achieve compliance within 12 months).

Core Standards	Total applicable	Fully compliant	Partially compliant	Non-compliant	Agreed actions
Domain 1: Governance	6	6			
Domain 2: Duty to risk assess	2	2			
Domain 3: Duty to maintain plans	11	11			1
Domain 4: Command and Control	2	2			1
Domain 5: Training and exercising	4	3	1		1
Domain 6: Response	5	5			
Domain 7: Warning and informing	4	4			
Domain 8: Cooperation	4	4			
Domain 9: Business Continuity	10	10			
Domain 10: CBRN	10	9	1		1
TOTAL	58	56	2		
Overall compliance (%)	95.6%				

The 2023/24 EPRR annual deep dive focused on EPRR responder training. EPUT was assessed as fully compliant.

Deep Dive	Total applicable	Fully compliant	Partially compliant	Non compliant	Agreed actions
Training	10	10			

The table below illustrates the 2 standards assessed, as "partially compliant" and the action required which has been taken forward:

Domain	Core Standard	Action	Timescale	Update
Domain 4: Command and Control	Trained on-call staff	Continue to escalate and seek improvements regarding on-call (particularly at a GOLD level) training compliance, with the AEO raising the importance of said training at a senior level.	March 2024	Action Complete 40% Executive Team 62% Director on Call Further staff scheduled to attend during 24/25 due to limited courses being made available
Domain 10: Hazmat/CBRN	Exercising	Continue the roll of out of these exercises across the whole organisation.	March 2024	Action Complete Details provided as part of the 'Tabletop exercise' section

During the assurance process, the following areas of good practice were identified:

- Effective use of the EPRR core standards self-assessment document throughout the year to track EPRR compliance and ongoing improvements made against the standards.
- Very comprehensive EPRR annual report to the organisation's board.
- Strong links between the EPRR responsible NED and the audit committee process
- Process for assessing and tracking newly identified risks, including maintaining a watching brief.
- Overall Governance process for EPRR and Risk Management.

CIVIL CONTINGENCIES ACT 2004

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level.

Under Section 1 of the CCA 2004, an "emergency" means:

(a) An event or situation which threatens serious damage to human welfare in a place in the United Kingdom;
(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;
(c) War, or terrorism, which threatens serious damage to the security of the United Kingdom.

For the NHS, incidents are classed as either:

- **Business Continuity Incident** - an event or occurrence that disrupts, or might disrupt, an organisations normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

- **Critical Incident** - any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions

- **Major Incident** - is an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. For the NHS this will include any event defined as an 'emergency' as detailed above.

An additional Incident specific to EPUT;

- **High Profile Incident** is a Trust definition for any incident that requires executive level oversight but does not fall into BCP critical or major incident.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies).

Category 1 responders are those organisations at the core of emergency response and are subject to the full set of civil protection duties:

1. Assess the risk of emergencies occurring and use this to inform contingency planning
2. Put in place emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance co-ordination
6. Cooperate with other local responders to enhance co-ordination and efficiency

The information contained throughout this report provides assurance in terms of how the Trust is meeting these duties as a Category 1 responder.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Davis

RISK ASSESSMENTS

The Civil Contingencies Act 2004 places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. EPUT is a member of both Bedfordshire Local Resilience Forum (BLRF) and Essex Resilience Forum (ERF) that undertakes this activity.

The purpose of the Community Risk Register is to reassure the communities of Bedfordshire and Essex that the risks of potential hazards have been assessed, and that preparation arrangements are undertaken and response plans exist.

The top five risks currently identified on both Risk Registers relate to

- Influenza-type disease (pandemic) / major outbreak
- Emerging infectious disease
- Malicious Attacks
- Chemical, Biological, Radiological, Nuclear, and Explosive materials (CBRNE) Incident
- Low Temperatures and Snow

The Trust's approach to emergency planning ensures that we would be in a position to respond appropriately in the event of an incident relating to those significant risks identified in the community risk registers. The Trust also uses its standard risk management framework and processes to identify any specific local risks relating to business continuity / resilience and these are managed in line with standard Trust risk management processes.

The Trust has developed a number of detailed plans to address the significant risks identified in the Local Resilience Forums' community risk registers. These align, where appropriate with Local Resilience Forum plans for the same incident types.

MAJOR INCIDENT PLAN

A Major Incident Plan has been developed by EPUT that details the role of EPUT in a major incident and how this role fits with those of other NHS organisations and the emergency services.

The Major Incident Plan is formally reviewed at least every three years, but is under continual review to ensure any required amendments are made to reflect learning, changes within the health sector, the Trust or Emergency Planning legislation.

CYBER SECURITY

The Trusts position on Cyber is report to the Finance & Performance Committee on a monthly basis by the Information Governance and Cyber Risk Teams. The report provides assurance that the trust has the appropriate protection and controls to prevent theft, loss or damage, via manual or electronic means, in place to secure data, devices, services and networks.

The overall trust Cyber BAF risk rating of **15** has not changed.

"If we experience a cyber-attack, then we may encounter system failures and downtime, resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage."

Likelihood based on the prevalence of cyber alerts that are relevant to EPUT systems. Consequence based on assessed impact and length of downtime of our systems

Initial risk score	Current risk score	Target risk score
C5 x L4 = 20	C5 x L3 = 15	C4 x L3 = 12

BUSINESS CONTINUITY PLANS

The Business Continuity Plan is the tactical document that supports the Major Incident Plan and ensures that in the event of a business interruption, the organisation will be able to maintain critical activities and restore normal business activities as soon as possible given the circumstances prevailing at the time.

As a provider service, the Business Continuity plan is the key plan within our Organisational Resilience planning. This plan underpins all other plans as it prioritises our critical activities and allows us to effectively manage our business whatever the incident may be, including Pandemic Flu, Severe Weather and Industrial Action etc.

To underpin the organisational Business Continuity Management Procedure, all services across EPUT have developed Business Continuity plans that:

- prioritise their service activities into 5 levels of priority from critical activities which need to be restored within 1 hour, through to activities which can be progressively restored after 7 working days;
- Detail the strategies for continued delivery of these activities.

Work progressed in 2023/4 to review and ensure local and central storage of all Trust Business Continuity Plans for inpatient services and non-critical sites. BCP compliance at the end of 2023/24 is outlined in the table below:

	% in date	Overdue	Total
Corporate	17%	30	36
Urgent Care & Inpatient Services	27%	27	37
Specialist Services	91%	2	23
Community Delivery Mid & South Essex	71%	16	56
Community Delivery West Essex	72%	8	29
Community Delivery North Essex	100%	0	15
Psychological Services	27%	8	11

The EPPR team continue to work with the care groups to ensure that compliance with updating BCPs is maintained and a follow up has been undertaken to all those requiring the annual review in order to improve the compliance rate.

COMMUNICATIONS PLAN

A well-informed public is better able to respond to an incident. To minimize the impact of any incident on the community, it is vital to ensure consistent messages that are appropriate to the needs of the audience are communicated effectively.

The Trust has a Communications Plan in place that ensures a timely relay of messages in the event of an incident. There are various means available for utilization i.e. Pando, WhatsApp, intranet, cascade text messages, resilience direct etc.

PARTNERSHIP WORKING

Under the CCA 2004, cooperation between local responder bodies is a legal duty and working jointly with partner agencies is critical to ensuring effective emergency planning and response. It is thus important that, as well as coordination within individual NHS organisations, the planning for incidents is coordinated between health organisations and at a multi-agency level with partner organisations.

During 2023/24, EPUT continued to attend and work collaboratively with NHSE/I, ICBs and other Trusts via Strategic and operational local resilience heath forums with representation from the EPRR team.

LOCAL RESPONDERS

Local Resilience Forums

Local Resilience Forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others (i.e. Category 1 Responders, as defined by the Civil Contingencies Act).

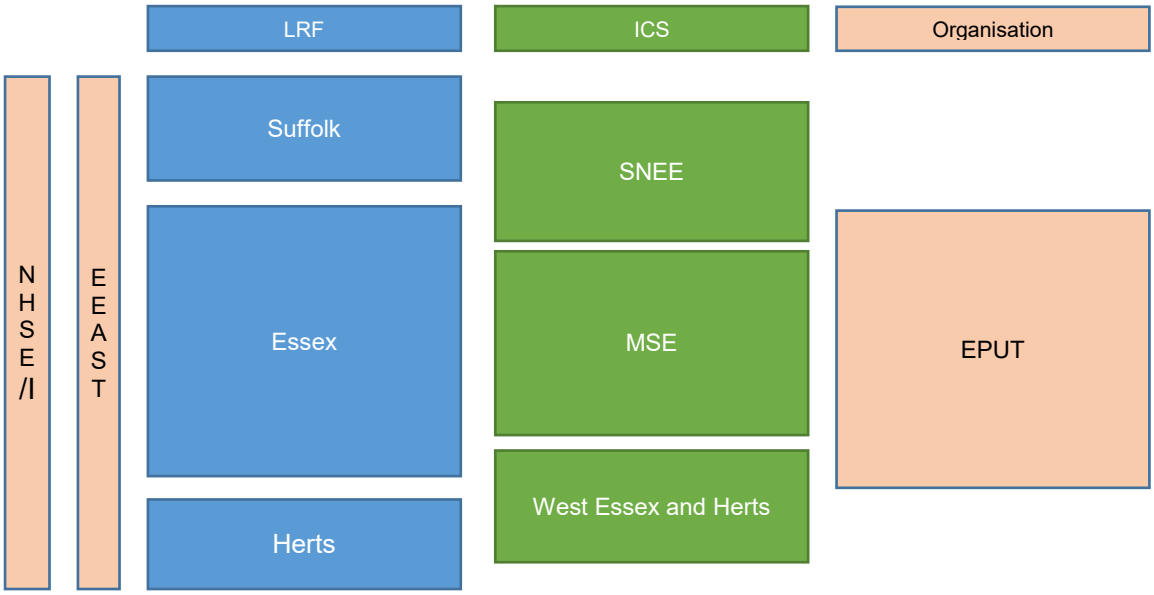
The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

An NHS England representative represents the Trust at the Bedfordshire Local Resilience Forum and Essex Resilience Forum, along with all other NHS providers. Two-way feedback into and from the LRFs is facilitated via Local Health Resilience Partnerships.

Local Health Resilience Partnerships (LHRP)

Local Health Resilience Partnerships (LHRPs) were established in August 2012 across the country as part of 'The Arrangements for Health Emergency Preparedness, Resilience and Response from April 2013' published by the Department of Health in March 2012.

Their purpose is to deliver the national Emergency Preparedness, Resilience & Response (EPRR) strategy in the context of local risks. They bring together the health sector organisations involved in EPRR at the Local Resilience Forum (LRF) level and provide a forum for coordination, joint working and planning for emergency preparedness and response by all relevant health bodies. The LHRPs' footprints map to the LRFs. They therefore offer a coordinated point of contact with the LRF and reflect a national consistent approach to support effective planning of health emergency response.



During 2023/24 the Trust has kept abreast of the work of the LHRPs and attended regular meetings for the three LHRPs

- Essex LHRP – this is the main forum for EPUT attendance
- West Essex and Hertfordshire LHRP
- SNEE EPRR Forum is in place of the LHRP Working Group in Suffolk and covering health and social care EPRR within the SNEE ICS

EPRR EXERCISES

National Guidance states that as a minimum requirement, NHS organisations are required to undertake the following exercised:

- Communications - every six months
- Table top - every year
- Live Play - every three years
- Command Post - every three years
- ICC Equipment test - every three months

COMMUNICATIONS EXERCISE

Exercise Flamingo – May 2023

Exercise Flamingo was an in-hours, no-notice, communications exercise held on the 25th May 2023 to test the ability to cascade an incident alert through the agreed incident cascade channels from the national, through regions and Integrated Care Boards to provider level.

EPUT responded in a timely manner with no issues identified.

Exercise Dial – September 2023

Exercise Dial was undertaken on the 25th September 2023; in collaboration with NELFT, in order to test the ICC resilience to ensure the ICC is ready to stand up should it be needed to co-ordinate an incident. As part of the exercise, NELFT tested EPUT's ability to

No issues were identified.

Throughout 23/24; communications is tested internally and by the ICB's however these are not formally documented. In the event the ICB has encountered any issues, an email is sent to the EPRR team to review.

TABLETOP EXERCISES

Exercise Winter Solstice – November 2023

Exercise Winter Solstice was a virtual system-wide winter readiness exercise held on the 21st November 2023. The purpose of the exercise is to support the Mid and South Essex ICS's preparations for Winter 2023-24 and support the implementation of the new OPEL Framework.

The Trust is still awaiting feedback from the ICB therefore will report any lessons learned upon receipt.

CBRN – Jan / Feb / March 2023

Following communication to the Admin / Reception area staff across the Trust, a tabletop exercise on the base of response to various questions was put in place to test knowledge and understanding in order to identify any further action that is required. A full report has not been collated yet however the initials findings have been identified:

- All staff were able to identify the Remove, Remove, Remove campaign.
- All staff took appropriate immediate action in regards to notification, however a limited number confirmed they would put on Datix, however it was discussed that this wouldn't necessarily be an immediate action.
- All staff were able to identify a suitable area within their working location to remove the individual to
- All staff were able to identify challenges that they face within their working location / environment such as other patients / staff / visitors in the area, availability of a suitable location (if they need to utilize a room)
- Although not all staff quoted who they should contact first, in regards to being notified of a major incident, as per the Major Incident Policy, upon reflection, as admin / reception area staff they would not necessarily contact the EPRR team direct, they would go via their line manager.

COMMAND POST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident.

The Trust have maintained a virtual Incident Control Centre. In 2023/24, Command continued to be held via Microsoft Teams with an electronic log maintained by a team of trained Loggists with the support of the EPRR team as required.

There were 11 EPRR events/incidents during 2023/24 whereby the virtual command post was stood up to successfully to manage the event/incident.

Exercise Dial – September 2023

Exercise Dial was undertaken on the 25th September 2023; in collaboration with NELFT, in order to test the ICC resilience to ensure the ICC is ready to stand up should it be needed to co-ordinate an incident.

EPUT responded in a timely manner with no issues identified.

ICC EQUIPMENT TEST

The Trust has processes in place within the EPRR team to ensure that the Incident Control Centre (ICC) at both The Lodge and the Hawthorn Centre is ready to be used in the event of a major incident. The equipment and rooms are checked quarterly to ensure they are ready to be used at any time. The checks include

room suitability, telephone lines, major incident paperwork, stationary box and loggist folders. The checks are documented for auditing purposes.

N.B – A number of exercises were planned during 2023/24; however had to be cancelled due to the managing and dealing with the Industrial Action Live BCP incidents.

EPRR EVENTS (incl Lessons Learned)

Coronavirus: January 2020 to May 2023

On the 19th May 2023, the NHS incident level for Covid-19 stepped down from Level 3.

EPUT command was formally stood down on 12th April 2023 due to no updates, decisions or approvals to be made for a substantial period of time. This was formally agreed by Gold Command with the understanding that it could easily be stood up if required.

The (virtual) Incident Control Centre (ICC) is still monitored in core business hours supported by the EPRR team with any urgent escalations out of hours managed by the Director on call via the contact centre.

The regular sit rep submissions required by the Centre continue, namely the National Covid daily sitrep (including weekends), Community discharge weekly sit rep, the regular patient Lateral Flow Testing numbers and Long Covid activity, are now being submitted by the Performance Team as part of business as usual.

EPUT reporting of Covid-19 positive cases continues to be managed by the IPC Team as part of business as usual. Communication was issued across the Trust to remind staff of the correct process to follow to report any RIDDOR reportable Covid-19 cases.

Due to Covid-19 no longer being a live incident, closure of the C19 Incident

Mailbox was recommended in line with partner trusts, and a Covid-19 incident debrief process developed to formally close the Incident for EPUT.

Junior Doctor Industrial Action 2023/24 (BCP Incident)

Lessons identified following the Industrial Actions held in 2022-23 Q4 enabled successful management of further industrial action undertaken. A critical incident was not declared by EPUT in Q1, however, a briefing command structure was set up to identify and mitigate any potential risks.

During Q2, a number of Industrial Actions that took place:

- 0700 13th to 0700 19th July - Junior Doctors
- 0700 20th to 0700 22nd July – Consultant
- 0700 11th t0 0700 15th August - Junior Doctors
- 0700 24th to 0700 26th August - Consultant
- 0700 19th to 0700 21st September - Consultants
- 0700 20th to 0700 23rd September - Junior Doctors

After incident debrief identified the positives as follows:

- Industrial action was managed well
- Command Structure process
- Engagement across Care Groups and Business Units which supported the mitigation plans
- Partnership working with JNC members
- Sitrep reporting (pre / during)
- Increased publication and communication
- 'Thank you' from Gold Command and Paul Scott

In Q3, there was one Junior Doctors Industrial Action that took place 0700 20th to 0700 23rd December; however planning occurred for a 2nd 0700 3rd January to 0700 9th due to time-period.

In Q4, there was one Junior Doctors Industrial Action that took place 0700 24th to 2359 28th February 2024. This was confirmed as a full stoppage of work.

The Trust was advised that the East of England region had declared an NHS Incident Level 3 for the industrial action. This was enacted in response to the potential for disruption, risk to critical services and impact on patients and staff following Industrial Action from BMA's Consultants and Junior Doctors.

EPUT reflected on the notification of NHS Incident Level 3 and agreed no further action as we had already established Command meetings as and when required. This ensured effective management over action, including risk identification, escalation and mitigation.

Heatwave Q1 2023/24 (BCP Incident)

A Yellow Heat Health Alert was issued for East of England on the 7th June from

9th to 12th June. This increased to an Amber Alert on the 8th June for the same time period. An amber alert means 'Met Office confirms heatwave (30 during day 15 overnight)'.

The Trust initiated the Heatwave Plan. A critical incident was not declared by EPUT

Generator Issue – Basildon Mental Health Unit Q3 (BCP Incident)

In Q3, an ongoing generator issue at Basildon Mental Health Unit resulted in a number of power cuts to the site leading to a secondary generator being ordered, delivered and connected. The site was powered by the secondary generator with no back up as the primary generator couldn't trip back on the mains when required. A watching brief was initiated.

Repair works to the primary generator were confirmed and were expecting to last 7 days with a potential risk of the site losing power. Assurance was provided to services with the main building having battery power and by having Estates on site at all times ensuring power outage would be minimal. The main risk identified was the ECT suite, with a high consequence should power be lost during treatment. To mitigate the risk, Basildon Hospital agreed theatre space for ECT treatments during repair works.

Mains power and primary generator were restored by 7th December following substantial testing.

Learning from Incident:
As per BCP, the Estates Department managed the incident well. Processes for support services to notify the EPRR Team where an incident is identified were reviewed to ensure robustness. As per policy, any issue that impacts the operation of any of the services across the Trust, should be reported to the EPRR for Command support in the event of a Business, Critical or Major Incident requiring to be declared.

Group G Streptococcus Q4

The Infection Prevention and Control (IPC) Team first reported a period of increased incidence of patients with Group G Strep infection on 18 January 2024. Patients were being cared for in South Essex Community Services. Working collaboratively with the services, local and regional partners, the IPC team managed the incident via incident management meetings.

Incident / Event Management

During 2023/24; there have been a number of potential incidents that EPRR have proactively managed to ensure an internal incident did not occur.

- Ride London

- Rail Strikes
- RAAC Lighthouse
- Mobius (Electronic Patient Record System) Downtime

Prior to the events; details were circulated asking Services to review the potential Impact and what mitigations they were to put in place.

TRAINING 23/24

An EPRR Training Framework has been designed and implemented within the EPRR Team to monitor the compliance with the Minimum Occupational Standards.

During the year a number of Organisational Resilience training courses have been completed by EPUT staff:

Internal Training

General Awareness Training

E-learning resources in relation to organisational resilience & response and Business Continuity Plans are available on the Trust's intranet. Introduction training is provided as part of the Risk Management section on the mandatory staff induction course whereby compliance is monitored via the Workforce Development Team.

External Training

Principles of Health Command Training (Previously Strategic Commanders Training) (Gold)

This programme is run by NHS England (East) and provides those who may become involved in managing a major incident response with appropriate knowledge and skills to undertake the role. A number of directors and staff are trained and up to date with their training.

- 40% Executive Team
- 62% Director on Call
- 100% EPRR Leadership

A limited number of courses were made available from NHSE/I.

Loggist Training

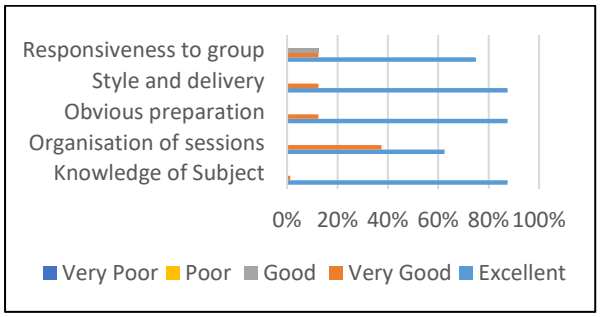
This programme is run by NHS England and the Joint Commissioning Team (based on Public Health England Loggist training) and provides staff with the knowledge and skills to be able to undertake the role of loggist Public Health England Loggist training) and provides staff with the knowledge and skills to be

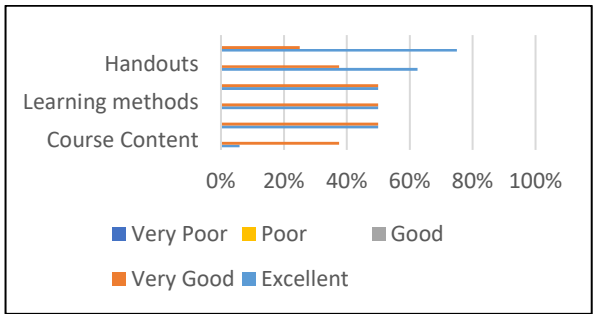
able to undertake the role of loggist in a Major Incident Response Team. A fundamental role within any major incident is that of the loggist: the person who is responsible for capturing, through decision logs, the decision-making process that might be used in any legal proceedings following an incident.

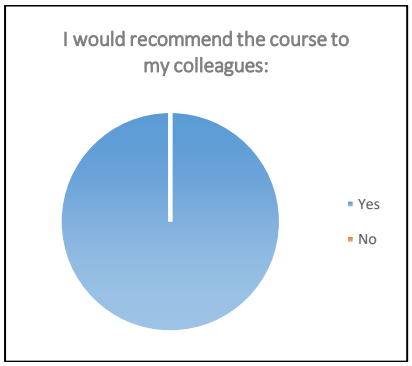
A Loggist must be available for all Gold Commands. Therefore, it is vital that a bank of individuals are available to cover the Loggist role in the event of a major incident.

Due to the limited availability of the national courses, an internal course has been developed and tested; in order to meet the Minimum Occupational Standards, aiding the development of EPUT Loggists, with the first course held with members of the Risk & Compliance directorate in Q3. A further 3 course have been held with more scheduled for 24/25 as part of an ongoing training programme. The Trust has 17 trained and in date Loggists; in addition to 2 Loggists requiring refreshers when the next course is held.

The internal course has been well received with positive feedback:







A proposal was put forward in Q3 to increase the number of trained Loggists, to mitigate the open corporate risk identifying a lack of trained Loggists in the Trust due to a number of factors. The proposal was approved by the Executive Team and work is underway to implement the approved recommendation.

Level 4 Diploma in Health Emergency Preparedness, Resilience and Response

The Diploma in Health Emergency Preparedness, Resilience and Response Programme has been available since 2005 and is recognised as the leading qualification for Health Emergency Preparedness, Resilience and Response professionals.

The Emergency Planning and Compliance Manager commenced the Level 4 Diploma in Health Emergency Preparedness, Resilience and Response in April 2023 and has successfully passed.

Level 4 Award in Health Emergency Preparedness, Resilience and Response

In Q3, the Trust submitted an expression of interest for a place on the Level 4 Diploma in Health Emergency Preparedness, Resilience and Response to develop and support the EPRR Team within EPUT. This was accepted and the Compliance Assistant will commence the course in Q1 2024/25.

EPRR WORKPLAN

EPRR Work plan for 2023/24 was developed to incorporate the actions required to fully comply with the Core Standards in addition to development actions identified by the EPPR Lead.

It should also be noted that during 2023/24 there were the following significant achievements by the EPRR team:

- Successful Core Standards Self-Assessment and Check and Challenge process
- Ongoing cover of the ICC, Covid19 outbreak and sitrep submissions.
- Support of incidents including preparation and organisation of Gold and Silver Commands.
- Implementation of the after action review to capture good practice, lessons learned in addition to review of BCP following the incident / exercise / event.
- The Senior Emergency Planning and Compliance Officer successfully passed the Diploma in Health Emergency Preparedness, Resilience and Response Programme.
- Regular attendance and participation within the three Local Health Resilience Partnerships (LHRPs)
- Developed networking and sharing of EPRR planning/resources with NELFT
- Improved connections with the three ICB EPRR Leads
- Involvement in regional exercises
- Effective managed of EPRR events to prevent escalation to Critical Incidents

ASSURANCE

The Health, Safety & Security Committee holds responsibility for and oversees delivery of the Trusts annual Emergency Planning, Resilience and Response work plan.

The committee is chaired by the Director/Associate Director of Risk & Compliance and includes representatives from all services areas. The Committee meets bimonthly and considers progress against the work plan as a standing agenda item on a quarterly basis.

A quarterly EPRR report is provided to the Trust Quality Committee, a standing committee of the Trust.

EPRR risks have been highlighted in 2023/24 and have been escalated to appropriate risk registers and included on the Board Assurance Framework presented to the Trust Board of Directors.

The Executive Director and Non-Executive Director who lead on EPRR have been actively involved in the EPRR work required in 2023/24 and have provided support to the EPRR Team.

Essex Partnership University NHS Foundation Trust

Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Tel: 0300 123 0808

8.3 INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2023/24

Information Item | AS | 5

REFERENCES

Only PDFs are attached

IPC Annual Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	07 August 2024

Report Title:	**Infection Prevention and Control Annual Report 2023/24**					
Executive Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Katheryn Hobbs, Head of Infection Prevention & Control					
Report discussed previously at:	Safety of Care Group, Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		✓
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with assurance of Infection Prevention and Control activity during the last financial year using the National IPC Code of Practice criteria.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Confirm acceptance and assurance given in respect of the risks and actions identified
3. Request any further information or action

Summary of Key Points

The aim of the Infection Prevention and Control (IPC) service is to ensure that all patients are provided with care in a clean safe environment by staff members who are competent and engaged with IPC.

The IPC team have continued to provide specialist advice to all levels of the organisation including clinical and non-clinical colleagues, not only as the nation has moved to a business as usual approach to Covid-19, but in relation to all other IPC matters. Any Covid-19 related decisions have been made by the Director of Infection Prevention and Control (DIPC) and the Head of IPC to align changes in national guidelines. The Trust Command structure was formally stood down in relation to Covid-19.

Assurance of compliance with the Code of Practice has been provided through regular updating of the Board Assurance Framework, which has been reviewed bi-monthly and reported through Quality Committee.

The IPC team are committed to ensuring learning from individual cases and outbreaks of health care associated infection. Learning is shared not only within the Trust but more widely across the health care system. Reflections and learning have been shared directly with those involved in cases, as well as via the Trust learning culture platform and the monthly IPC newsletter.

In order to provide assurance of compliance with the Hygiene Code an audit programme is undertaken each year, in part by the IPC team members and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, cleaning, and mattresses are audited. The auditing of inpatient services has become more robust during the last year. Focus has also been given to understanding the challenges faced by staff working in community settings including patients own homes. This has supported the development of a community services audit tool which is currently being piloted. A similar approach will be followed for providing assurance in relation to outpatient clinical settings in the coming year.

The IPC team play an active role in essential safety committees including water quality, ventilation safety, medical devices and harm free care. A quarterly Infection Prevention and Control Group (IPCG) meeting is held as a part of the wider clinical governance structures within the organisation, which includes engagement of key stakeholders. From April 2024 onwards the IPCG will transition to align with the Trust quality framework, providing an opportunity to review terms of reference, membership and structure of the meeting.

Our commitment to closer working with our care partners has seen us have regular discussion and policy alignment with our partners in the Mid and South Essex Community Collaborative, taking into consideration differing needs of the sovereign organisations. The desired outcome is a smoother patient journey across Essex. EPUT is the lead provider for IPC within our Mid and South Essex (MSE) Community Collaborative, and continue to work closely with commissioning and provider colleagues across the whole geographical area of the Trust on a regular basis.

The team have continued to provide training for staff as part of the Trust Induction Programme. Ongoing mandatory training is provided via e-learning where the national IPC training is provided. Ad-hoc training sessions have been arranged for clinical teams as the IPC team has increased in number. The team held two successful IPC conferences in Autumn 2023, for colleagues from inpatient and community services, both of which were well attended. Delegates demonstrated a high level of engagement and commitment to supporting improvement in IPC in their work place. The education provided at the conferences is being supplemented on a continual basis as monthly IPC Link Champion events which have been held since January 2024. The team would like to thank a staff member who demonstrated her commitment to improving patient safety and speaking up at the first forum, as she highlighted a concern which prompted the identification of a period of increased incidence of infection in the community. A summary of this situation is detailed within the report.

The Trust has acknowledged the impact that the IPC team have had during the pandemic period and as a result agreed to commit to a programme of recruitment into the team which was completed in early 2024.

Each care unit within the Trust now has an IPC Nurse supporting them, providing colleagues and patients with a broad spectrum of knowledge and skills within the specialism.

Key Infection Prevention and Control achievements are identified within the main report.

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

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

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

Acronyms/Terms Used in the Report			
IPC	Infection Prevention and Control	MSE	Mid and South Essex
IPCG	Infection Prevention and Control Group	EPUT	Essex Partnership University NHS Foundation Trust

Supporting Reports and/or Appendices
Infection Prevention & Control Annual Report 2023-2024

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Infection Prevention and Control ANNUAL REPORT 2023-2024

EPUT

CONTENTS

EXECUTIVE SUMMARY

The purpose of this report is to provide assurance that the Trust delivers a robust, proactive and effective Infection Prevention and Control (IPC) service; and can demonstrate complaince with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This assurance also extends to the Care Quality Commission's quality statements.

It is important to acknowledge the contributions made to this report by key stakeholder colleagues both within the IPC team and wider organisation.

The report outlines the achievements and activities in relation to IPC across the organisation during the year and includes the work and audit programme for 2024/2025.

The aim of the IPC service is to ensure that all our patients are provided with care in a clean safe environment by staff members who are competent and engaged with IPC.

The IPC team have continued to provide specialist advice to all levels of the organisation including clinical and non-clinical colleagues not only as the nation has moved to a business as usual approach when managing those infected with Covid-19, but in relation to all other IPC matters. Any Covid-19 related decisions have been made by the Director of Infection Prevention and Control (DIPC) with the Head of IPC to align changes in national guidelines. The Trust command structure was formally stood down in relation to Covid-19 in line with national changes in guidelines.

Assurance of compliance with the code of practice has been provided through regular updating of the IPC Board Assurance Framework, which has been reviewed bi-monthly and reported through Quality committee.

The IPC Team are committed to ensuring learning from individual cases and outbreaks of health care associated infection. Learning is shared not only within the Trust but more widely across the health care system. Reflections and learning have been shared directly with those involved in cases, as well as via the Trust learning culture platform and the monthly IPC newsletter.

In order to provide assurance of compliance with the Hygiene Code an audit programme is undertaken each year, in part by the IPC Team members and in part self-audit carried out by clinical teams. Key elements such as the environment, hand hygiene, cleaning, and mattresses are audited. The auditing of inpatient services has become more robust during the last year. Focus has also been given to understanding the challenges faced by staff working in community settings including patient's own homes. This has supported the development of a community services audit tool which is currently being piloted. A similar approach will be followed for providing assurance

in relation to outpatient clinical settings in the coming year.

The IPC team play an active role in essential safety meetings and groups including water quality, ventilation safety, medical devices and harm free care. A quarterly Infection Prevention and Control Group (IPCG) meeting is held as a part of the wider clinical governance structures within the organisation, which includes engagement of key stakeholders. From April 2024 onwards the IPCG will transition to align with the Trust quality of care governance framework, providing an opportunity to review terms of reference, membership and structure of the meeting.

Our commitment to closer working with our care system partners has seen us have regular discussion and policy alignment with our partners in the Mid and South Essex Community Collaborative, taking into consideration differing needs of the sovereign organisations. The desired outcome is a smoother patient journey across Essex. EPUT is the lead provider for IPC within our Mid and South Essex (MSE) community collaborative, and continue to work closely with commissioning and provider colleagues across the whole geographical area of the Trust on a regular basis.

The team have continued to provide training for staff as part of the Trust induction programme. Ongoing mandatory training is provided via E-learning where the national IPC training is provided. Ad hoc training sessions have been arranged for clinical teams as the IPC team has increased in number and aligned team members to the Trust's care units. The team held two successful IPC conferences in autumn 2023, for colleagues from inpatient and community services, both of which were well attended. Delegates demonstrated a high level of engagement and commitment to supporting improvement in IPC in their work place. The education provided at the conferences is being supplemented on a continual basis as monthly IPC Link Champion events have been held since January 2024. The team would like to thank a staff member who demonstrated her commitment to improving patient safety and speaking up at the first forum, as she highlighted a concern which prompted the identification of a period of increased incidence of infection in the community. A summary of this situation is detailed within the report.

The Organsation has acknowledged the impact that the IPC team have had during the pandemic period and as a result agreed to commit to a programme of recruitment into the IPC team. This was completed in early 2024. Each care unit within the Trust now has an IPC Nurse supporting them, providing colleagues and patients with a broad spectrum of knowledge and skills within the specialism.

Key Infection Prevention and Control Achievements in the organisation:

- The IPC team have continued with the robust response to requests from the National Government, UKHSA, NHS England in relation to the ongoing management and stepping down of the COVID 19 pandemic
- Provision of expert advice and leadership on the management of nosocomial outbreaks of infection within the organisation
- Bi-monthly review and submission of the national board assurance framework
- Maintained levels of support in relation to all related IPC issues/ queries
- Supportive site visits for clinical and non-clinical staff and provided

bespoke responses to team IPC needs

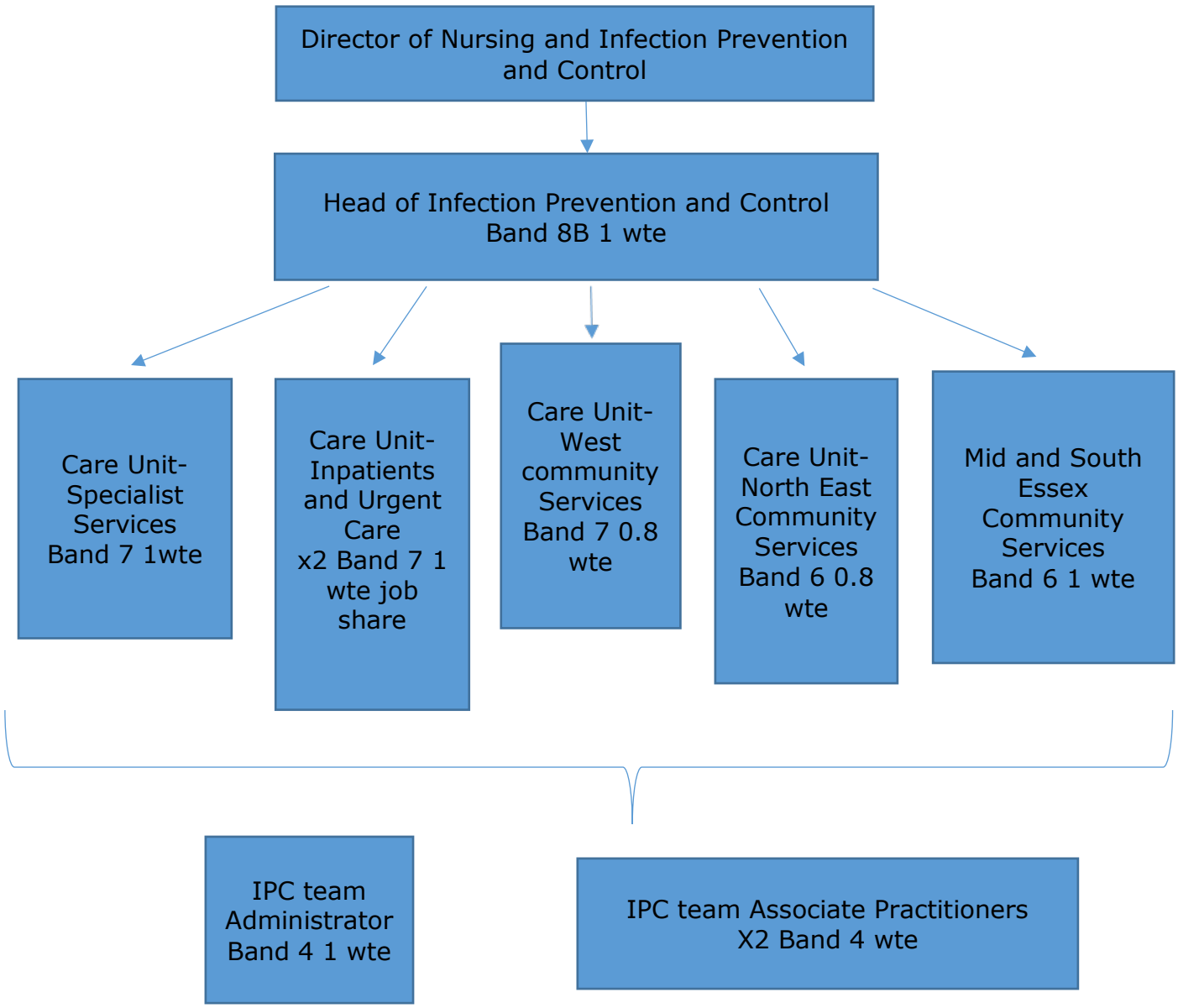
- Carried out yearly IPC audits as per the annual audit programme in order to assist teams in identifying and actioning areas of good practice and improvement in accordance with evidence based best practice and national technical memorandum standards
- Supported the Trust estates teams in refurbishment and change of use projects, providing advice to align with the national health technical memorandums to ensure health care standards are met when changes of use or refurbishment projects are in the planning stages
- Attendance at and provision of expert IPC advice at the Trust water and ventilation safety committees
- Review of inpatient IPC audit programme, including the creation of an overarching IPC audit tool for monthly completion by clinical teams
- Development and pilot of community services auditing tool in order to support improved practices
- Worked alongside our ICB colleagues and community collaborative partner organisations to secure staff testing services as required during periods of increased incidence or outbreaks of infection
- Collaboration with ICB specialists in urinary catheter care in order to support reduction in gram negative infections as well as work towards evidence based best practices across the system
- Active member of the harm free care group focusing on the physical health of patients within our care
- Placement provided by the IPC team for one of the Trust international nurses during 2023 giving them an opportunity to learn about the specialty and evidence based best practice
- Worked in collaboration with estates colleagues to review clinical hand wash sink provision within the organisation, leading to the replacement of in order to meet current health technical memorandum standards
- Review of fit testing programme of staff for respiratory protection masks and continuation with the provision of fit testing across the organisation
- Continued support of the Antimicrobial Stewardship Group led by Pharmacy
- Contact with over 500 staff during hand hygiene week in May 2023 followed by roadshows on site during IPC week in Autumn 2023
- Hosted two IPC conferences for Trust staff in November 2023 which, was well attended with staff who demonstrated real engagement with IPC
- Established a monthly IPC Link Champion forum as an education and Q&A platform from January 2024
- On discussion with community nursing colleagues, a group now meets on a regular basis as an opportunity for staff to review patients with the IPC team who have longer term infections/ colonisation such as MRSA
- The community collaborative has developed a forum for Band 6 IPC nurses tonetwork across the geography of Mid and South Essex

- Support of the Trust facilities team on the development of the Trust response to the National Cleaning Standards
- Support of the staff influenza vaccination campaign which was led by EPUT vaccination teams
- Lead provider of the MSE community IPC collaborative work stream working to unify aspects of IPC standards and policy across Essex
- Delivery of the Trust induction programme for staff including face to face sessions for international colleagues joining the organisation
- Provision of adhoc training sessions in the workplace for staff
- Creation of a monthly IPC newsletter providing updates, education and lessons learned whilst out in the clinical departments
- The mass vaccination teams have offered COVID 19 vaccinations both to staff and patients in mass vaccination centres, inpatient and care home settings and patient's own homes
- Provided expert IPC advice to EPUT teams working with migrant populations across the geography of the trust
- Support of Trust tender processes in relation to waste and laundry management as well as Occupational Health services
- Review of IPC guidelines
- Updating of patient information leaflets
- Joint IPC, E+F and Clinical leaders walk rounds

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

The Trust has acknowledged the key role that IPC teams play in the provision of safe care for patients and reduction of risk to staff. As a result of this recognition, the IPC team have successfully recruited into the team. The new structure of the team aligns with the organisation strategy of a care unit/ specialty approach.



Role of the IPC team members within the Care Units:

- Work in collaboration with the Deputy Directors of Quality and Safety (DDQS) for the Care Unit.
- Establish a good understanding of the services provided in the care unit and build positive working relationships with the staff in order to increase staff engagement and therefore, quality of care
- Spend approximately 50% of the working week in clinical departments, supporting practice, ad-hoc education, case review
- Visit sites within the care unit to complete annual environmental audit and action planning which will inform training/ teaching requirements
- Support clinical teams with their auditing and reporting into KPI including provision of narrative when required
- Delivery of appropriate IPC training sessions as required by the care unit, driven by local and national direction
- Support the DDQS in providing robust reporting into the IPCC and other relevant committees including HCAIS reporting
- Support fit testing of the staff in the care unit , in line with the organisational PPE risk assessment
- Support the delivery of the annual influenza vaccination programme
- Assist in IPC winter planning for the care unit
- Attend Care Unit Quality and Safety Meetings ensuring IPC is on the agenda and reported on at each meeting with the aim the DDQS will deliver IPC report by exception in the longer term
- Support team colleagues who may have competing work demands as required
- Monitoring of relevant incident reporting and action planning where appropriate
- Be open and available to take direction from other members of the senior nursing team in the absence of the Head of IPC
- Band 4 Administrator and Associate Practitioners support all team members as required

A service level agreement is in place with a Consultant Microbiologist who continues to work within the local acute Trust, and provides expert clinical advice to the organisation and on an individual basis when required.

A quarterly Infection Prevention and Control Group meeting is chaired by the DIPC or Head of IPC with key stakeholder attendance and engagement (including clinical and estates and facilities representation). The meeting is also attended by all three commissioning board colleagues. This meeting provides oversight and assessment of IPC assurance across the Trust.

IPC information training and supervision:

The IPC team deliver induction training as part of the Trust corporate induction programme.

Mandatory training is provided for all staff using the Oracle Learning Management Platform. The Trust has procured IPC training via the national skills for health programme to ensure training is updated in a timely way as changes in national guidelines are made, as well as to align with our partner community Trust organisations.

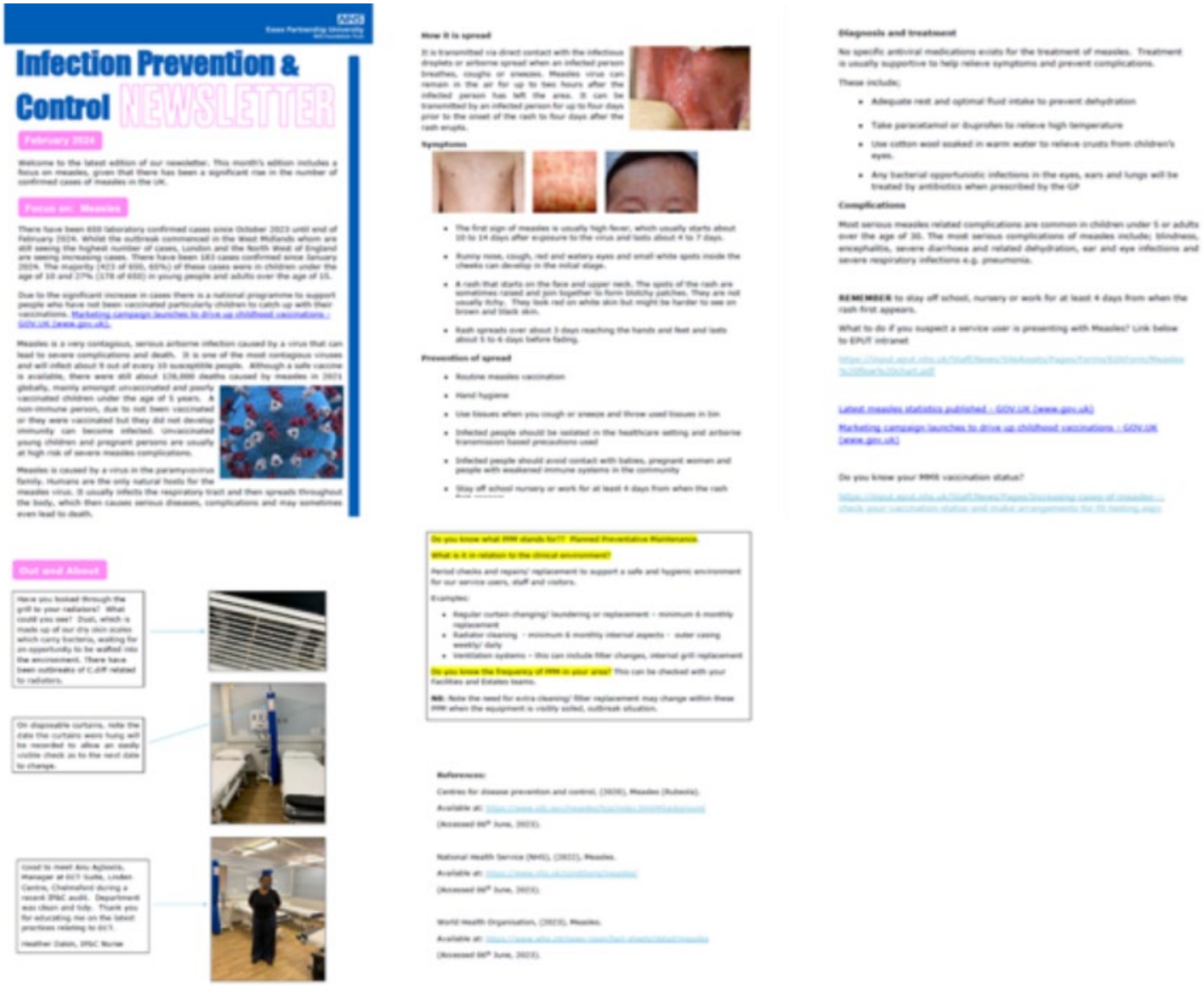
As of March 2024, the Trust training department have reported compliance with IPC mandatory training as follows:

1 Yearly mandatory training compliance	3 Yearly mandatory training compliance
93%	96%

Ad hoc training is delivered in the workplace by the IPC team as required, following audit, site visits or as part of lessons learned following incidents of health care associated infection or nosocomial outbreaks.

The monthly IP&C Newsletter is available on the intranet focusing on education relating to topics e.g. Measles identification and management. It is an opportunity to promote IP&C events, share good IP&C practice from clinical areas and share learning points from IP&C incidents.

It is promoted via the Link Champion forums and it is increasingly noted to see a printed off copy in clinical area offices. It is circulated via EPUT weekly communications once a month to reach as many staff as possible. An example of the newsletter can be seen below (for illustrative purposes);



Infection Prevention & Control NEWSLETTER

February 2024

Welcome to the latest edition of our newsletter. This month's edition includes a focus on measles, given that there has been a significant rise in the number of confirmed cases of measles in the UK.

Focus on: Measles

There have been 658 laboratory confirmed cases since October 2023 until end of February 2024. Whilst the outbreak commenced in the West Midlands whom are still seeing the highest number of cases, London and the North West of England are seeing increasing cases. There have been 183 cases confirmed since January 2024. The majority (403 of 658, 65%) of these cases were in children under the age of 10 and 27% (178 of 658) in young people and adults over the age of 15.

Due to the significant increase in cases there is a national programme to support people who have not been vaccinated particularly children to catch up with their vaccinations. Marketing campaign launches to drive up childhood vaccinations - GOV.UK (www.gov.uk).

Measles is a very contagious, serious airborne infection caused by a virus that can lead to severe complications and death. It is one of the most contagious viruses and will infect about 9 out of every 10 susceptible people. Although a safe vaccine is available, there were still about 128,000 deaths caused by measles in 2021 globally, mainly amongst unvaccinated and poorly vaccinated children under the age of 5 years. A non-immune person, due to not been vaccinated or they were vaccinated but they did not develop immunity can become infected. Unvaccinated young children and pregnant persons are usually at high risk of severe measles complications.

Measles is caused by a virus in the paramyxovirus family. Humans are the only natural hosts for the measles virus. It usually infects the respiratory tract and then spreads throughout the body, which then causes serious diseases, complications and may sometimes even lead to death.

Out and About

Have you looked through the grill to your radiators? What could you see? Dust, which is made up of our dry skin scales which carry bacteria, scabies for an opportunity to be wafted into the environment. There have been outbreaks of C.diff related to radiators.

On disposable curtains, note the date the curtains were hung will be recorded to allow an easily visible check as to the next date to change.

Good to meet Anu Agboola, Manager at NHT Suite, Linden Centre, Chelmsford during a recent IPAC audit. Department was clean and tidy. Thank you for educating me on the latest practices relating to NHT.

Heather Dalzin, IPAC Nurse

How it is spread

It is transmitted via direct contact with the infectious droplets or airborne spread when an infected person breathes, coughs or sneezes. Measles virus can remain in the air for up to two hours after the infected person has left the area. It can be transmitted by an infected person for up to four days prior to the onset of the rash to four days after the rash erupts.

Symptoms

- The first sign of measles is usually high fever, which usually starts about 10 to 14 days after exposure to the virus and lasts about 4 to 7 days.
- Runny nose, cough, red and watery eyes and small white spots inside the cheeks can develop in the initial stage.
- A rash that starts on the face and upper neck. The spots of the rash are sometimes raised and join together to form blotchy patches. They are not usually itchy. They look red on white skin but might be harder to see on brown and black skin.
- Rash spreads over about 3 days reaching the hands and feet and lasts about 5 to 6 days before fading.

Prevention of spread

- Routine measles vaccination
- Hand hygiene
- Use tissues when you cough or sneeze and throw used tissues in bin
- Infected people should be isolated in the healthcare setting and airborne transmission based precautions used
- Infected people should avoid contact with babies, pregnant women and people with weakened immune systems in the community
- Stay off school nursery or work for at least 4 days from when the rash

Do you know what PPM stands for?? Planned Preventative Maintenance.

What is it in relation to the clinical environment?

Period checks and repairs/ replacement to support a safe and hygienic environment for our service users, staff and visitors.

Examples:

- Regular curtain changing/ laundering or replacement – minimum 6 monthly replacement
- Radiator cleaning – minimum 6 monthly internal aspects – outer casing weekly/ daily
- Ventilation systems – this can include filter changes, internal grill replacement

Do you know the frequency of PPM in your area? This can be checked with your Facilities and Estates teams.

NB: Note the need for extra cleaning/ filter replacement may change within these PPM when the equipment is visibly soiled, outbreak situation.

References:

Centres for disease prevention and control. (2020). Measles (Rubeola).

Available at: https://www.cdc.gov/measles/hcp/index.html#References

(Accessed 06th June, 2023).

National Health Service (NHS). (2022). Measles.

Available at: https://www.nhs.uk/conditions/measles/

(Accessed 06th June, 2023).

World Health Organisation. (2023). Measles.

Available at: https://www.who.int/news-room/fact-sheets/detail/measles

(Accessed 06th June, 2023).

Diagnosis and treatment

No specific antiviral medications exists for the treatment of measles. Treatment is usually supportive to help relieve symptoms and prevent complications.

These include;

- Adequate rest and optimal fluid intake to prevent dehydration
- Take paracetamol or ibuprofen to relieve high temperature
- Use cotton wool soaked in warm water to relieve crusts from children's eyes.
- Any bacterial opportunistic infections in the eyes, ears and lungs will be treated by antibiotics when prescribed by the GP

Complications

Most serious measles related complications are common in children under 5 or adults over the age of 30. The most serious complications of measles include; blindness, encephalitis, severe diarrhoea and related dehydration, ear and eye infections and severe respiratory infections e.g. pneumonia.

REMEMBER to stay off school, nursery or work for at least 4 days from when the rash first appears.

What to do if you suspect a service user is presenting with Measles? Link below to EPUT intranet

https://input.eput.nhs.uk/Staff/News/SiteAssets/Pages/Forms/EditForm/Measles%20flow%20chart.pdf

Latest measles statistics published - GOV.UK (www.gov.uk)

Marketing campaign launches to drive up childhood vaccinations - GOV.UK (www.gov.uk)

Do you know your MMR vaccination status?

https://input.eput.nhs.uk/Staff/News/Pages/Increasing-cases-of-measles-...

check your vaccination status and make arrangements for fill lacking jags

IPC annual report 2023/24 Katheryn Hobbs Head of IPC on behalf of Angela Wade Director of Nursing and DIPC 10

Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Water Management:

This has been a challenging but positive year in regards to water management across the Trust. There have been a number of changes that the Trust has worked on and continues with.

1.1 – Water Risk Assessments

In line with the Trust Policy, the following sites have had new water risk assessments throughout this period:

- Basildon Mental Health Unit
- Crystal Centre
- Derwent Centre
- Edward House
- 5 Heath Close (Byron Court)
- Ipswich Road
- Kings Wood Centre
- Lakes
- Landermere
- Linden Centre
- 295 Long Lane
- Robin Pinto
- St Aubyn Centre
- Thurrock Hospital
- Woodlea Clinic
- Rochford Hospital
- Mountnessing Court
- All Saints House
- Brentwood Resource Centre
- Chelford Court
- Cherry Trees
- C&E Centre
- Clough Road
- Coach House Halstead
- Doolittle Mill
- Gables
- Gordon Road
- Grays Hall
- Harland Centre
- 1,2, 3, 4 & 4A Heath Closes
- Herrick House
- Holmer Court
- Hospital Road
- Independent Living Centre
- Knightswick Clinic
- Lakes Bungalow
- Maldon Clinic
- Northgate Centre
- Reunion House
- Rivendell Flats

- Sankey House
- Severalls House & Training Centre
- Sydervelt
- The Lodge
- Warrior House Kingsley Ward

Following completion of the Risk Assessments, market testing took place for the remedial programme via the Backlog Maintenance Programme due for completion by the end of March.

1.2 – Pre-Planned Maintenance Contracts

Following poor performance by the previous organisation, the Trust made the decision to terminate the pre-planned maintenance (PPM) contract early. An interim contractor was procured to cover the contract whilst a full market test took place.

The contracts were in line with HTM05-01 and L8 ACOP with specifications taken directly from the SFG20.

As opposed to the previous contract, the Trust moved to split the PPM programmes for market testing with a spate Lot for thermostatic mixer valve (TMV) servicing. Following a successful market test, 4i Water Services and Evolution were commissioned to take forwards water PPM contracts for the next 3 years.

Zetasafe

As part of the new PPM contract, the Trust procured its own license for the Zetasafe system to negate any risk of data property issues experienced in the previous contract.
Zetasafe is a cloud based system enabling contractors to upload data upon completion of PPM tasks along with service reporting.

This enables the Trust to evaluate compliance on water systems identifying any risks to be taken forwards under its Estates Reactive Maintenance programmes.

3.0 – Water Co-Ordinator

To support the new contracts procured as well as the new Zetasafe system, the Estates Compliance Team recognised the need to have resource available to enable correct co-ordination of Zetasafe.

A new Water Co-Ordinator role was created to evaluate Zetasafe and all PPM tasks including ones that were unable to be completed or non-compliant. The Co-Ordinator will work with Estates maintenance and Contractors, raising tasks on helpdesk to complete reactive tasks on PPM's highlighted as non- compliant.

The role also co-ordinates the WRA remedial programme and data provided in the Water Quality Group Report.

4.0 – Water Quality Group

The Water Quality Group have continued to meet on a bi-monthly basis with engagement and reporting now provided by both new water contractors as well as PFI organisations and NHS Property Services.

A new water reports detailing the status throughout the year has also been produced giving data on Zetasafe on both PPM contracts and remedial programmes.

5.0 – Water Management

The Trust has had to deal with a number of water issues on the following sites which has been successfully resolved:

- Saffron Walden
- Rochford Hospital

The Trust is continuing to resolve existing issues at the following sites.

Thurrock Meadowview

It was identified an issue with the buffer vessel resulting in non-compliant flow and return temperatures in the calorifier. Sampling on the site confirmed 3 rooms G05, G68, G42 with positive counts with one room being used as storage.

An action is included in the supporting documentation with the following works undertaken as part of the ongoing water management.

- Room G05 – 8 degree variance identified, Estates confirmed the flow adjusted to correct temp the variance. This will continue to be monitored.
- Flushing to G05/G68/G42 increased to daily.
- WHB in G68 locally disinfected.
- New Calorofier in process of being installed.
- Ongoing sampling of 3 rooms identified.
- Rooms G68 & G42 TMV's replaced.

Landermere

There have been ongoing issues with the hot water temperatures onsite over a 6 month period. Initial issues related to a boiler malfunction which has now been resolved however temperatures remain non- compliant. Complications around accessing the site Building Management System are in the process of being resolved with Contractors evaluating the site for any further plant issues.

Sampling has taken place with a number of outlets identified in the old Bernard ward.

An action plan has been created for implementation which has been included in supporting documentation. Further works are ongoing along with sampling of the remaining outlets without 3 clear sample results as per policy.

The following works have been undertaken as part of the ongoing water management:

- Bernard Ward – Removal of obsolete Showers IPS46 & IPS47.
- Tower Ward – Local Disinfection of Tower Ward Bedroom 8 WHB Mixed Hot IPS 14
- Ongoing evaluation of pre-planned maintenance schedules.
- Ongoing completion of WRA remedial programme.
- Increase in flushing programme on Bernard to x5 weekly.
- Cleaning of strainers on Calorifier and low loss header.
- Calorifier – Blow Down
- Calorifier – Replacement Drain Valve

St Margarets Hospital (NHS PS Building)

The Trust have been alerted to positive sampling by the landlords NHS Property Services, filters are in place on all outlets where positive legionella samples have been identified.

There are a number of outlets which continue to provide positive samples due to pipework between the filter and wash hand basins.

The Trust continue to work with NHS PS on solutions with a number of schemes in hand to resolve going forwards.

We acknowledge that this has impacted our patients and staff, and have mitigations in place to ensure their safety during this time. Patients, their families and operational colleagues have been kept up to date with the situation as it continues.

6.0 Future Plans Going Forwards

As well as continuing the above programmes, the Trust is also looking at innovative projects to improve further its water management programmes including new technology such as its plans to pilot electronic flushing monitoring via Zetasafe as well as concluding a project on installation of water temperature sensor on Building Management Systems across the Trust due for completion this March.

The Trust will continue to work with all partners inside and outside the Trust including its IPC Teams, Microbiologist, Authorised Engineers, Estates & Facilities and outside organisations to ensure the highest quality water management can be delivered to continue high quality care to its patients using all services across the Trust.

Estates Capital Projects 2023 2024 Programme:

Introduction

The Estates Capital Project Team delivered a number of projects in 2023/2024 including major refurbishments of Hadleigh Unit and the ECT Suite at Basildon Mental Health Unit with works currently continuing at Wood Lea Clinic in Bedfordshire.

During the reporting period, the Infection Prevention Control Team have continued to work with the project team on the design phase to reduce risks, providing expert advice with the types of fixtures and fittings, carrying out commissioning inspections and being involved in the signing-off process.

All of the capital projects undertaken this year have used Dulux Trade Sterishield paint, which is a quick drying, water-based coating containing an in-film active silver bactericide, which inhibits bacteria and reduces populations of MRSA and E. coli. when combined with appropriate cleaning practices, Sterishield paint helps to promote a more hygienic environment. It is a tough, scrubbable, durable, stain resistant paint.

The Capital Project Team have been providing the Clinical Teams with advice on style of furniture appropriate for the environment, taking into account all risks including those that may impact infection prevention and control. The Si-Leather can be cleaned with clean or soapy water as well as professionally cleaned with 23 different professional cleaning products.

When ordering office furniture for administration areas the Capital Project Team has ensured that all chairs are ordered in vinyl, which is easier to clean.

The Patient Safety Team have installed anti-ligature noticeboards across all of the wards, which has helped to cut down on the number of posters displayed and not cleaned.

Hadleigh Unit Refurbishment

With a spend of £1.9m for the Hadleigh Unit refurbishment, works commenced on the 5th June 2023 and completed on the 15th December 2023. The purpose of this project was to upgrade the existing environment for better patient experience and to the meet the Trust Risk Stratification standards to reduce potential ligature issues. Works included new flooring, redecorations and new ceilings, artwork to

the communal areas, modifications to the heating, ventilation and air conditioning systems and an upgraded Clinic Room. The unit now also benefits for Kingsway fully alarmed doors, Bridge soft en-suite doors and a larger seclusion room. The works were to a high specification, which included welded joints, cap and cover flooring in en-suites and clinical areas, mastic to all joins and washable paint throughout. The bedroom walls are fully white rocked so that they are wipable.

As part of the refurbishment, the seclusion walls and floor were coated in a resin coating so that the all surfaces of the room can be cleaned.

Basildon Mental Health Unit ECT Suite Refurbishment

Running parallel to this project was the ECT refurbishment at Basildon Mental Health Unit. These works included an upgrade to the ventilation system, new flooring, white rocked walls and new kitchenette. Mirroring the Hadleigh Unit works, all flooring was installed with cap and cove, welded joints and mastic around edges to allow for cleanliness. All surfaces have either washable paint, whiterock or gloss surfaces, which allows the Domestic Team to ensure this area, can be cleaned to high standard.

Wood Lea Clinic Refurbishment Works

In October 2023, works commenced on the refurbishment of Wood Lea Clinic in Broham, Bedfordshire to enhance the internal environment for the comfort and protection of our patients and to safeguard its future for its intended purpose. Works are currently on going and being carried out in phases with Phase 1 completed on the 12th April 2024, which included 4 bedrooms, clinic room, kitchen, laundry, de-escalation and shower room. Feedback from patients on the new bedrooms has been positive.

Phase 2 Works are currently taking place with the final phase 3 scheduled for completion on the 4th August and the unit to be fully operational by the end of August 2024.

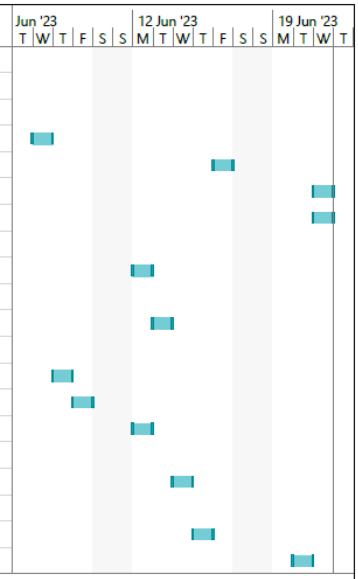
Other Infection Prevention Control Related Projects

The below projects were also completed in 2023/2024 with Infection Prevention Control Team involvement:

Project Name	Location	Completion Date
Grays Hall Clinic	Grays, Thurrock	March 2024.
Robin Pinto Bathroom to Shower Room Conversion	Luton	February 2024
Robin Pinto Bedroom Sink Replacement Project	Luton	March 2024

Sink Replacement Programme of Works 2023 2024

ID	Task Name	Duration	Start	Finish
1	**Sink Replacement Works**			
2				
3	**Thurrock Hospital**			
4	Meadowview Ward Sluice Room - Trovex Unit	1 day	Wed 07/06/23	Wed 07/06/23
5	Gloucester Ward Cleaners Store Room - Franke Janitorial Sink	1 day	Fri 16/06/23	Fri 16/06/23
6	Meadowview Ward Cleaners Cupboard - Franke Janitorial Sink	1 day	Wed 21/06/23	Wed 21/06/23
7	Meadowview Ward Cleaners Store - Countour 21 Mixer Tap	1 day	Wed 21/06/23	Wed 21/06/23
8	**Crystal Centre**			
9	Ruby Ward - Room G0147 - Thermostatic Tap	1 day	Mon 12/06/23	Mon 12/06/23
10	**Rochford Hospital**			
11	Cedar Ward - Clinic - Wall mounted Thermostic Tap	1 day	Tue 13/06/23	Tue 13/06/23
12	**Kingswood Centre**			
13	Gosfield Ward - Healthcare Room - Trovex Unit	1 day	Thu 08/06/23	Thu 08/06/23
14	Gosfield Ward - Clinic Room - Trovex Unit	1 day	Fri 09/06/23	Fri 09/06/23
15	Hennage Ward - Kitchen - Contour 21 Basin & Taps	1 day	Mon 12/06/23	Mon 12/06/23
16	**The Lakes**			
17	Ardleigh Ward - Kitchen - Trovex Unit	1 day	Wed 14/06/23	Wed 14/06/23
18	**Kingwood Centre**			
19	Emerald Unit - Cleaners Cupboard - Trovex Unit	1 day	Thu 15/06/23	Thu 15/06/23
20	Peter Bruff Ward - Old Sluice Room - Trovex Unit	1 day	Tue 20/06/23	Tue 20/06/23



Project: Sink Replacement Prog
Date: Fri 26/05/23

Task
Split
Milestone
Summary
Project Summary
Inactive Task
Inactive Milestone
Inactive Summary
Manual Task
Duration-only
Manual Summary Rollup
Manual Summary
Start-only
Finish-only
External Tasks
External Milestone
Deadline
Progress
Manual Progress

Page 1

Facilities:

The EPUT Facilities department, are responsible for ensuring that the Trust is delivering a high quality and safe environment that meets the needs and expectations of patients, the staff and public, contributing to the overall patient experience and high quality patient centered care.

Facilities deliver a high-quality Soft Facilities Management (FM) healthcare service that encompasses:

- Cleaning
- Catering
- Grounds Maintenance
- Portering
- Waste Management

The aim is to ensure that all Soft FM related risks are identified, minimised and managed on a consistent and long term basis.

Our service aims to:

- Be patient and customer focused
- Provide clarity for all personnel responsible for ensuring that the healthcare environment is safe and fit for purpose
- Enhance quality assurance systems
- Address governance and risks
- Be consistent with national and local IPC standards
- Have clear objectives that provide a foundation for service improvements
- Have the flexibility to meet the needs of specific healthcare environments and circumstances and priorities
- Well documented policies and procedures
- Provide a culture of continuous improvement
- Have the flexibility to meet the ongoing needs of operational service delivery

The above service delivery is enabled by the Facilities department's organisational structure, and their inter-dependencies across the department and wider trust. (Please see Appendix 1 for Facilities Organisational Chart)

Facilities Officers work across all functions of the Organisation, relying on specialist roles such as the Catering Manager / Food Safety Advisor / Waste Manager to undertake daily tasks in line with national standards and requirements and ensure that tasks are actioned in line with Risk Management and Infection Prevention and Control regulations.

All inpatient facilities and community clinics have a dedicated Facilities Officers as an initial point of contact, with support from site based Facilities Supervisors as day to day support to encourage full engagement with clinical colleagues to ensure that the facilities (Soft FM) enable a holistic, patient centered care to be delivered

by nursing and medical colleagues.

Domestic Services:

Domestic Services staff work across all areas of the Trust, making sure that all facilities and environments are clean and safe places where staff can care for patients while reducing the risk of infection.

The Domestic Services Staff provides a routine and responsive service in accordance with the National Standards of Healthcare Cleanliness. Staff are trained and adhere to, robust methods statements and Infection Prevention and Control (IPC) guidance.

The team is augmented by external contractors, managed by the Facilities Management Team, who undertake the window cleaning and pest control.

As far as practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness and by input from the Clinical teams.

We continue to review these considering changes to national IPC guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the new National Standards. Feedback is given to staff on the areas from these audits.

Annual Summary 2023/2024	North	South	West	Averages
Functional Risk Cat 2	96%	98%	97%	97.00%
Functional Risk Cat 3	95%	97%	96%	96.00%
Functional Risk Cat 4	93%	97%	96%	95.33%

Catering:

All healthcare organisations have a responsibility to provide the highest level of care possible for their patients, staff and visitors. This includes the quality, nutritional value and the sustainable aspects of the food and drink that is served, as well as the overall experience and environmental in which it is eaten.

EPUT recognises the intrinsic value in the view of 'food as medicine' and remains a prevalent subject on the Trust Agenda.

The Standards describe the methods by which organizations must ensure the quality and sustainability of their food and drink provision for patients, staff and visitors and how they should be applied and monitored, as well as recommending future improvements, aspirations and actions.

The Trust has implemented a number of measures to comply with the National Standard of Healthcare – Food and Drink including:

- The specific tailored food safety training, which is the process of being implemented across the Trust.
- Random food spot checks across all inpatient facilities.
- Food auditing firmly in place will all Environmental Health Officer inspections awarded at the highest mark of 5 star including revisits
- A trial of light meals completed on Tower Ward have indicated positive results.
- EPUT have undertaken a supplier site visit to the Bon Culina factory to gain further understanding of the food production process.
- A food council has been established with the Trusts main provider (Bon Culina) to progress catering requirements.
- Street Food demonstration has been commissioned at the St. Aubyn's Centre.

Progress continues to be monitored via internal departmental meetings.

Waste Management:

The total recycling rate for the trust in 2022/2023 was 6.56% of total domestic waste.

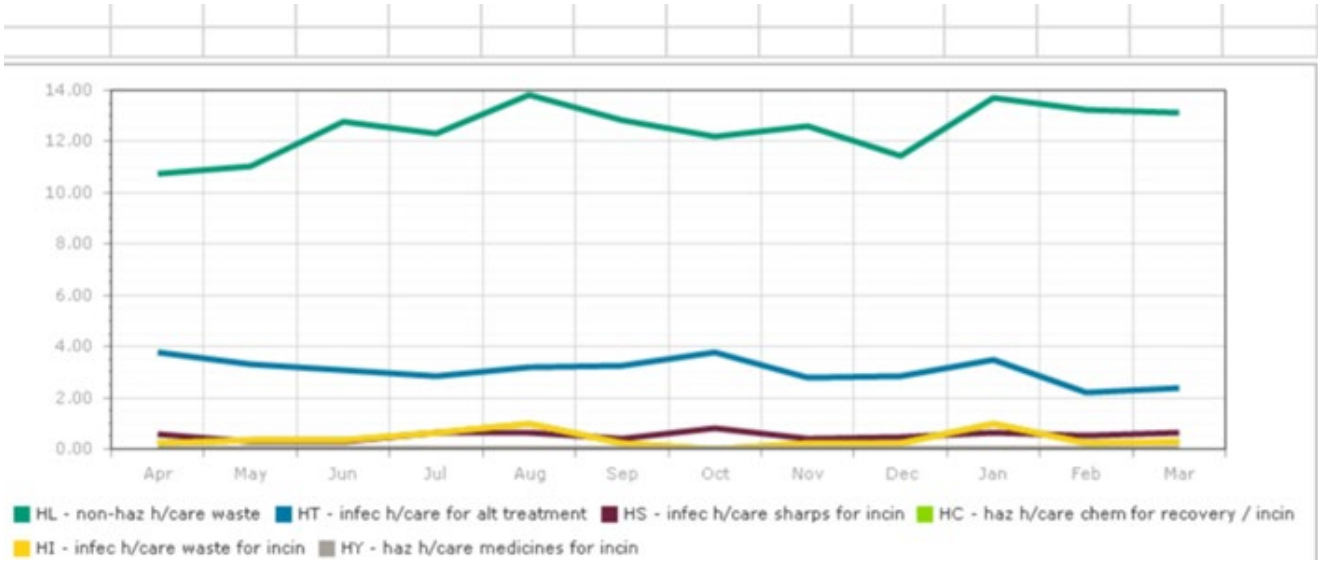
We can compare this to the recycling rate of March 2024 (The user portal currently just gives data from Feb 2024 onwards) which is currently 13.91%.

In 2022/2023 13 EPUT sites were without provision for the separation of Dry Mixed Recycling (DMR). Including St Margaret's which, is one of the Trust's biggest waste producers.

As it stands all EPUT sites have now had bins installed to facilitate this. Skips have been installed in St Margaret's to dispose of DMR

All domestic waste produced by EPUT is sent to diversion stations meaning it is processed for separation of recyclate, and ultimately sent to incineration for energy production. None of our waste is sent to landfill.

Below is the figures for the split of our clinical waste segregation:



This shows a yearly trend of surpassing the targets set out in HTM07-01.

- 78% of our clinical waste is sent to the offensive waste stream
- 18% is sent for alternative treatment
- 8% is sent for High temperature incineration

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship (AMS) is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. Antibiotics should never be prescribed or supplied for viral infections.

Antimicrobial prescribing continues to be audited within the organisation on an annual basis as part of the code of practice, which supports compliance with the Health and Social Care Act (2008). All prescriptions of antimicrobials within the organisation are governed by national and local prescribing guidelines, which advocate the use of specific antimicrobials for a specified period of time. Non-formulary antimicrobials are only available following advice from consultant microbiology colleagues in the local acute Trusts. These are not dispensed by pharmacy unless assurances are received that the prescription has been discussed and agreed. Prescriptions for inpatient settings are clinically screened by a pharmacist for:

- Appropriateness including route, dose, duration and frequency taking into account patient co-morbidities
- Selection of antimicrobial according to guidelines for specific clinical indications and any microbiological samples
- Length of treatment and potential switches from IV to oral (only applicable in community health service settings)

Education relating to antimicrobial stewardship is promoted by the annual audit of antimicrobial prescribing and taught in the mandatory medicines management training courses for both medical and nursing staff.

In 2023, an Antibiotic Stewardship Group was formed which sits separately to the existing IPC group. The group reports directly to the relevant medicines management group with a responsibility to feed any relevant decisions into the IPC group. Membership includes the DIPC for the Trust, a microbiologist, Pharmacist lead, Head of IPC, Quality leads and representation from nursing and medical teams. As of Q4 2023/24, there have been two meetings (two meetings were cancelled due to not being quorate) and the group will continue to promote the principles and encourage engagement from colleagues. The medicines management team will also produce a business case with a view to recruiting a permanent antimicrobial specialist pharmacist who will drive the antimicrobial stewardship agenda forward and act as the chair of the antibiotic stewardship group. The remit of the group aligns with the Health and Social Care Act 2008, criterion 3: antimicrobial use, and focusses on:

- Monitoring the use of antimicrobials across the Trust to ensure inappropriate and harmful use is minimised, drawing on local or national guidance where appropriate.
- Education and training to medical, nursing and pharmacy staff, promoting constant review of prescriptions and embedding an awareness within the Trust.
- Promotion of European Antibiotic Awareness Day.

Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The IPC team have developed patient information leaflets on MRSA, Clostridiodes difficile, Norovirus, hand hygiene and general advice for patients and visitors. To ensure that those we care for have access to appropriate information relating to some common infections and how to assist in preventing their transmission.

The Patient Information and Plain English (PIPE) group have been actively involved in the review as an integral part of the development process. Leaflets are currently undergoing branding within the turst inpreparation for printing and distribution.

Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

IPC Policy Reviews Undertaken in 2023-2024:

All IPC policies are reviewed on a 3 yearly basis or when national guidance changes. In the reporting period, the overarching IPC policy (ICPG1 INFECTION PREVENTION AND CONTROL) was reviewed and updated in line with the national infection prevention and control manual and the following guideline sections:

- IGPC1 INFECTION PREVENTION AND CONTROL PROCEDURAL GUIDELINES – SECTION 1: INFECTION AND COMMON INFECTIOUS DISEASES
- ICPG1 INFECTION PREVENTION AND CONTROL PROCEDURAL GUIDELINES SECTION 2: STANDARD INFECTION PREVENTION AND CONTROL PRECAUTIONS
- ICPG1 INFECTION PREVENTION AND CONTROL, SECTION 4: COMMUNICABLE DISEASES AND OUTBREAK CONTROL
- ICPG1 INFECTION PREVENTION AND CONTROL SECTION 8: GUIDELINES FOR THE MANAGEMENT OF INFESTATIONS
- SECTION 11: GUIDELINES FOR THE CARE AND DECONTAMINATION OF MATTRESSES AND COVERS

ICPG1 SECTION 9; PREVENTION AND MANAGEMENT OF SHARPS INJURIES/ CONTAMINATION INCIDENTS has been reviewed and will be implemented following final ratification in June.

Whilst reviewing section 2 of the guidelines it became evident that further guidelines in relation to transmission based precautions were required and these have been formulated:

- ICPG1 Infection Prevention and Control Procedural Guidelines SECTION 13: Transmission based Precautions

All COVID guidelines have been under regular review and changes were made in April and August with appropriate communications to all staff.

IPC have continued to work in collaboration with our estates and facilities colleagues throughout the year and contributed to their review of RM 20 cleaning policy.

Cases of Reportable Health Care Associated Infection:

All cases of mandatory reportable health care associated infection are fully investigated with the clinical team involved and a post infection review process to identify any learning follows:

Clostridium difficile – Clostridium difficile incidence is assessed as cases detected after 3 days of admission (these are considered to be 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.	2 cases attributed to the Trust
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.	zero cases of MRSA bacteraemia attributed to EPUT. However, have supported the investigation of a case identifed in the acute trust
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
Hand hygiene monitoring – We monitor compliance with best practice for hand hygiene through monthly audits by our clinical inpatient teams.	Overall compliance 99%
Covid-19 Outbreaks – EPUT have been committed to following the guidance issued by Public Health England (PHE). All staff have had the opportunity to undertake a risk assessment ensuring their health and safety within the workplace. Staff have access and training regarding the use of personal protective equipment (PPE).	There have been 119 outbreaks of nosocomial infection in EPUT. (2023/24)

Clostridioides difficile

There has been one case of Clostridioides difficile on Beech Ward and one case on Plane Ward at Epping Forest unit, during the reporting period. The learning identified included:

- The need for prompt implementation of isolation precautions at time of suspecting infection
- Clear documentation of the reason for antibiotic prescribing and regular review of antibiotics prescribed for all patients
- Clear communication ensuring all staff members are aware of the need to increase cleaning frequency and methodology in light of case.
- Clear communication between clinicians and Consultant Microbiologist with regards to appropriate treatment decisions.

The IPC team have delivered C difficile training sessions to enhance knowledge and share key learning for future practice.

MRSA Bacteraemia

One case of MRSA bacteraemia was identifed in June 2023 within the acute trust provider. The patient was receiving wound care provided by community teams in mid and South Essex. The IPC and clinical team worked collaboratively with commissioning colleagues

Good practice identified:

- Staff complied with the trust policy on swabbing.
- Staff were engaged fully with the investigation
- The IPC team shadowed some of the staff in the team and supported the team in reviewing practice

Reviews to practice made:

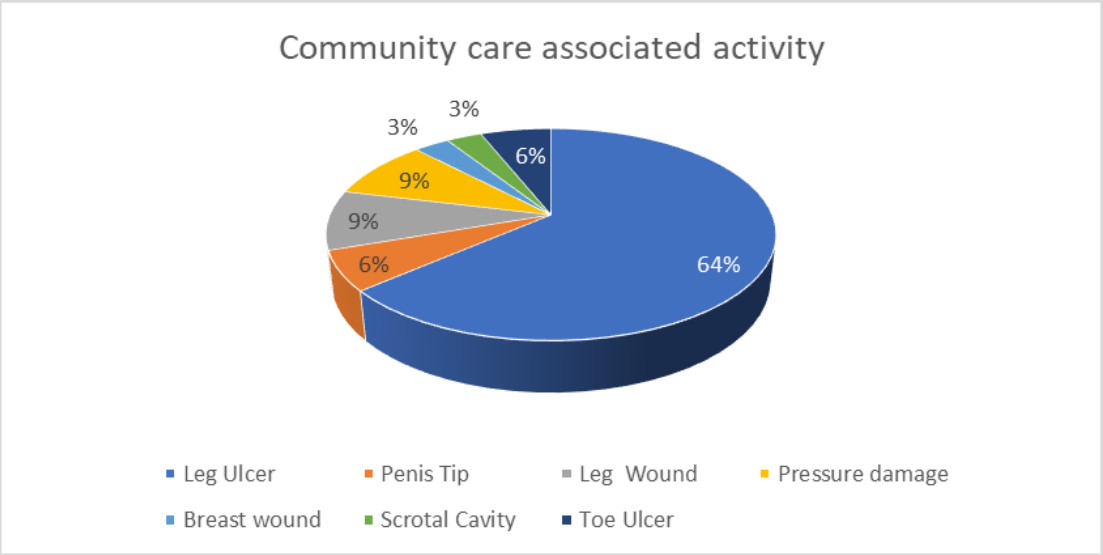
- The team created a MRSA pack to assist patients, carers with decolonisation of patients,
- They also created a patient handover to be able to identify patients with MRSA and ensuring they got the support required and set up regular catch up with the IPC team to discuss care been provided for patients identified to be colonised.
- They have also shared good practice with other teams in the region and trust.

Cases Group G strep Period of Increased Incidence – Jan-March 2024

The IPC team first became aware of and reported a potential period of increased incidence of patients with Group G Streptococcus infection on 18th January 2024. A staff member felt able to speak up about her concerns at the IPC link Champions forum. All the affected patients were being cared for in South Essex Community services in their own homes.

A total of 33 patients were identified as having Group G streptococcus infection across South Essex with links to health care provision across the geography by EPUT services as well as other health care providers and domiciliary care.

The chart below demonstrates the groups of patients affected:



Leadership of the situation was provided by the Head of EPUT IPC, with support and oversight provided by UK Health Security Agency and ICB colleagues all of whom were active members of the incident management team throughout.

All patients and staff involved were communicated with verbally and by letter to ensure they were kept fully informed of the situation. The Trust provided communications more widely both within and externally to the organisation. All staff involved demonstrated full engagement with the situation and were professional in the way they dealt with a challenging situation, which included a cohort of staff being tested for Grp G strep.

Case definitions were agreed following extensive review of each case from a clinical perspective, strain typing and review of health care interventions. This was undertaken in collaboration with clinical teams, IPC and field epidemiology colleagues in UKHSA. Through the level of detail provided, a low likelihood of direct transmission was agreed by the Incident Managemnt Team (IMT) and therefore, declared as a period of increased incidence rather than an outbreak of infection.

The incident was stood down on 7th March 2024 with a return to usual surveillance levels, and a continued low threshold for sending swabs when a patient has clinical signs of infection.

A review of clinical practice was undertaken by clinical leaders and the IPC team. All actions have been linked to the Hierarchy of Controls and can be seen below.

Management of the situation

- The outbreak was declared a period of increased incidence after limited epidemiological links could be established
- UKHSA field service developed a social network analysis which supported the declaration of PII rather than outbreak
- The incident was managed and led by the community provider Head of IPC
- Oversight and supportive oversight led by the Consultant Nurse within the ICB
- UKHSA provided clinical and epidemiology support

Reflection

- Whilst there were no epidemiological links established, it meant that the original hypothesis could be realised.
- Whilst come practices were identified as areas for improvement by the clinical and IPC teams, positive aspects were also identified in the situation. Again, there were no epidemiological links to frame this incident as an outbreak.

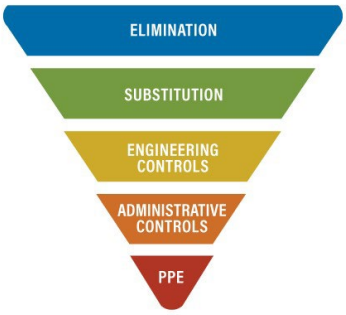
Positive that were identified

- The IPC Link Champion bravely spoke up about a concern they had relating to an increase in patients on the case books who had recently received positive GGS results on wound swabs.
- Each matron and their clinical team were fully engaged with the process of investigation from start to finish. A huge amount of extra work was undertaken by them in order to support the collection of as much evidence, data information as possible.
- An example of strong collaboration between provider, ICB and UKHSA teams in order to understand and manage a complex situation. Clinical teams reviewed their own practices independently of the IPC team and came up with some solutions
- Communication with patients and staff was provided both verbally and in writing
- UKHSA developed a fact sheet for GGS as this was a new situation for them as well

Learning

- Revisit the hierarchy of controls pertinent to a community setting

Hierarchy of Controls



MRSA death - June 2023

A patient sadly passed away in the care of a community health services ward having been admitted for rehabilitation following a fall. He was receiving treatment for infected wounds in his heels and sacrum.

A clinical review was undertaken in order to examine the care given from the time of admission which was itemised and tracked against established policy/ guidelines/ SOP; identify both good practices and any learning that could be established utilising SEIPS technology.

Summary of findings:

The patient was cared for in a side room throughout his admission to the ward.

The ward team completed a tissue viability referral.

The therapy team escalated concerns relating to the patient's physical condition to nursing staff.

Clinical indications were clearly documented on antibiotic prescription charts.

Next of kin were informed of his deterioration and invited to the ward to visit at this time.

A Datix was recorded following the death of the patient.

Organisational/ Task related factors: The lack of communication and delays in the assessment of patient, and timely treatment have prompted a review of the current EPUT guidelines to ensure all staff are fully aware of their responsibility. The guideline will be simplified and will involve clinical staff to support the practical application across the organisation. Review should be completed and signed off by IPCG at the December meeting 2023.

Person/ Task related factors: Staff should be competent and confident in assessing NEWS 2 physical health observations and care bundles. A review of the education and ways in which competency is assessed across the organisation is recommended to be carried out by the Head of Deteriorating patient and the physical health committee. The trust has sourced an e- learning module for this training which all relevant staff within the organisation will be encouraged to complete. This is a vital component of clinical training for a variety of reasons including the management of patients with known or suspected Covid 19.

Internal environment/ Organisational related factors: It is recommended that support services leads create cleaning schedules of their teams to refer to and also to sign off when a cleaning activity has been completed. To be included in the EPUT Cleaning policy.

This can be kept as evidence/ assurance of cleaning should it be required at any time. Feedback to be given at December IPCG meeting.

Task related factors: Operational team to give consideration to be given to whether lack of medical cover over night and at weekends is appropriate in EPUT services and the patient group being cared for.

Organisational factors: All EPUT documents to be reviewed in relation to headers and footers with version control and all out of date documents to have access removed.

Person/ Task factors: Review of education provided for medical staff relating to death certification, and effective medical prescribing to be carried out by November 2023.

Covid deaths

A review of the data bases linked to EPUT patients who have died as a result of covid has been undertaken by the IPC and Inquiry team. This was to establish a single point of information used by relevant colleagues and ensure accuracy relating to EPUT patients who died whilst inpatients as well as those who died in community settings or acute NHS trusts. This work will assist colleagues involved in both the Covid and Lampard Inquiries.

Outbreak management

The definition of outbreak is two or more connected cases of infectious disease in either patients, staff or visitors. Outbreaks in EPUT services over the period 2023/2024 have been predominantly, but not exclusively, COVID 19. The prevalence rate within services often have been commensurate with community prevalence rates. There have been fewer outbreaks this years in comparison to 2022-2023 and significantly fewer patients affected. The numbers of staff members affected during outbreaks is also reduced but less markedly.

National guidelines in relation to patient and staff testing and isolation have been changed during this reporting period.

This year the IPC team have continued to ensure that all outbreaks have been reported in line with national policy, and local, and regional requirements. This also includes reporting to UKHSA. The submission of IIMarch reports has continued and IPCT have coordinated regular Incident Management Team (IMT) meetings for all suspected and confirmed outbreaks. These have been upon identification, at appropriate intervals during the course of the outbreak, and at closure. In addition to being fact finding, these meetings are supportive in nature. The discussions and additional analysis have helped reiterate IPC measures, define good practice and lessons learned. At the closure of an outbreak teams are asked to complete a learning lessons slide.

The table below provides a summary of the outbreaks during this period:

Care unit area	Number of Outbreaks		Number of patients affected		Number of staff affected		Number of deaths
	2023	2024	2023	2024	2023	2024	
Mid and South Essex Community	8	**7**	16	**5**	27	**30**	
North East Essex Community	1	**4**	0	**0**	5	**16**	
Specialist Services	14	**11**	62	**3**	41	**29**	
Urgent Care and Inpatients	37	**17**	184	**68**	87	**63**	
West Essex Community	10	**10**	50	**46**	44	**29**	
TOTALS	70	**49**	312	**152**	204	**167**	

Lessons learned from the COVID outbreaks have been shared throughout the organisation as part of EPUT's culture of learning.

Norovirus/ Diarrhoea and Vomiting outbreaks

There has been a slight increase in the number of outbreaks in the reporting period. This again appears to follow both regional and national picture.

In December 2023 3 patients and 1 staff member experienced symptoms of diarrhoea and vomiting on Finchingfield ward. At the time there was a concurrent COVID outbreak. The unit was closed to admissions from 29/12/23 until 02/01/24 when it was opened to admissions based on balance of risk in line with COVID guidelines. No causative organism was identified.

On the 1st February 2024 on Rainbow mother and baby unit 4 mothers and 3 babies were affected with either diarrhoea or vomiting. There were no empty beds at the time and no admissions pending. No causative organism was identified.

Two stool samples sent from an outbreak on Plane ward were positive for Norovirus in February 2024. In total 11 patients and 5 staff experienced symptoms, between 21.2.24 and 3.3.24. IPC measures in place included isolation of symptomatic patients, enhanced cleaning, the use of PPE and closing bays to admissions. Any admissions to the ward were to be based on balance of risk. A deep clean was undertaken once all patients were 48 hours symptom free. On the

15th March 2024 it was reported that 2 patients in bay 8 experienced symptoms of diarrhoea. Although one of these patients had a potential alternative diagnosis, precautionary IPC measures as described above in place were put in place and a further deep clean carried out. IPC visited the ward to review practices and were assured that there were no breaches or gaps in practice. Between the 23rd-25th March 6 further patients experienced symptoms and IPC measures were re-instated until patients were 48 hours clear and a clean instigated.

On March 1st, IPCT were informed that three patients on Meadowview had symptoms of diarrhoea. IPC measures were immediately implemented and a deep clean was undertaken, allowing all measures to be lifted by the 6th. No causative organism was detected from 2 stool samples taken.

From the above described outbreaks the following lessons/ learning was identified:

- Prompt reporting is required to enable IPC to support the teams to put robust IPC measures in place.
- Daily consistent contact with IPC is important. Virtual contact was maintained via phone calls and teams calls and visits to the clinical environment helped support teams where necessary.
- It is not always easy to obtain stool samples and viral results are not immediately available.
- Accurate documentation of symptoms and timings is crucial to help ensure that periods of isolation for individuals remain minimal.

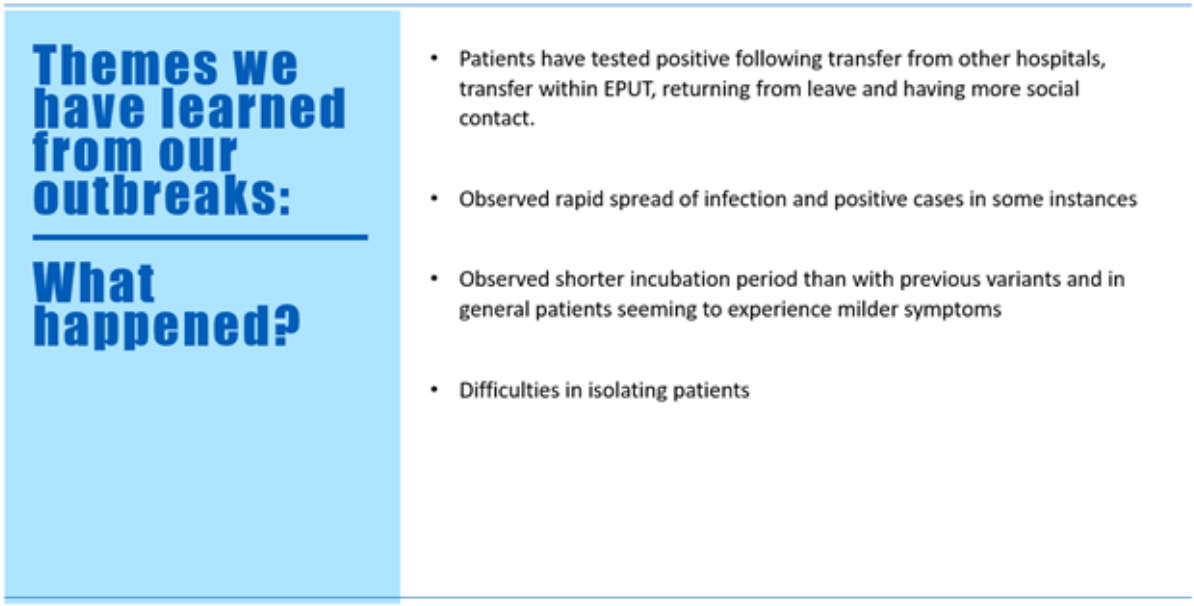
Scabies outbreak

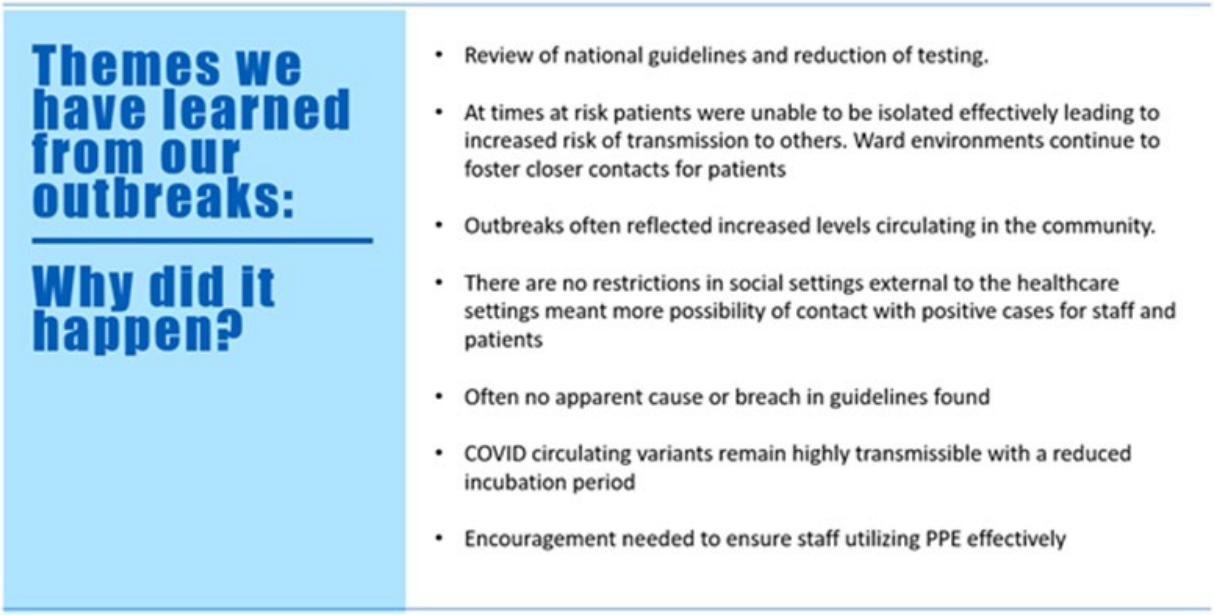
In January 2024, 2 cases of scabies with probable links were identified on Robin Pinto Unit (the first case having been identified in December). Following investigation an outbreak was declared. IPC supported the clinical team in conducting contact tracing and coordination of the required subsequent mass treatment. A total of 18 patients and 67 staff were identified and mass treatment took place on 6/2/24. Treatment was provided by EPUT pharmacy. A period of 8 weeks surveillance is in place until April the 2nd as 1 patient declined to be treated.

The following issues and lessons learned were highlighted:

- Robin Pinto is a significant distance from the location of the EPUT IPC team. Regular contact and communication was maintained through the use of phone calls, emails and teams meetings. More physical presence form the IPC may have provided support for the clinical team.
- The staff team worked hard to ensure that the impact on the patients was as short as possible.
- A mass treatment adds to the workload of all clinical, and non-clinical teams. The estates and facilities colleagues and pharmacy were instrumental in the success of this.
- IPC have fostered improved relationships with the IPC team from East London Foundation Trust who cover the adjoined unit.

- Scabies is hard to diagnose. The team are now more aware of signs and symptoms and when to escalate for further review.



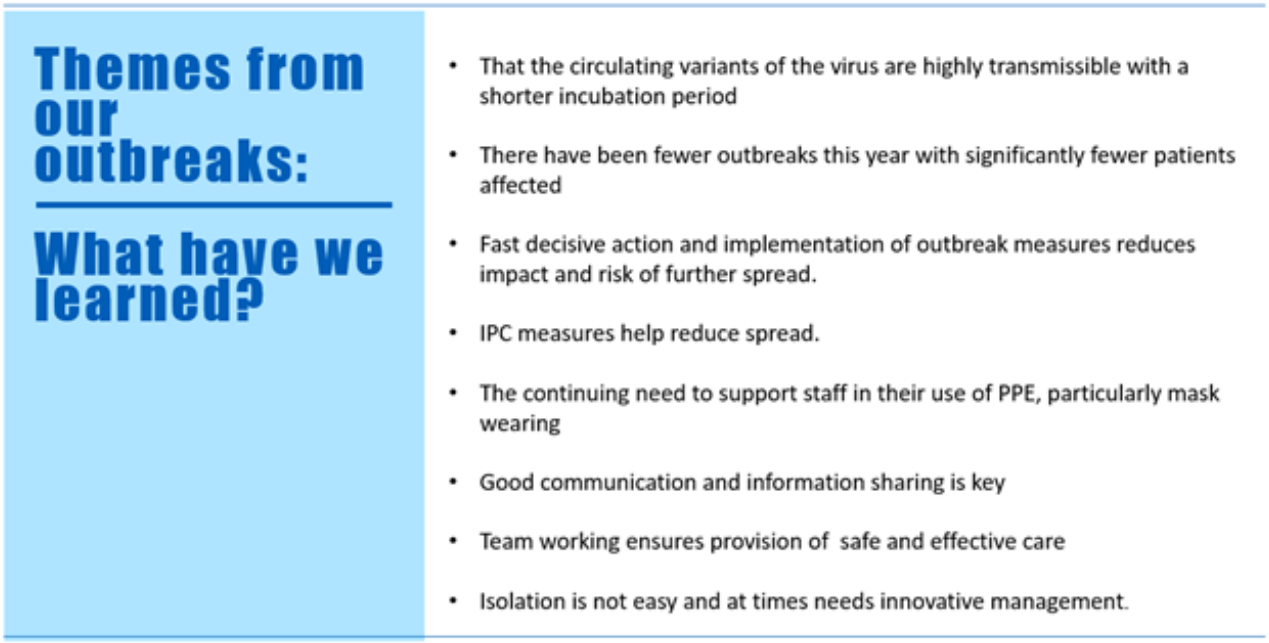


Themes from our outbreaks: What are we doing about it?

- Reinforcement of IPC principles and outbreak measures
- Encouraging patients to isolate and utilising alternative management strategies where this is not possible
- Continuing to ensure all EPUT policies and guidance documents are reviewed regularly in line with national guidance, local prevalence rates and lessons learnt
- IPC support for all staff ongoing, particularly in the use of PPE
- Encouraging reflection throughout the outbreak process to identify lessons learned and sharing the learning regularly throughout the organisation
- Ensuring temporary staff have full and comprehensive induction to units

Themes from our outbreaks: What did we do well?

- Teams have been much more able to recognize signs and symptoms and acted quickly meaning that testing was carried out and isolation was implemented fast.
- IPC team support and guidance
- Followed IPC outbreak precautions, often at the identification of the first case and before outbreak considered
- Maintained excellent communication with relatives and friends so that everybody was fully advised of the situation
- All patients' physical health closely monitored and appropriate action taken in the event of any deterioration
- Continued provision of support during isolation for patients



MRSA outbreak

An outbreak of MRSA, was declared in July 2023 on Plane Ward at St Margaret's Hospital. In total 6 patients were identified as MRSA positive between June and August 2023.

All isolates were sent for typing and a total of 2 strains were identified, 4 cases were a common typing MLST 8 and 2 cases were an unusual type in the UK, MLST 672 from the Indian subcontinent. Not all patients had bene idnetifed as MRSA positive previously.

Visits to the ward were undertaken from the ICB, infection prevention and control team, and DDQS to ensure collaborative working with the clinical team, looking at practice, supporting staff and providing training. Alongside the visits the IPC team supported the ward with regular phone calls and there were also the weekly IMT's with support from clinical colleagues, UKHSA and the infection control doctor.

A program of refurbishment was undertaken including redecoration of the bays and 2 deep cleans.

This outbreak was declared over in September and normal screening as per policy resumed which included all new admissions being placed in a side room until MRSA screening was compelted and a negative result obtained.

The team are committed to monitoring the environmental elements on the ward and clinical leads walkabouts continue. The situation was very challenging for all involved but staff were committed to revisiting IPC practices and maintaining consistency going forward.

Outbreak of Group A Streptococcus

In May 2023, an outbreak of Group A Streptococcus was idnetifed in a care home in South Essex. EPUT community teams support residents by providing clinical care within the care home setting.

Good practices identified:

- A good working relationship between the community nursing team and the care home staff
- Strong collaboration between the care home, EPUT clinical team, IPC team, UKHSA and ICB colleagues working

Actions taken:

- The IPC team shadowed the community nursing team involved and held meetings to provide support in addressing issues identified including ANTT and the use of ANTT trays in wound dressings
- Staff members were also supported to address issues identified in their storage area

Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

All Trust job descriptions have IPC responsibilities included within them as detailed below.

Infection Control:

The post holder is accountable and responsible for the prevention of healthcare associated infections by complying with all Infection Prevention & Control policies and procedures in line with legislation (Health Act 2006; Code of Practice for the Prevention and Control of Healthcare Associated Infections.)

All staff are encouraged to professionally challenge colleagues and be challenged themselves if they are not compliant with IPC policies. Additional training for staff is provided by the IPCT ad hoc within the workplace as a need is identified in order to support best practice

As per criterion 1; all staff attend Trust induction where an IPC session is delivered by the team and all staff are to complete their on line mandatory training whether they be clinical or non-clinical. The trust provided staff with the national skills for health e-learning module, which is auto, updated as national changes in practice occur; ensuring the programme is current.

All staff can access IPC contact details, guidance and policies on the staff intranet, where IPC has its own page.

The IPC team celebrated Global Hand Hygiene Day in May 2023 with increased site visits to staff from all specialities including those who support clinical colleagues. The team had contact with over 500 staff and patients during the week.

IPC Link Champions:

IPC Link Champions Conference

Infection Prevention and Control is seen at EPUT as an important Patient Safety and Quality element for high quality patient outcomes together with staff engagement and work satisfaction.

Therefore during 2023/24 work to reinvigorate the Infection Prevention and Control Link Champions Role post COVID was undertaken by the IP&C team. There were two IPC conferences in November 2023 which were supported by MSE ICB with funding where a total of 64 delegates attended from across EPUT.

The programme was designed to include a number of topics IP&C related drawn from the learning from recent incidents & audits, queries to the IP&C team, National and Local Outbreaks together with emerging points of interest. These included but not exclusive to Sharps management awareness; Outbreak management; Oral Health; MRSA; Group A streptococcus invasive infection; Facilities & Estates team function and how this supports best practice in IP&C.

The delegate feedback was very positive, staff were able to engage and network with other IP&C champion colleagues across EPUT including a work group focusing on Oral Health in development post the conference.

The New Year has seen the commencement of a monthly virtual meeting for IP&C Champions with an opportunity for an education element, update of IP&C news across the Trust, followed by an opportunity for the Champions to share work and issues in their areas.

IPC Link Champions Forum

The Infection Prevention & Control team have reinvigorated the role of the IPC link champions across the organisation and are holding monthly one hour IPC Link Champion Forums via teams. The main focus being support and education and we have a range of speakers covering a variety of relevant topics including Measles and TB.

The Forum gives an opportunity to understand the role of the link champion, act as a key link with the IPC nurse for their care group, networking, education and problem solving.

PROGRAMME IP&C Study Day for Champions 7th November 2023		
09:15 – 09:25	Introduction to the Day and Welcome	**Angela Wade** Director of Nursing and Director of Infection Prevention and Control, EPUT & **Heather Dakin** Chairperson/ Infection Prevention & Control Nurse Specialist, EPUT
09:30 – 10:15	Sharps Awareness and Practical Safety	**Mark Brothers/ Anna McEwen** Daniels Representative
10:15 – 11:15	What COVID-19 teaches us about the importance of Oral Health	**Dr Graham Lloyd- Jones** Consultant Radiologist at Salisbury Hospital and Educator in the Field of Medical Imagining Via Microsoft Teams
11:15 – 11:45	Fundamentals of IP&C	**Dr Louise Teare** Consultant Microbiologist /Infection Prevention & Control Doctor for EPUT Via Microsoft Teams
11: 45 – 12:00	COFFEE BREAK	
12:00 – 12:40	Curiosity and IPC	**John Swanson** Infection Prevention and Control Specialist Nurse MSE ICB
12:40 – 13:00	Role of the Infection Prevention and Control Link Champion	**Katheryn Hobbs** Head of Infection Prevention and Control, EPUT
13:00 – 13:35	LUNCH	
13:35 – 14:05	Facilities Roles and Responsibilities and Working Together	**Fiona Benson** Deputy Director of Facilities EPUT & **Tom Blake** Waste Manager EPUT
14:10 – 14:35	An IGAS outbreak in Inpatient Unit	**Rachel Cryne** Infection Prevention & Control Nurse Specialist, EPUT & **Annette Knott** Ward Manager, Tower Ward, EPUT Via Microsoft Teams
14:35 – 15:05	Wound Management	**Rebecca Phillips** Tissue Viability Nurse & **Tracey Waterman** Tissue Viability Associate Practitioner
15:05 – 15.25	Sepsis	**Nick Archer** Head of deteriorating Patient Pathways and Resuscitation Officer, EPUT
15:35 – 15:40	Closing Session	**Heather Dakin & Carla Mountney** Infection Prevention and Control Specialist Nurses, EPUT

Audit Programme:

Environmental audits are carried out on an annual basis by the IPC team and involve revisits to areas in order to reassess any deficits highlighted in the audit. This ensures the process is effectively followed through and managed.

A total of 73 areas were audtind by the IPC team during 23/24

Capacity in the team has impacted on baseline audits of all community teams being completed. These have not been completed as planned, but IPCT will aim to conduct these over the year ahead.

The audit is based on the Infection Control Nurses Association (ICNA) audit tool which has been amended to take into account mental health settings and is carreidout using the ICAT electronic auditing platform. This is an extremely stringent and thorough audit that assesses every room in each clinical area, thus providing a comprehensive and in-depth view of cleanliness, status of fixtures, fittings, furniture and infection control procedures and processes.

Compliance scores and RAG ratings are as below:

- Compliance 85% >
- Partial compliance 76% - 84%
- Minimal compliance < 75%

On receipt of the audit outcome, the Matrons in conjunction with the ward manager / team leaders and support services are required to complete an action plan to address any areas that are amber or red. Matrons are required to complete a sign off sheet to provide assurance that the actions have been completed.

Overall scores were calculated by taking the total number of greens against the total number of amber/ reds.

Some common themes that reduced scores for inpatient areas included:

- Food not being stored in airtight containers in kitchens
- ADL kitchen areas
- Consistently uncompleted checklists
- Fridge and clinic room temperatures not being completed
- Sharps managment
- Signage unavailable in bathrooms to direct staff/ service users to clean appropriately
- Sharps packs missing some of contents
- Estates themes relating to the clinical and care environment

The enhanced cleaning audits are addressed by the action plan and any training identified by the current themes are incorporated in the link nurse training sessions and highlighted at the IC Group meetings.

The IPCT have continued to provide additional support in between formal audits by way of ad hoc site visits.

The challenge of auditing sites which are shared with other provider organisations and those that are leased from external landlords continues. The IPCT team encourage communication and partnership working with the other providers and building landlords in order to address areas for improvement, and have worked closely with EPUT Estates and Facilities as well as care unit colleagues in order to identify areas of concern and support resolution

The addition of the DDQS role within care units has reinforced the need for accountability and provided the additional experiential support for clinical teams to take timely improvement action.

Commissioning colleagues and the Trust Compliance team undertake quality assurance visits as part of their annual plans of work and feedback to the IPCT and care units following these

Quality Assurance Visits (QAV)

Several QAVs have been carried out in Mid and South Essex and West Essex over the year by commissioning colleagues either as part of more general compliance visits or specific IPC visits.

These have been carried out in a supportive manner on each occasion and have been completed in order to gain assurance that the Trust have robust processes embedded into clinical practice.
Action plans were sent to clinical leaders who have been supported by the IPC nurses in resolving any areas of concern identified.

Plans are in place to continue with these visits over the coming year as well as some peer review visits with colleagues from another Mental Health and Community services provider. Both are an excellent opportunity for sharing practice and learning from each other.

Self audit within Inpatient wards

A review of the inpatient audit programme was undertaken in spring 2023. An over arching IPC audit tool was created on the Tendable electronic auditing platform in order to reduce the number of individual audit required of clinical staff but that captured all required information on IPC standrds in practice.

The audit tool was launched in June 2023 for all inpatient services with a plan for monthly completion. Compliance with the audit programme completion has been varied over the year and the IPC team continue to support clinical colleagues in the workplace, not only to complete but to begin to give some focus on closing the audit loop and ensuring any data produced is meaningful and areas requiring attention are addressed.

Further work on the audit tool programme itself is underway as we move into 24/25 as part of the wider Trust project linked to the Tendable audit platform and data collection systems.

Work continues with the performance team on the creation of an IPC dashboard to support easy to access, accurate, meaningful data in a timely way.

Plans are in place to give some focus to appropriate auditing tools within out patient and community servies settings in the coming year.

Fit testing for FFP3 masks:

Although the country has continued to move out of the pandemic over the last year, the long term requirement for the fit testing of clinical staff continues to prove challenging for many NHS Trusts including EPUT.

Fit testing is an essential element of long term preparedness not only for future pandemic but also for use with patients who are suspected or known to have diseases of high consequence and other infections transmitted by the respiratory route such as Influenza, Measles, and Chicken pox. Relevant staff should be fit tested every two years if organisations are to evidence they are protecting staff in accordance with national guidelines.

The IPC continue to provide some level of fit testing for the fitting of these high level protection masks for relevant staff as part of the wider work stream; and have provided external accredited training for staff within the care units to encourage active support of the programme. The team are grateful for the support that has been provided temporarily by the mandatory training team.

The alteration in the number of staff who are required to attend basic and immediate life support, has seen the denominator of those requiring fit testing increase significantly. This has been identified as a risk on the trust risk register. Work is underway with corporate colleagues to find a solution both for meeting the needs of staff on the backlog as well as new starters to the organisation.

Criterion 7

The provision or ability to secure adequate isolation facilities.

Trust inpatient services are provided using both bays of beds and individual side rooms. Many of which have ensuite bathrooms. This means that patients who require isolation can be accommodated in this sense across our services. However, it must be noted that not all side rooms are ensuite. Individual risk assessment should be carried out by the clinical team to ensure a safe approach is taken in situations where patients require isolation due to infectious reasons.

It should also be noted that due to the provision of rehabilitation services provided across the Trust EPUT inpatient services have communal social, activity and eating areas allowing patients to participate in active rehabilitation. However, if a patient is required to isolate due to infection, provision is made for them as individuals following risk assessment undertaken by the clinical team with the support of the IPC nurses.

Ward closure decisions may be made as part of outbreak management. Outbreak meetings specify that wards will not admit patients during the emerging and critical stages of an outbreak of infection. However, it is acknowledged that for a variety of clinical reasons the risk of not admitting would be greater than the risk of transmission of covid. A clinical risk assessment is to be carried out and fully documented by the clinical team with support of IPC if required.

Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

EPUT services are provided across a wide geographical area, as a result of this contracts are in place with accredited pathology services provided by the acute NHS trusts across the geographical area.

Over the period of the pandemic a contract has been in place with Broomfield Hospital laboratory to provide services relating to the processing of covid 19 polymerase chain reaction samples send via EPUT services.

Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

An overarching IPC policy is accessible to all staff via the intranet page, it includes the following subject matters by way of individual sections as seen below:

- Common Infectious diseases
- Standard precautions
- Infection Control in clinical practice
- Communicable diseases and outbreak control
- Prevention and management of MRSA
- Prevention and management of *clostroidoides difficile*
- Prevention and management of Tuberculosis
- Prevention and management of infestations
- Prevention and management of sharps injuries and contamination incidents
- Pets and pests
- Care and decontamination of mattresses
- MPox

Each policy is subject to review on a three yearly cycle or as national guidance changes. The policy is informed by the National Infection Prevention and Control Manual for England.

All policies reviews include comment from expert colleagues who form the Infection Prevention and Control Group; following this update all polices are taken for final approval to the Trust policy ratification group.

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Occupational Health (OH) Services:

The trust employee Occupational Health (OH) services are contracted via an external provider.

Staff can access their services and advice using a range of methods including via telephone, posters, guidance on the staff intranet page. Line managers have information in order to signpost their staff to these as required as well as access to make referrals and view reports for their team members via the OH portal.

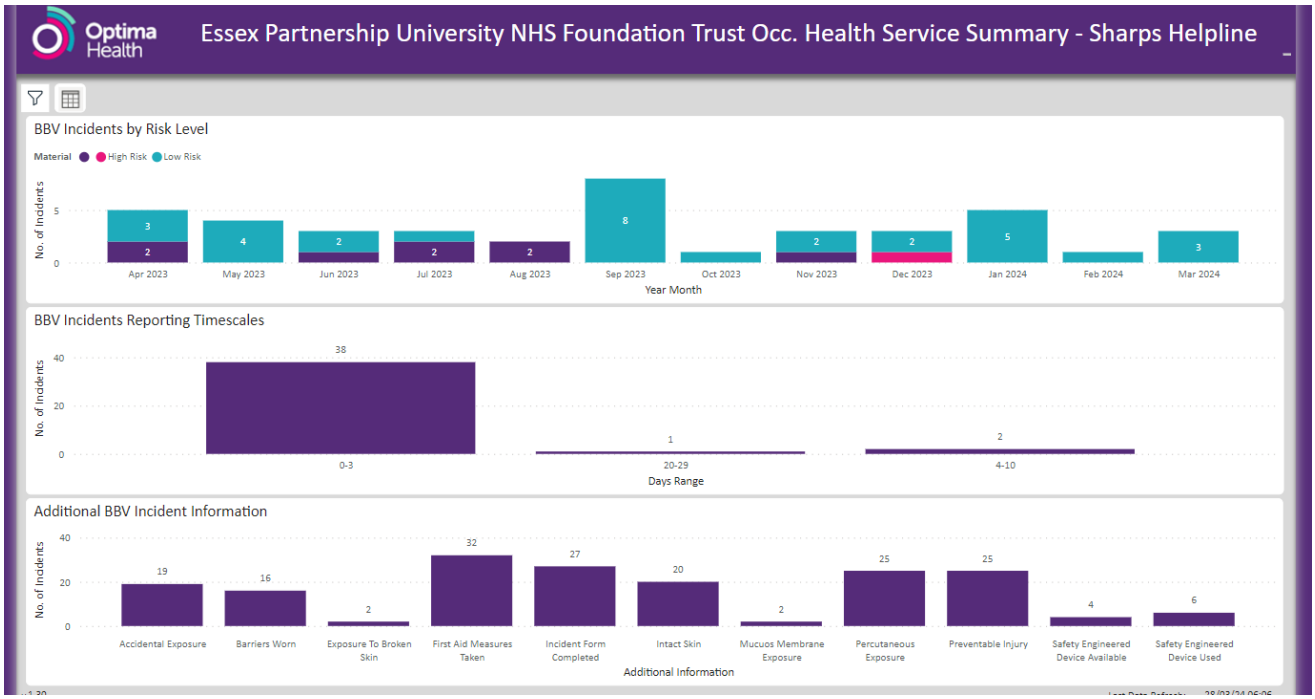
OH policies and procedures can be accessed on the staff intranet pages. The Trust Human Resources team work together with OH in relation to the organisation sickness policy

The IPC team provide general principles relating to staff becoming unwell; during the delivery of the Trust induction programme, these are also covered in the national mandatory training skills for health E-learning module that all staff undertake.

Sharps injuries:

Occupational Health lead on risk assessments and providing expert advice for staff sustaining sharps injuries, calling on the IPCT if required. An in-hours and out-of-hours telephone number is provided for staff to call, should they sustain a sharps or bodily fluid contamination injury.

Overview of reported NSIs



Contamination injuries reported to NSI/BBV Helpline April 2023 to March 2024

Month	Total	High Risk
April 2023	5	0
May	4	0
June	3	0
July	3	0
August	2	0
September	8	0
October	1	0
November	3	0
December	3	1
January 2024	5	0
February	1	0
March	3	0

Total	**41**	**1**

NSI/BBV Reporting Timescales

Timescale	Number reported	Percentage of reported
0 to 3 days	38	92.68%
4 to 10 days	2	4.88%
11 to 19 days	0	0%
20 to 29 days	1	2.44%

Wellbeing resources:

All staff working within the organisation can access free wellbeing services

Examples of these include:

Support following incidents

Psychological support

Financial

Physical health checks

Staff swabbing during outbreaks of infection:

The IPC service led a project with community collaborative partners to secure the services of an external contractor for the swabbing of staff in outbreaks of infection such as group A strep as these services are not currently provided by the current OH service provider.

Immunisations:

The OH team collect and keep records of staff immunisations as part of the new joiner risk based screening assessment. Any immunisation recommendations made by them align with the national Green Book. Although a regular review of immunisation status is not currently undertaken, if staff members change their role whilst working with the organization, immunisation status is checked again at that point by OH services.

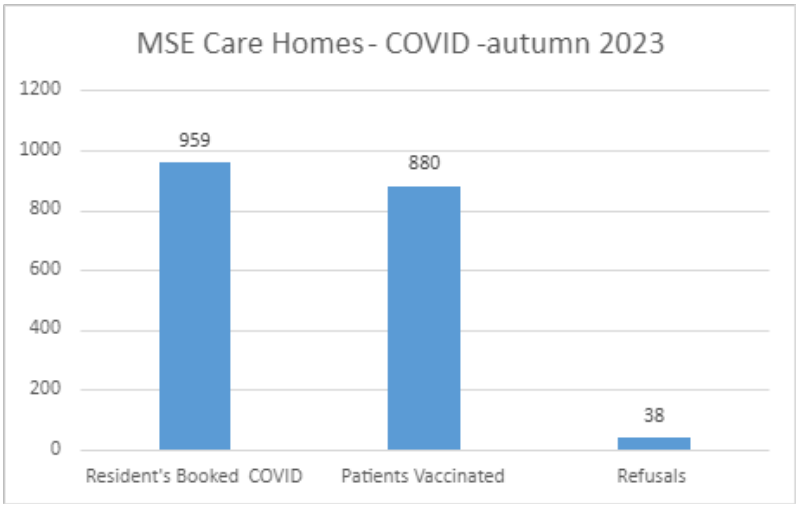
All staff are offered a free influenza vaccination each year and were also offered

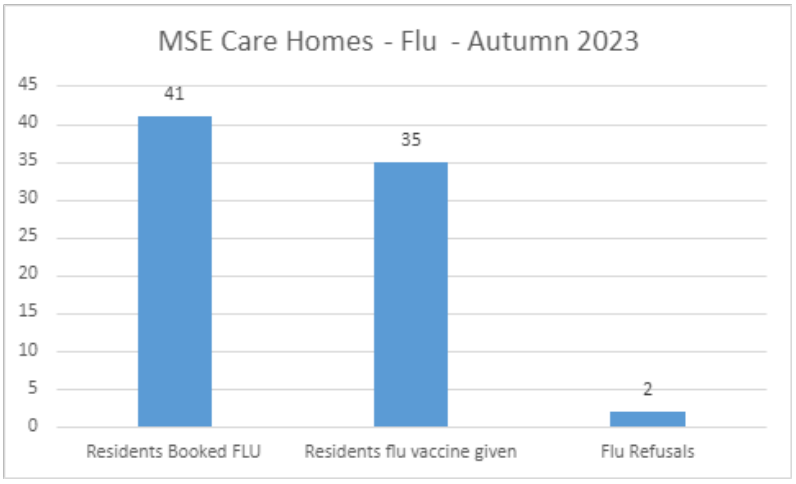
all relevant covid vaccinations as part of the national vaccinations programmes. These were provided by Trust vaccination and IPC teams with the support of OH services

Covid vaccination programme – Autumn/Winter 2023/24

Care Homes:

Following government guidelines vaccinating residents in care homes were of highest priority early in this campaign. Care homes visits across Mid and South Essex (MSE) occurred between 14th September and 13th October. Some visits and revisits continued until 17th November. The initial plan was to offer residents Covid and flu vaccinations on the same visit, but contracts for flu delivery were not in place until after most visits were completed. We offered care home staff Covid vaccinations on the same visits.





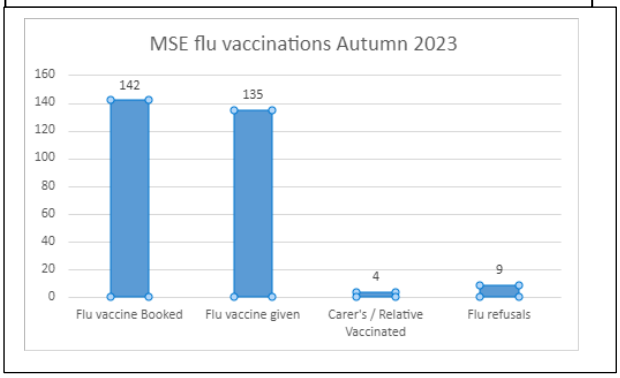
Housebound Visits:

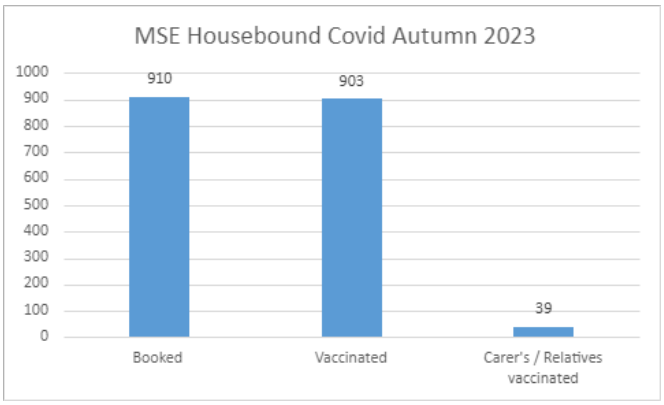
Patients who are housebound were also a high priority in this campaign. Visits began on September 20th across MSE and in Suffolk and North East Essex (SNEE) on 5th October and continued mainly 3rd November. Since then, follow up and newly identified patient visits have continued until January 2024.

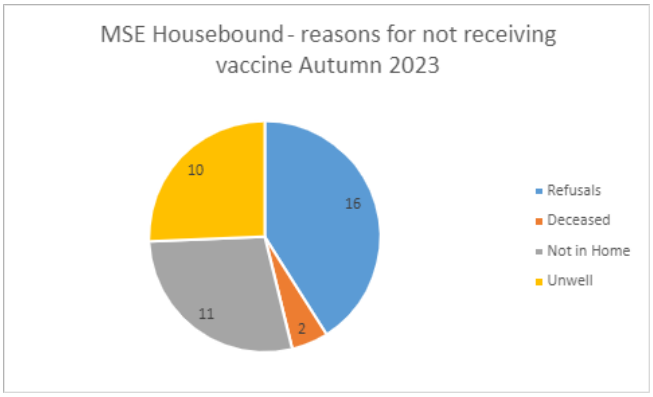
903 Covid vaccinations were administered across MSE and 1430 vaccinations were administered across SNEE. Even though appointments were booked directly with, patients or their carer's, many refused to have the vaccine, some were unwell and some were not at home.

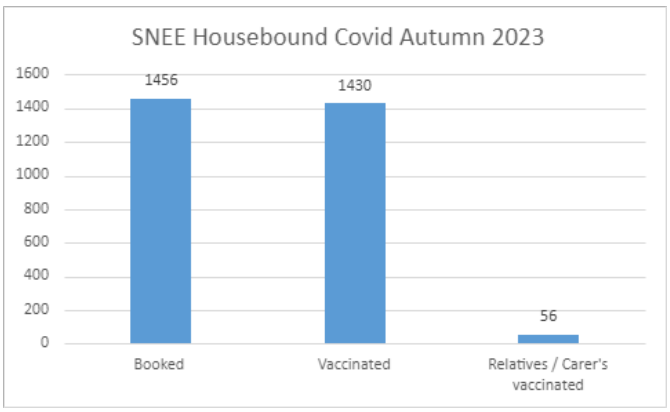
Relatives / Carer's were offered vaccinations on the same visit – 95 relatives / carer's received a vaccination.

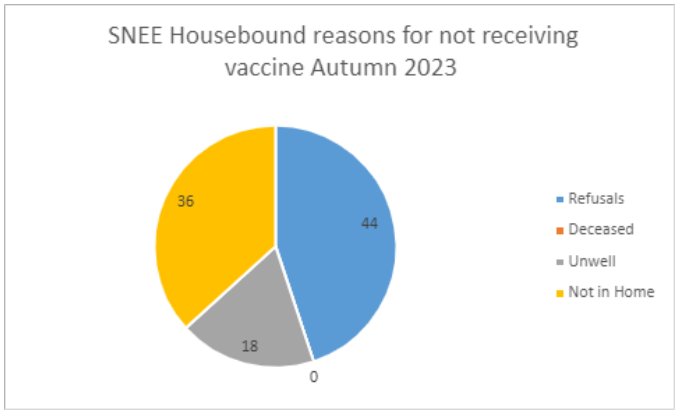
135 Flu vaccinations were administered – some of these were co administered with Covid, but some patients had already received and some refused their Covid vaccination.





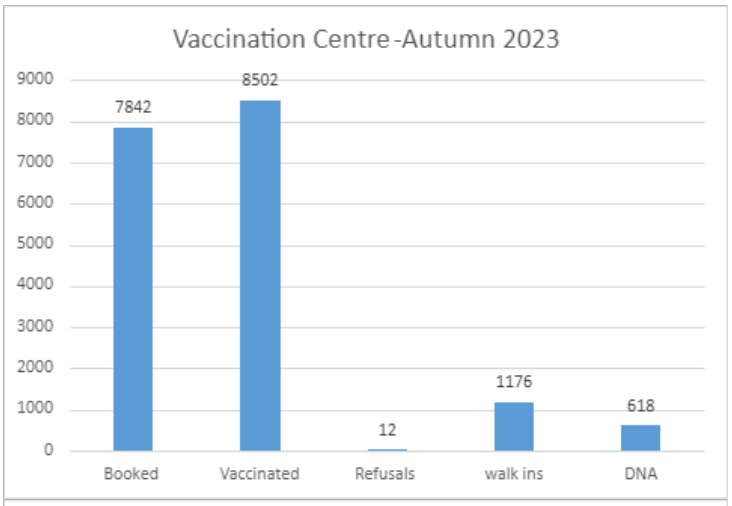




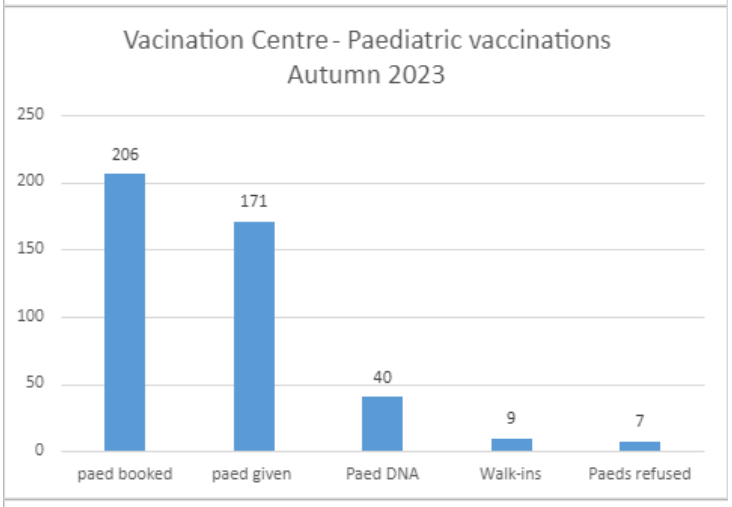


Vaccination Centre:

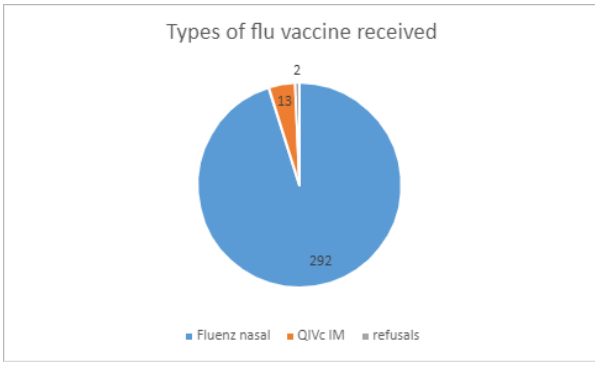
The Vaccination Centre at EPUT headquarters was opened during this campaign to booked and walk in appointments from 20th September until 16th December 2023. 8502 people received their Covid vaccination, with 1176 of those being walk in appointments. There was a 7.3 % did not attend (DNA) rate.

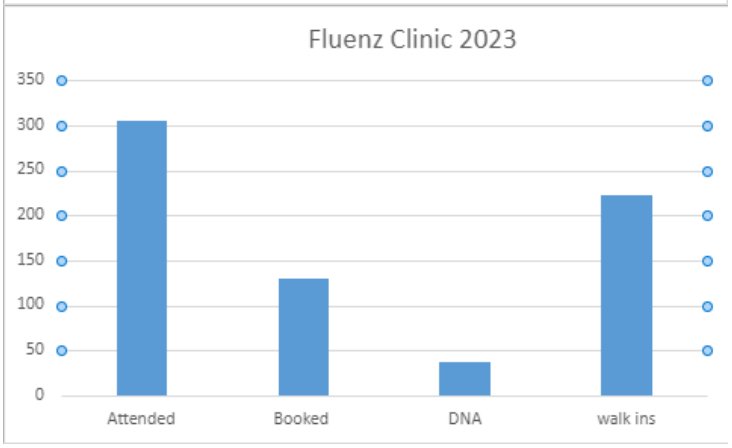


From October, the Vaccination Centre offered booked and walk in appointments for Covid vaccinations to eligible children aged 5 years and above. 171 children received their Covid vaccination but there was a 23.4 % DNA rate.



At the end of November, additional children's flu clinics were added to the vaccinations Centre offer. Three clinics ran with walk in appointments and one clinic had booked appointments. A total of 305 children received a flu vaccine.

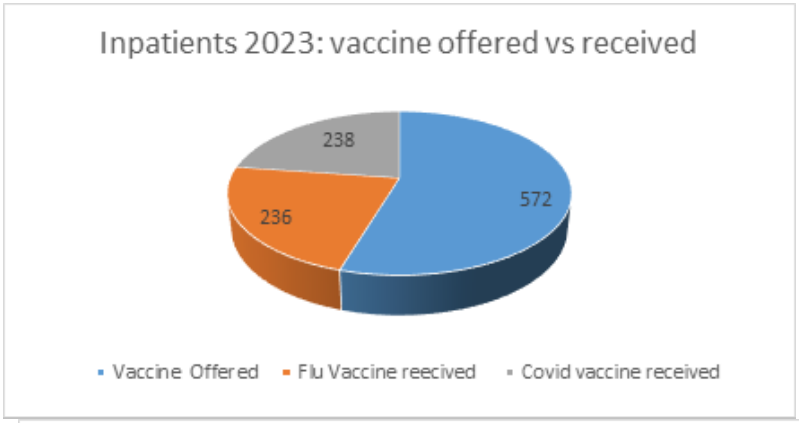


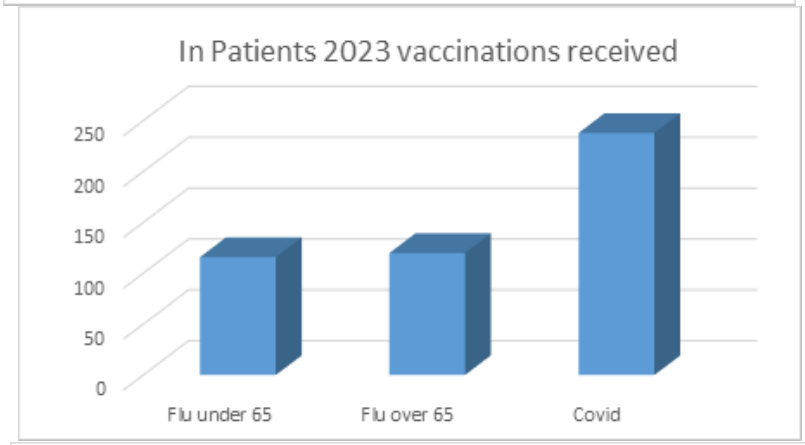


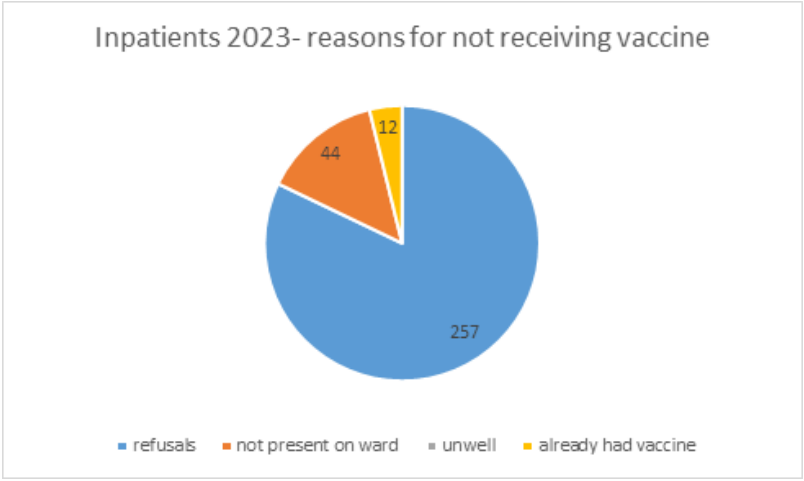
Inpatient vaccinations:

As part of the autumn 2023 seasonal vaccination programme all EPUT inpatients were offered both Covid and Flu vaccinations. Each area was contacted and a visit arranged at a suitable time / date for the ward and the delivery team. At the same time, the delivery team would offer vaccines to any staff member who wished to receive them. Once visit agreed – the ward staff were informed via email the date and time of visit and the details of vaccines to be prescribed in readiness.

There we some challenges with these visits. On many occasions, although the visit was planned, the vaccines were not prescribed for the patients and medical staff were not immediately available to do this resulting in waits of up to two hours before vaccination could proceed. On some occasions on visits, some of the staff acted as 'gatekeepers' and would not allow the team to speak with patients to ascertain their wishes for a vaccine.

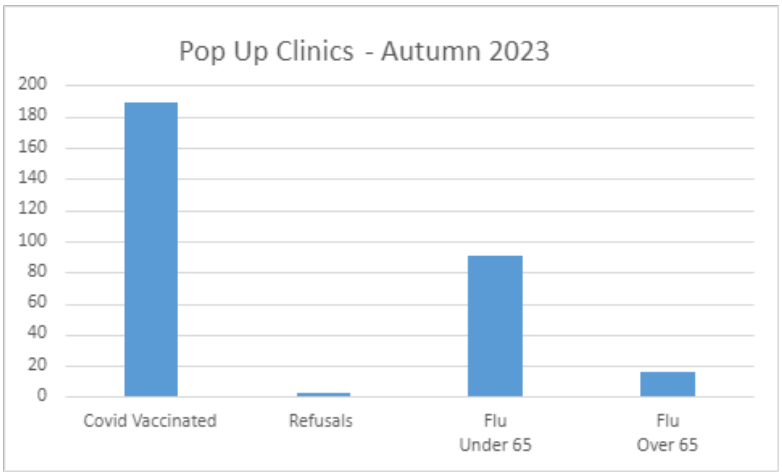






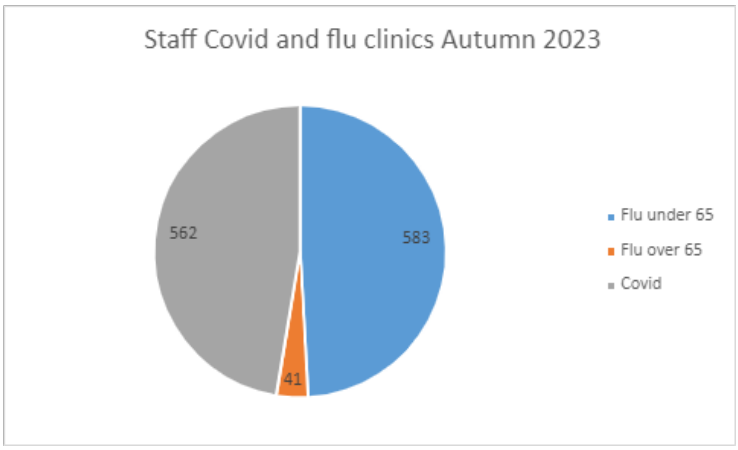
Pop up Clinics

It was requested by MSE ICB that number of pop up vaccination clinics were offered at the end of the autumn / winter programme to cover some areas of low uptake. We worked alongside partners in Southend Borough Council and others to maximise opportunity, promotion and offer of these clinics. Clinics were delivered in Trust buildings, council site and local community hubs in libraries. The clinics were offered for staff to attend for seasonal vaccines. Uptake was variable across the clinics and the most popular were ones that had time to be promoted actively across social media platforms, local papers, flyers in the locality and by local GP's. We offered a number of first Covid vaccinations in these clinics and some people it was opportunistic rather than sought out a vaccination service. A total of 189 Covid vaccinations and 107 flu vaccinations were administered over 12 clinics. Three refusals were due to not fulfilling the eligibility criteria or already received vaccine.



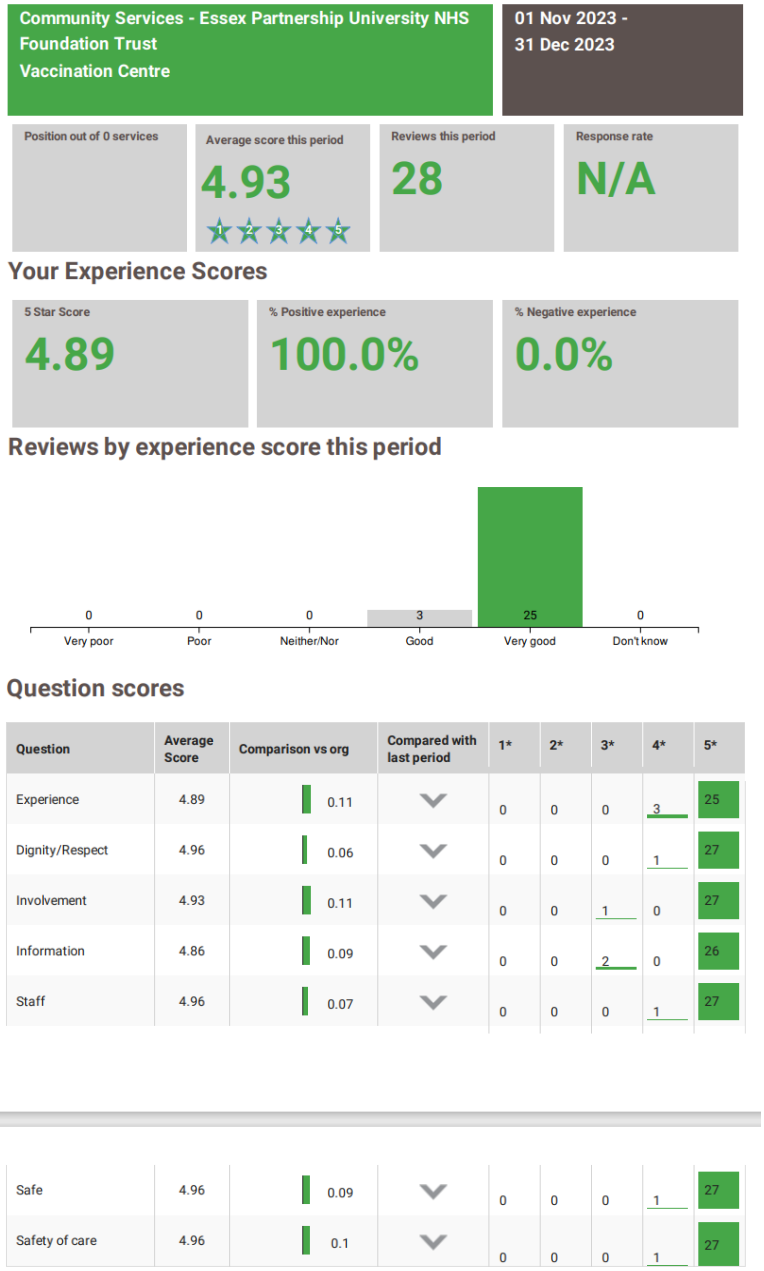
Staff Flu and Covid vaccinations:

At all opportunities at the Vaccinations Centre, in - Patient vaccination visits or static clinics there was availability for EPUT staff to receive Covid and flu vaccinations. 622 flu vaccines and 562 Covid vaccines were administered over 92 clinics.

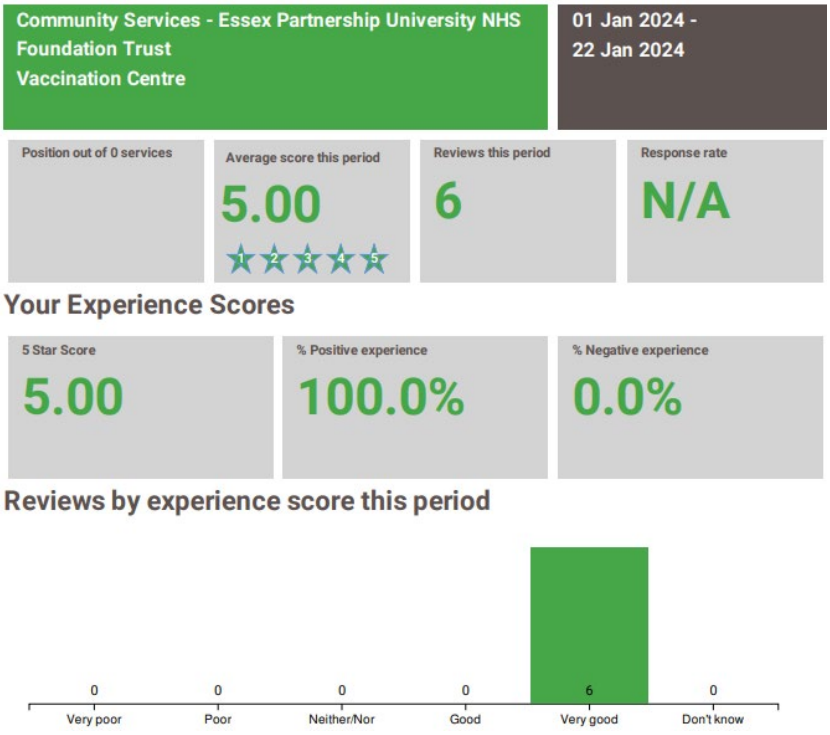


Feedback

The team requested feedback from people attending the Vaccination Centre from mid-November and the results are summarised below. The full report is available as a separate document. Most of the feedback was very positive and there was some constructive criticism, e.g. no sign on the outside of the door as to location of Vaccination Centre – this was immediately rectified. The feedback was shared with the team in the clinics as it arrived. The service also received two compliments - one from a member of the public and one from a senior member of EPUT staff. Feedback was also sought from the pop up clinics in January 2024 and the summary is below.



Feedback from pop up clinics in January 2024



Incidents

There were a total of xxx incidents reported via Datix related to Mass Vaccination. These are itemised in Appendix One.

Annual programme of work 2024/ 2025

An extensive annual programme of work has been underway with regards to IP&C during the last year; Trust compliance with the Code of Practice has been reported on a bi monthly basis. A summary of over all compliance can be seen below:

The annual programme of work for 24/25 focuses on elements of the Code of Practice which require improvement in compliance and the Trust Qlautiy Framework strategy and can be seen in the following slides:

NHS
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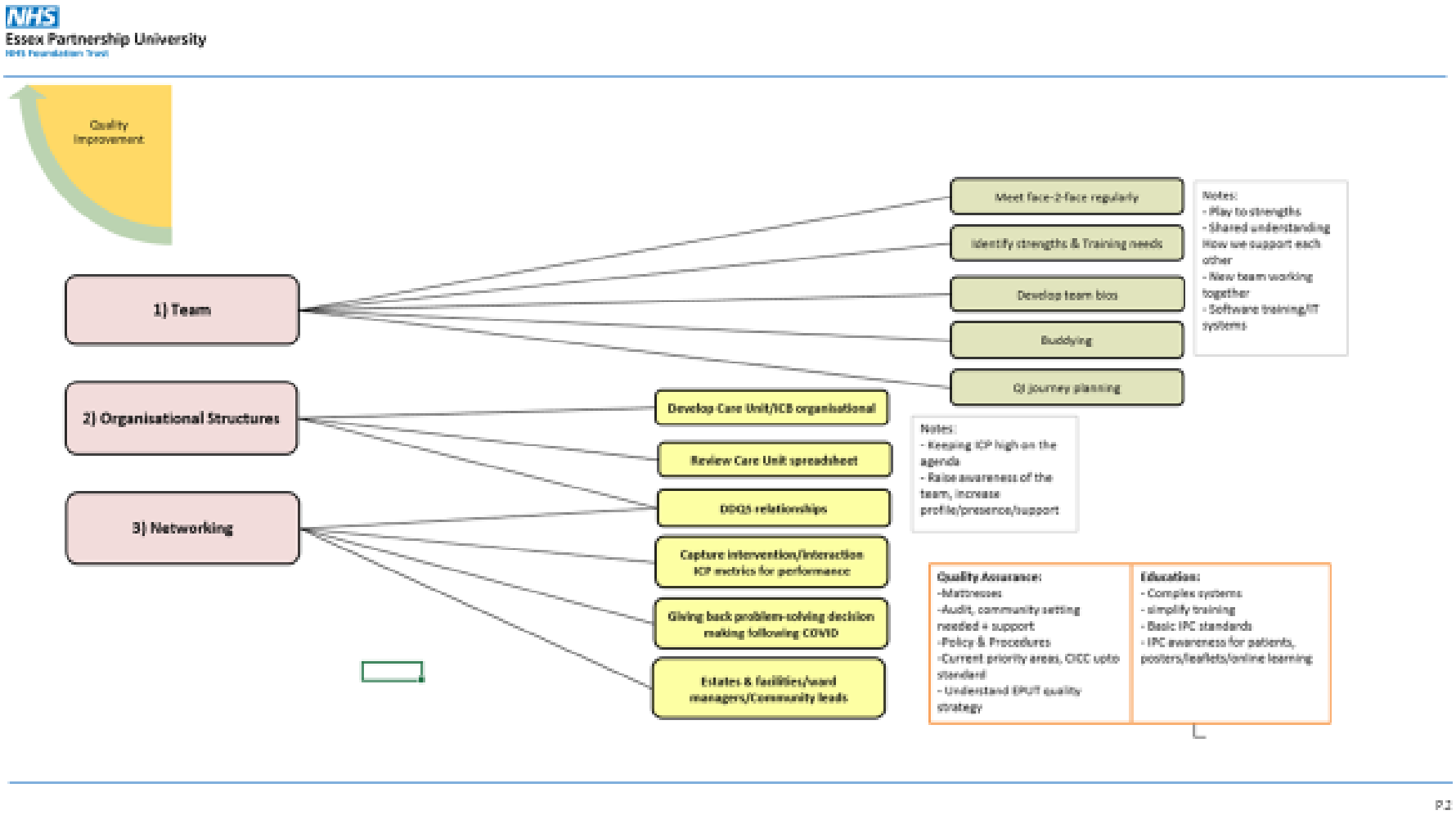
Infection Prevention and Control 2024/25

Background and Contextual Factors

- Infection Prevention and Control (IPC) is unique in the sphere of patient safety and quality of care, as it is relevant to every service user, healthcare worker and during every health and social care interaction. Poor IPC practice causes harm. It is recognised that those we care for have unique risk factors and are highly vulnerable to infection acquisition risks, due to underlying physical and mental health conditions; weakened immune systems; self-harm; poor personal hygiene and poor environmental hygienic living conditions can also serve as significant infection risk factors
- Partnering with Estates and Project Planning colleagues provides expert advice in relation to the built environment. This has been ongoing and is key to continued improvements within the built estate in the support of quality of care
- Analysis from 23/24 IPC environmental audits has evidenced that our patient environments are not all of a standard expected in health care premises. The IPC Service plan to continue supporting engagement with and progression in the improvement of patient environments over the coming year. This Trust-wide work will be ongoing and in collaboration with our Project Planning and Estates colleagues
- To support the strategic goal of the provision of safe care, reduction in health care associated infection and supporting staff safety in the workplace is essential in community and mental health trusts as it is in acute NHS organisations
- There is an increasing body of national guidelines that support best IPC practices within healthcare including Care Quality Commission Standards, Health and Social Care Act, IPC Code of Practices, National IPC Manual, Board Assurance Framework, Health Technical Memorandum for the built environment and National Standards of Cleanliness
- CQC Quality Statements (2023)

Priority 1: Improved patient environment	• Support of Estates led Water and Ventilation Safety meetings • Undertake yearly IPC environmental audits across the organisation, providing expert advice on and supporting improvements to be led by operational colleagues • Attendance at Capital Projects meetings to provide feedback on environmental auditing and compliance with Health Technical Memorandum • Collaboration with Trust Facilities Team to ensure high standards of cleanliness where Trust services are delivered • Collaborative approach to IPC walkarounds with Estates, Facilities and operational colleagues
Priority 2: Systems to manage & monitor the prevention and control of infection	• Development of IPC dashboard which will give clinical leaders and corporate colleagues oversight at a glance and the ability to work through IPC challenges with the IPC Team and other key stakeholders - themes can be easily identified and be acted upon at local and Trust level to support evidence based best practice • Roll-out of community and out-patient audit tools • Investigation into robust alert organism surveillance system to provide timely relevant information as part of collaborative work with system partners including ICB
Priority 3: Systems to ensure the appropriate risk assessment & management of infection	• Oral Health-Utilising work produced by colleagues in Salisbury with their permission a base line of our current position in relation to oral health and the provision of mouth care will be established from staff and then followed-up in a similar way with our patients. Information gathered will inform a QI project to support improvement in oral health provision for our patients. Poor oral health has been proven to negatively impact patients not only in relation to long term health conditions but also their response to infection • Support Pharmacy in relation to antimicrobial stewardship ensuring reports are provided and fed into the IPC Steering Group • Provide expert IPC advice in system-wide urinary catheter and gram negative infection reduction working groups • Provide expert advice in the management of individual cases and outbreaks of infection
Priority 4: Review of practices in community settings	• Following a recent period of increased incidence of infection across South Essex, a full review of practices within community care teams the Trust using the national hierarchy of control • Close collaboration with clinical teams and our ICB and UKHSA colleagues • Utilisation of the hierarchy of controls to identify evidence based changes to practice • Standardisation of practice across the Trust within community services • Trial of alternative hand sanitiser that is alcohol free, which if successful, may impact hand hygiene across all services within the organisation • Local, regional, national sharing of the experiences had during the PII for the learning of others across the healthcare system
Priority 5: Ready and competent workforce	• Provision of IPC training as part of Trust Induction, national mandatory E-learning and ad-hoc sessions • Review of Trust position in relation to staff training and competence in Aseptic non-touch technique in collaboration with education colleagues • Co-ordinate and deliver activities in relation to Global Hand Hygiene Day - focus on appropriate glove use using the addition of sustainability as another angle of approach • Review and update IPC guidelines to align with national changes • Ensure all relevant staff are provided with Face Fit Testing for FFP3 masks for use with certain infectious illnesses and as part of long term NHS preparedness for future pandemic • Advise Occupational Health Service Provider on the collection and maintenance of staff immunisation records • Investigation of more sustainable ways of managing IPC risks in ways which do not increase risk to patients and staff


NHS
Essex Partnership University
NHS Foundation Trust
Quality Improvement
1) Team
2) Organisational Structures
3) Networking
Meet face-2-face regularly
Identify strengths & Training needs
Develop team bios
Buddying
QI journey planning
Notes:
- Play to strengths
- Shared understanding How we support each other
- New team working together
- Software training/IT systems
Develop Care Unit/ICB organisational
Review Care Unit spreadsheet
ODQS relationships
Capture intervention/interaction ICP metrics for performance
Giving back problem-solving decision making following COVID
Estates & facilities/ward managers/Community leads
Notes:
- Keeping ICP high on the agenda
- Raise awareness of the team, increase profile/presence/support
Quality Assurance:
-Mattresses
-Audit, community setting needed + support
-Policy & Procedures
-Current priority areas, CICC upto standard
- Understand EPUT quality strategy
Education:
- Complex systems
- simplify training
- Basic IPC standards
- IPC awareness for patients, posters/leaflets/online learning
P2

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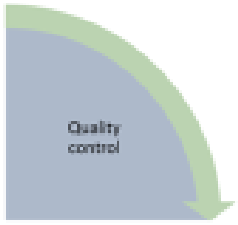
Infection Prevention and Control 2024/25



Q1 – No changes expected as we introduce our interventions

BY Q4 – 10% expected

Quality Outcome Measure/ Indicator	Measure	Monitor	Challenges
Quantitative			
Monthly Tendable Audit (key measure)	10 % improvement in IPC standards in care over the year	IPC Group and Care Unit	Acuity, staff skills, resources to support change
IPC team Audit ICAT (Key measures)	10% annual improvement in IPC environmental standards over the year	IPC Group and Care Unit	Acuity, staff skills, resources to support change
Facilities cleaning Audit (Key measure)	Annual improvement in clean environmental standards	IPC Group and Care Unit	Acuity, staff skills, resources to support change
Outbreak - frequency and organism included	Standards in compliance/ lessons learned.	IPC Group and Care Unit	Acuity, staff skills, resources to support change
Timely and robust surveillance of alert organisms	Improved diagnostic and treatment times and management	IPC Group and Care Unit	Acuity, staff skills, resources to support change
Staff face fit testing for FFP3 masks	Increase seen in the number of staff fit tested month on month	Care unit and IPC steering group	Resources within IPC team and care units
Qualitative			
Thematic review of patient understanding of oral health	Improvement in the provision of assessment and treatment of oral health	IPC Group	Acuity, staff skills, resources to support change
Thematic review of care environments	Improvement in the estate to meet national standards	IPC Group	Acuity, staff skills, resources to support change
Review of staff attitudes towards risks and Standards	Understanding of principles of IPC	IPC Group	Resources to support change

IPC annual report 2023/24 Katheryn Hobbs Head of IPC on behalf of Angela Wade Director of Nursing and DIPC
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Infection Prevention and Control 2024/25

Collaborative partner quality visits

As a collaborative we are responsible in assuring the quality of each others IPC work and have a schedule of Peer review visits across the year.

Quality and Safety Review and Patient Safety Walkarounds

Our Quality and Safety Review process and Patient Safety Walkarounds together with our Safety Partners will enable us to engage with clinical services around Safety, Experience and Effectiveness. The reviews and Walkarounds will help us learn how we are safely managing IPC standards and how the people we care for feel confident in care provided .

Proactive management of audit results and trend identification

We will continue to use data to focus our improvement work to improve IPC standards .

We will continue to capture feedback from our staff, patients and carers

Through engagement forums, compliments, complaints and purposeful questionnaires such as an Appreciative Inquiry we will continue to capture feedback from our staff, patients and carers.

P4

IPC annual report 2023/24 Katheryn Hobbs Head of IPC on behalf of Angela Wade Director of Nursing and DIPC
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8.4 LEARNING FROM DEATHS ? QUARTERLY OVERVIEW OF LEARNING AND DATA (Q3 & Q4) 2023-2024

Information Item AS 5

REFERENCES

Only PDFs are attached

Learning from Deaths Q3 & 4 2023-24.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Learning from Deaths – Quarterly Overview of Learning and Data (joint report Quarters 3&4 2023/24)**					
Executive / Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Michelle Bourner, Projects					
Report discussed previously at:	Learning from Deaths Oversight Group, Learning Oversight Sub-Committee, Safety of Care Group, Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	None		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		✓
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with the *Learning from Deaths – Quarterly Overview of Learning and Data (Q3 & Q4 2023/24)* report, which includes the following: • An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and actions being taken as a result; • Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements; • Information relating to developments to mortality data processes currently being progressed;	**Approval**	
	Discussion	
	Information	✓

• Data relating to deaths recorded on Datix for updated data for Q1 – Q2 2023/24; Q3 2023/24 (1st October – 31st December 2023) and Q4 2023/24 (1st January 2024 – 31st March 2024). • Updated data for deaths relating to previous years.		

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report; and
2. Request any further information or action.

Summary of Key Points

1. The Trust implemented the current Learning from Deaths Policy and Procedural Guidelines from 1 April 2022. Prior to that, the Trust had a Mortality Review Policy and Procedural Guidelines in place.

2. The attached report is a joint report for Q3 2023/24 and Q4 2023/24. The data and learning was considered via the Trust's internal governance structures at the time of production (i.e. Q3 2023/24 – February / March 2024 and Q4 2023/24 – May / June 2024).

3. The report provides an overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements and examples of actions being taken as a result. This learning is presented on a monthly basis to the Trust's Learning from Deaths Oversight Group, Learning Collaborative Partnership and Learning Oversight Sub-Committee. There are immediate actions taken as a result of learning identified, as well as longer term actions that form part of the Trust's Safety Improvement Plans.

4. The attached report also presents data that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – i.e. the number of deaths in scope; the number reviewed and level of those reviews; and the assessment of problems in care. Q3 2023/24 data was extracted and analysed as at 15/02/24 and Q4 2023/24 data was extracted and analysed as at 11/05/24. Any updates to information after this date will be included in future reports. There are no issues of significant concern to note from the Q3 or Q4 data, which is broadly in line with that of previous quarters.

5. Key points of note are:
   - As at 15/02/24, a total of 169 deaths had been reported on Datix for Q3 with 40 of those deaths being "in scope" of the learning from deaths arrangements
   - There has been an improvement in the number of outstanding Stage 1 reviews being completed, with work continuing to ensure that remaining Stage 1 reviews are completed as soon as possible. In addition, 115 death reviews for Q1 – Q3 have been reviewed by Care Unit leads and closed at Stage 1 over the past quarter and 3 Stage 3 PSIRF death reviews have been approved in the past quarter.
   - As at 11/05/24, a total of 143 deaths had been reported on Datix for Q4 with 45 of those deaths being "in scope" of the learning from deaths arrangements
   - 40 deaths in Q4 had been closed at Stage 1 to date, with 5 referred for a Stage 3 PSIRF review, 7 to be included in thematic reviews and 2 for individual Stage 2 clinical case note review.

   - The total number of death reports on Datix (n. 654) for the full year 2023/24 is higher than 2022/23 (n. 520). However the number of deaths in scope of the Policy (n. 210) for the full year 2023/24 remains consistent with 2022/23 (n. 236). This indicates an increased reporting of deaths that are not mandated for report within the Policy scope, potentially reflecting an increasing awareness of the learning from deaths arrangements improving the Trust's ability to learn from deaths.

6. At the point of extracting the data for Q3 (15/02/24), a total of 83 Stage 1 reviews had been undertaken by local service managers in relation to deaths occurring between 01/10/23 – 31/12/23 to ascertain learning and identify those for further detailed review. At the point of extracting the data for Q4 (11/05/24), a total of 88 Stage 1 reviews had been undertaken by local service managers in relation to deaths occurring between 01/01/24 – 31/03/24. This is a review stage that did not form part of the

previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally.

7. As part of the Trust's mortality surveillance arrangements, a comparison to the categories under the previous Mortality Review arrangements has also been undertaken whilst a longer period of comparative data under the new arrangements was built up. This has enabled identification of any increases in death numbers against the previous scope categories which are outside of Statistical Process Control limits and should thus be investigated further. This was undertaken for Q3 for the data as at 15/02/24 and is included at Appendix 1e - there are no issues of concern to note.

8. As there was 24 months of data for the new learning from deaths arrangements as at the end of Q4, it has been possible to produce Statistical Process Control charts from Q4 onwards for the new arrangements with control limits based on the first 20 months of data. These are included, together with commentary, in the attached report at Appendix 1f and 1g.

9. The Trust is currently progressing work to further enhance the production and analysis of mortality data; details of that work are included in the attached report.

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

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

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

Acronyms/Terms Used in the Report			
LDOG	Learning from Deaths Oversight Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	LOSC	Learning Oversight Sub-Committee
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness
PSIRF	Patient Safety Incident Response Framework	EDAP	Essex Drug and Alcohol Partnership

Supporting Reports and/or Appendices

Attached:

- Report: Learning from Deaths – Quarterly Overview of Learning and Data (Q3 & Q4 2023/24)
- Appendix 1: Summary of Quarter 1 - Quarter 4 2023/24 mortality data
- Appendix 2: Summary of previous years mortality data

"National Guidance on Learning from Deaths" Quality Board March 2017:
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" NHS Improvement July 2017:
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

"Using the Care Review Tool for mortality reviews in Mental Health Trusts" Royal College of Psychiatrists November 2017:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

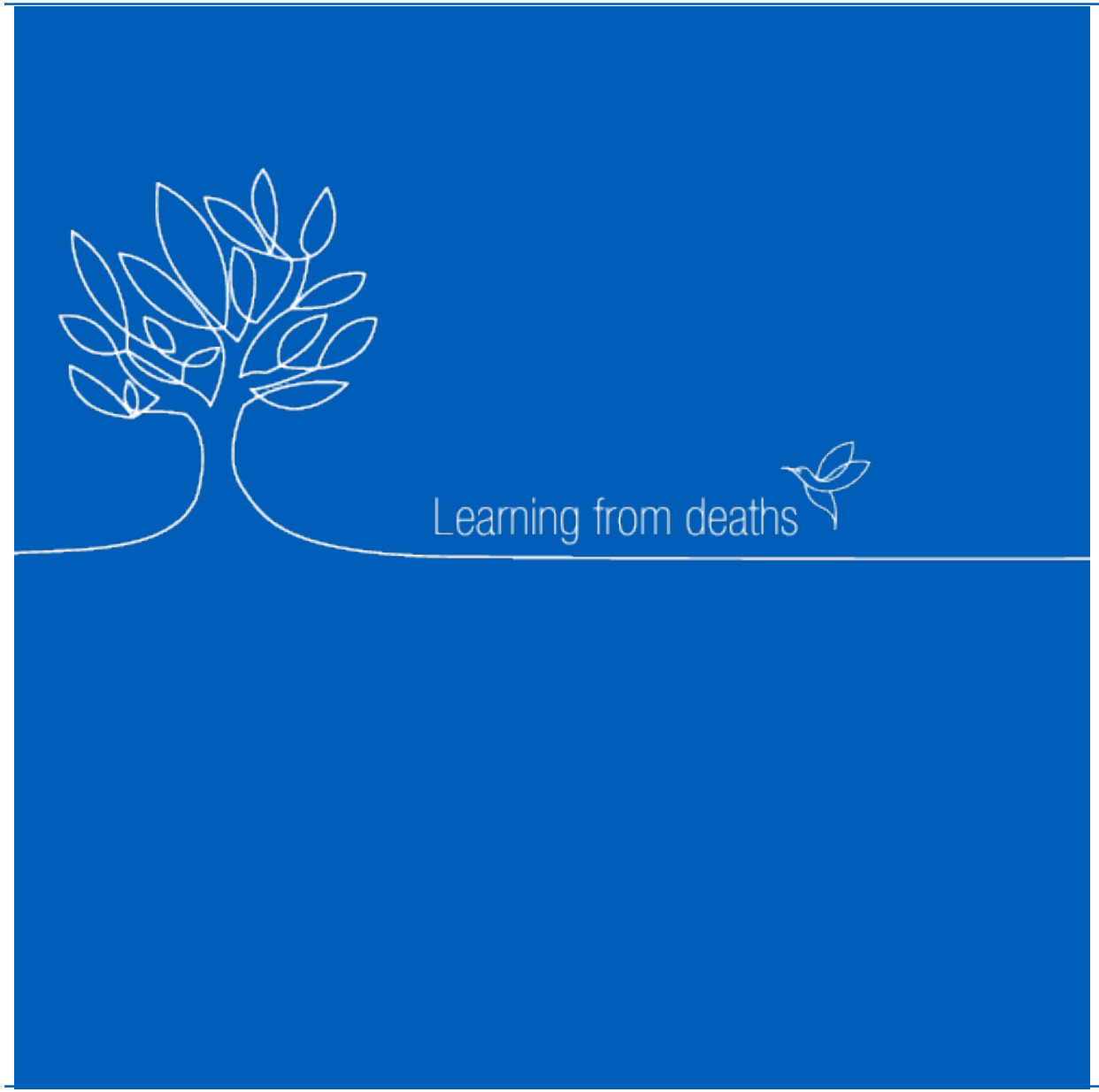
Ann Sheridan
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

QUARTERLY OVERVIEW OF LEARNING AND DATA

Learning from deaths

QUARTERS 3&4 - 2023/24

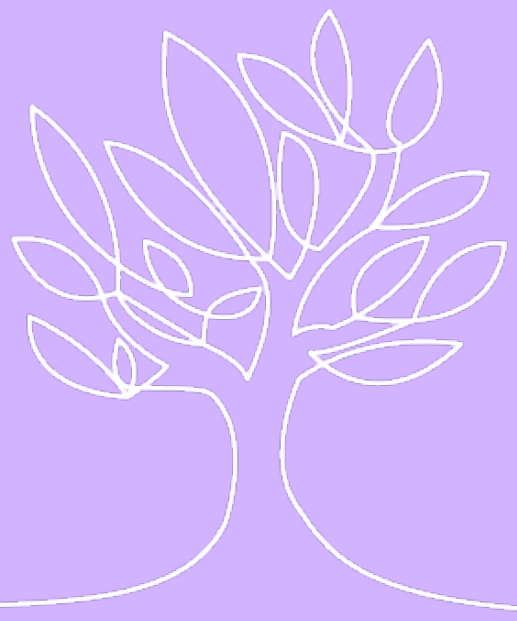


PURPOSE OF REPORT

This report sets out:

- An overview of learning resulting from the reviews undertaken under the Trust's Learning from Deaths arrangements since the last report to the Board of Directors (January 2024) – i.e. learning identified between December 2023 – May 2024 (pages 4 – 20);
- Information relating to the context of mortality data and surveillance under the Trust's Learning from Deaths arrangements in place since 1st April 2022 (pages 21 – 24);
- An overview of changes to reporting and review processes being made from 1st October 2024 (page 25);
- Data relating to deaths recorded on Datix for Q3 2023/24 (1st October – 31st December 2023) and Q4 2023/24 (1st January – 31st March 2024); and updated data for Q1 and Q2 (pages 26 – 32 with detail in Appendix 1); and
- Updated data for deaths relating to 2022/23 and previous years (pages 33 – 34 with detail in Appendix 2).

THE TRUST'S APPROACH TO LEARNING FROM DEATHS - CONTEXT



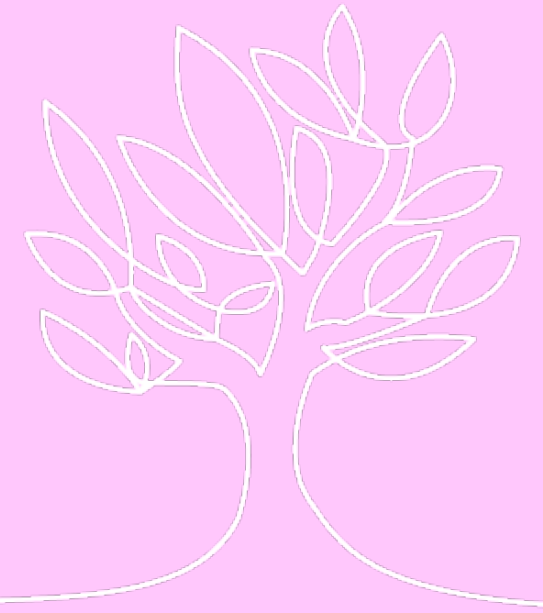
The aims of the Trust's Learning from Deaths Policy are to provide a robust governance framework for undertaking mortality review in order to:

- improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it;
- further develop systems of care to continually improve their quality and efficiency;
- improve the experience for patients, their families and carers wherever a learning issue from the review of deaths is identified;
- improve the use of valuable healthcare resources; and
- improve the working environment for staff in relation to their experiences of reviewing deaths and associated reviews / investigations.

The Trust sets out to achieve these aims by:

- ensuring that deaths that occur within the Trust are subjected to appropriate review based on the circumstances of the death which enables any good practice, or conversely problems in care, to be identified on an individual basis;
- ensuring that any problems in care for individual cases are addressed appropriately and appropriate actions taken in relation to that death;
- ensuring that any good practice and lessons learnt are shared across the Trust where appropriate and local actions taken to ensure that good practice is increased and improvements in care are implemented across the Trust where necessary; and
- ensuring that the Trust has a corporate oversight of deaths of patients in its care and identifies any trends or themes of concern or good practice emerging which may require further investigation and action.

LEARNING FROM REVIEWS OF DEATHS December 2023 – May 2024



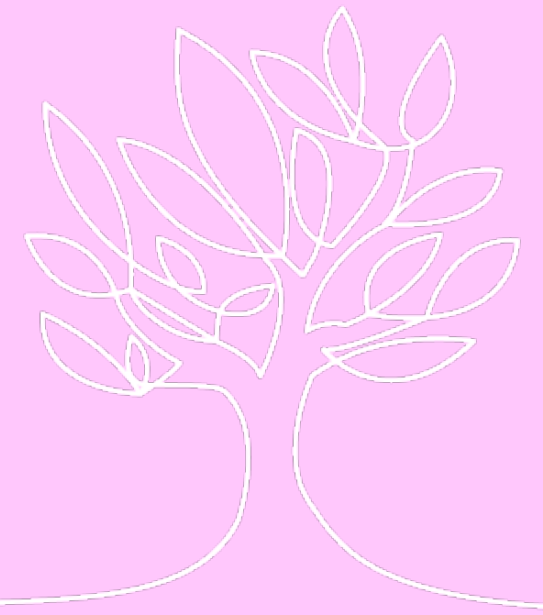
This section on learning details:

- Sources of learning (page 4)
- Examples of good practice identified (page 5)
- Learning emerging from Stage 1 reviews (pages 5 – 7)
- Learning emerging from Stage 2 reviews (pages 8 – 9)
- Learning emerging from various other review processes (pages 10 – 14)
- Learning emerging from PSIRF reviews (page 15)
- Examples of actions being taken to address and action learning from learning from deaths reviews (pages 16 – 20)

Sources of learning:

- Completed Stage 1 local service reviews
- Approved Stage 2 clinical case note reviews
- Approved Stage 3 (Patient Safety Incident Response Framework - PSIRF) reviews
- Completed Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative reviews
- Completed end of life care reviews
- Completed National Learning Disability and Autism Mortality Review Programme (LeDeR) reviews

Examples of good practice and learning themes emerging from Stage 1 reviews December 2023 – May 2024 [1]



The following pages outline examples of some of the learning and themes emerging from reviews of deaths. Pages 16 – 20 of this report go on to outline some examples of the actions being taken in response to learning.

GOOD PRACTICE:

- Inpatient deaths – a number of examples of good care being delivered, appropriate Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documents in place, families being complimentary about / appreciating care given by Ward staff, relevant MDTs and Care Coordinators involved, identification of physical health deteriorations and appropriate transfers to acute Trust, good communication.
- Community deaths – a number of examples of the person being offered all appropriate services on occasions presented to EPUT, standards of care being as expected and in accordance with systems and processes, necessary support being provided.

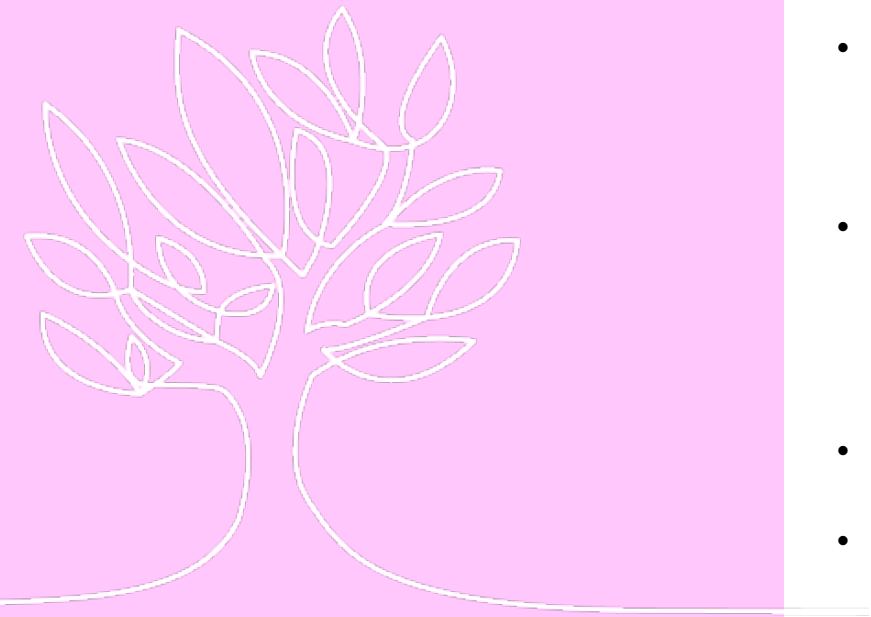
CONTINUING THEMES:

- Often **cause of death is not available** at the point of completing Stage 1 review – limits conclusions (and causes issues for timing of PSIRF / Stage 2 reviews)
- Majority of the deaths reviewed are from **physical health causes** (e.g. long terms conditions, multiple co-morbidities, end of life care, physical health crisis) – importance of integrated working between mental and physical healthcare services and awareness of impact of mental health medications on physical health

Learning themes emerging from Stage 1 reviews December 2023 – May 2024 [2]

- **Disengagement –** e.g. appropriate involvement of family in circumstances of client – consider more robust guidance in the Disengagement Policy to support clinicians to contact family at an earlier stage to ensure all involved can do their utmost to support the client and prevent harm; consider contacting referrer when no call backs to attempted contacts received from client; ensure there are appropriate follow up plans in place for clients known to disengage with services; exploration of mental health state and suicide risk on phone for clients who have DNA'ed appointments
- **Clients not open to services at time of death –** e.g. Coroner Do You Know? enquiries
- **Record keeping** – e.g. ensuring follow up phone calls are documented, updating the clinical record system to discharge a patient from the community team when their care is transferred to the palliative care team; ensuring next of kin details are held; recording clear instructions related to outcomes of appointments
- **Person awaiting assessment at time of death –** e.g. routine referral received but sadly patient passed away 10 days later prior to assessment being able to take place (a plan was in place to assess)
- Importance of considering timeliness of **referrals** to appropriate services
- **Communication within team** – e.g. active listening in handover to support colleagues with complex presentations; consideration of intensive support with particular cases; **Communication between Trust teams** – e.g. mental health team and district nursing team in relation to wound / self care; **Communication between partner agencies –** e.g. on discharge from acute Trust

Learning themes emerging from Stage 1 reviews December 2023 – May 2024 (3)



- **Medications** – e.g. expediting medication reviews where appropriate; GPs prescribing medications recommended
- **Policies and procedures** – e.g. enforcing standardised treatment protocols to ensure consistency and effective care delivery
- **Face to face appointments –** egg importance of ensuring appointments take place at appropriate location taking account of individual's circumstances
- **Waiting times –** egg importance of timely appointments with clients, actions taken whilst clients awaiting assessment

EXAMPLES OF NEW LEARNING:

- Ensuring all staff working in the identified service are aware of the **procedure to follow in the event of an expected death** (including who to contact and care to provide)
- **End of Life Care related:** Importance of putting timely PEACE plans in place for patients in receipt of end of life care; having an Advanced Care Plan in place to support family and assist patient in achieving their wishes; knowing patients, respecting their values and ensuring they die with dignity.
- Importance of **robust pathways** for supporting clinician decision making
- Importance of completing **demographics** during the assessment and treatment process

Learning themes emerging from Stage 2 Clinical Case Note Reviews December 2023 – May 2024 [1]

STAGE 2 CLINICAL CASE NOTE REVIEWS:

Six Stage 2 Clinical Case Note reviews have been approved in the six month period to end May 2024. Key learning emerging from those reviews was as follows:

- **Communication / family involvement x2:** *Review 1:* Communication with the patient and family member had been appropriate whilst under the care of EPUT services. Whilst the patient was not under the care of EPUT services at the time of death, it would have been a kind gesture to extend condolences and support to family at time of bereavement. *Review 2:* There had been no involvement of family but it appeared that the patient had no contact with their family.
- **Record keeping x2:** *Review 1:* Strengthening the detail contained in records in terms of decisions and rationale would improve the Trust's ability to learn from the review of deaths. *Review 2:* Importance of documenting whether appointments went ahead and their outcomes / DNAs
- **Physical health:** Importance of collaborative working with primary care GPs in relation to the physical health of clients and documenting such collaboration in the clinical records. Recording Vital Signs monitoring in the correct place on clinical records. Ensuring that Annual Physical Health checks are offered on a timely basis and the outcome clearly documented in the clinical records.
- **Risk assessments:** Ensuring regular review and updating of risk assessments.
- **Integrated working with partner agencies – good practice:** The services provided to the client were a good practice example of effective integrated working between a number of different agencies involved to meet complex needs.

Learning themes emerging from Stage 2 Clinical Case Note Reviews December 2023 – May 2024 (2)

- **Provision of care – good practice x3:** *Review 1:* The patient had had a care coordinator throughout their care under the CMHT Team as the patient remained on section 117; and had had a good number of contacts with the patient throughout their care. *Review 2:* A number of areas of good practice were identified and it was assessed that, from the psychiatric point of view, there was adequate engagement and response to treatment. *Review 3:* Good quality mental health care was provided to the patient – the overall care included a comprehensive approach. The care catered to the needs of various domains like mental health, physical health, emotional and social needs with a supported environment to live in. It was tailored to meet the specific needs of the patient.
- **Dual diagnosis:** The patient received adequate care under EPUT mental health services. They refused to address their alcohol issues and subsequently died due to physical health problems related to alcohol abuse.
- **Referral for other specialist service intervention where appropriate:** Value of mental health services considering the possibility of other specialist services intervention e.g. specific psychological therapies and pain management services for patients with long term physical health conditions
- **Challenges created by out of area placements in Care Homes due to local availability:** difficulties placed on teams continuing to provide face to face services to clients placed out of area (the review was an example of good practice where this had been achieved)

Learning themes emerging from Stage 2 thematic reviews and national reviews December 2023 – May 2024

EPUT THEMATIC REVIEWS:

- A thematic review of n.36 non-Patient Safety Incident related deaths of patients with Severe Mental Illness (2022-23) has been completed by the Trust's Nurse Consultant in Physical Health. Early learning has been presented within the Trust and to Integrated Care System colleagues.
- More detailed information in terms of learning and actions taken will be included in the Q1 report to the Board of Directors.

NATIONAL LEARNING DISABILITY AND AUTISM DEATHS MORTALITY REVIEW PROGRAMME (LeDeR):

- The National LeDeR Annual Report 2022 was published in November 2023 and is available to view here:

Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) - King's College London (kcl.ac.uk)

- The Southend, Essex and Thurrock (SET) LeDeR Annual Report 2022/23 was published during the period and is available to view here:

Item 7.1. SET LeDeR Annual Report V2_3 - Final.pdf (thurrock.gov.uk)

- The learning emerging from these reports has been considered by the Trust and action plans have been put in place by the SET LeDeR Quality Panel and Essex Learning Disability Partnership. A quarterly update on progress is being provided to the Trust's Learning from Deaths Oversight Group.

Learning themes emerging from End of Life care reviews December 2023 – May 2024

END OF LIFE CARE REVIEWS:

Examples of learning identified via reviews of end of life care in the period include:

- Recognising that different environments (e.g. care homes) may use different "symbols" on doors / bedside to denote that a patient is at end of life. Staff have therefore been advised to ensure that they are aware of the relevant symbol in each environment otherwise there is a risk that staff may not be aware that a patient is approaching end of life and may deliver responsibilities inappropriately e.g. disturbing families sitting with dying loved ones.
- Learning and guidance issued in terms of medication delivery using ambulatory infusion pumps following a national report on this issue from the Health Services Safety Investigations Body (HSSIB) after an incident in another Trust.
- A complainant who was concerned about the lack of compassion shown by a member of staff to their family member has supported the Trust in identifying learning to share with staff for future care provision to other patients.
- Guidance and briefings issued to staff about use of different syringe pumps following identification of patients being discharged from some London Trusts with different pumps.
- Identifying and sharing lessons learnt from a no harm drug related error by a family member.
- Providing system access and training for staff who it was identified were unable to access electronic referrals systems.
- Supporting work in relation to home oxygen therapy for palliative care patients following an incident.

Learning themes emerging from EDAP multi-agency collaborative reviews December 2023 – May 2024 [1]

ESSEX DRUG AND ALCOHOL PARTNERSHIP (EDAP) MULTI-AGENCY COLLABORATIVE REVIEWS:

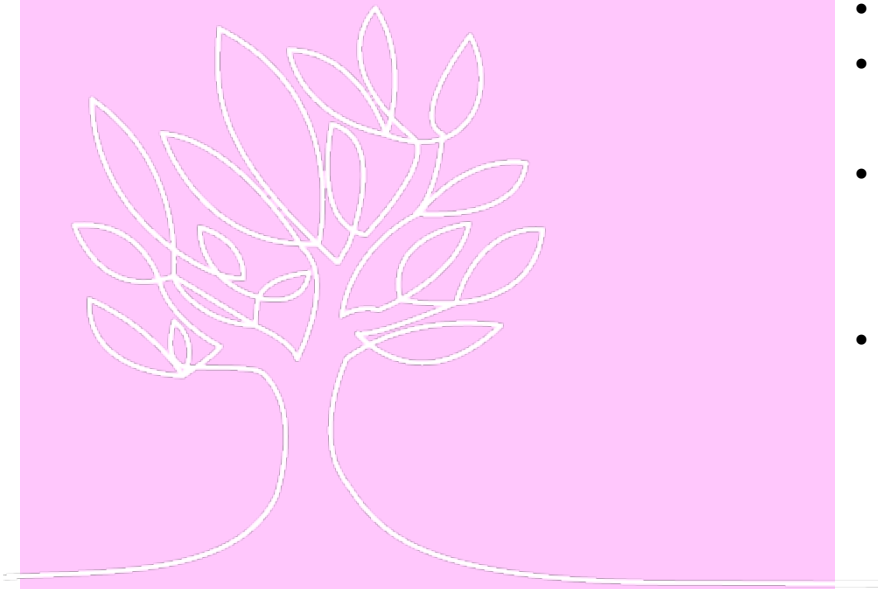
Good practice examples included:

- Excellent example of collaborative working between EDAP and end of life care services
- Good communication / joint working between the EDAP partners and examples of good working with partners e.g. probation service, GP, social care
- Evidence of exceptional care in the community

Learning examples included:

- Opportunities for strengthening communication / joint working with acute Trusts and with EPUT mental health services
- Avoiding medication changes on Fridays
- Exploring training for staff to increase awareness and skill sets in terms of suicide prevention opportunities and actions
- Exploring training for staff to address changing landscape of substances clients are using etc.
- Opportunities for strengthening prison pathways
- Ensuring, where both patient and their partner are service users, that both sets of clinical records are appropriately updated with relevant information

Learning themes emerging from EDAP multi-agency collaborative reviews December 2023 – May 2024 [2]



ESSEX DRUG AND ALCOHOL PARTNERSHIP (EDAP) MULTI-AGENCY COLLABORATIVE REVIEWS:

Learning examples included:

- Putting in place appropriate support for staff who will obviously be impacted by the deaths of their clients – e.g. psychological support, practical training for inquest involvement etc.
- Exploring links with Registry Offices to obtain formal causes of death where unable to confirm from other sources
- Importance of contemporaneous record keeping and documenting transfers of care
- Exploring how to improve access to GP services for service users
- Raising awareness amongst staff of the Shared Care Record to support background knowledge of client's health position
- Strengthening relationships with pharmacists to improve communication between services when, for example, clients fail to collect their prescribed medications
- Exploring follow up of Duty of Candour a period of time following death and re-offer as family / carers may not always want support immediately following a death but may wish for that support after a period of time

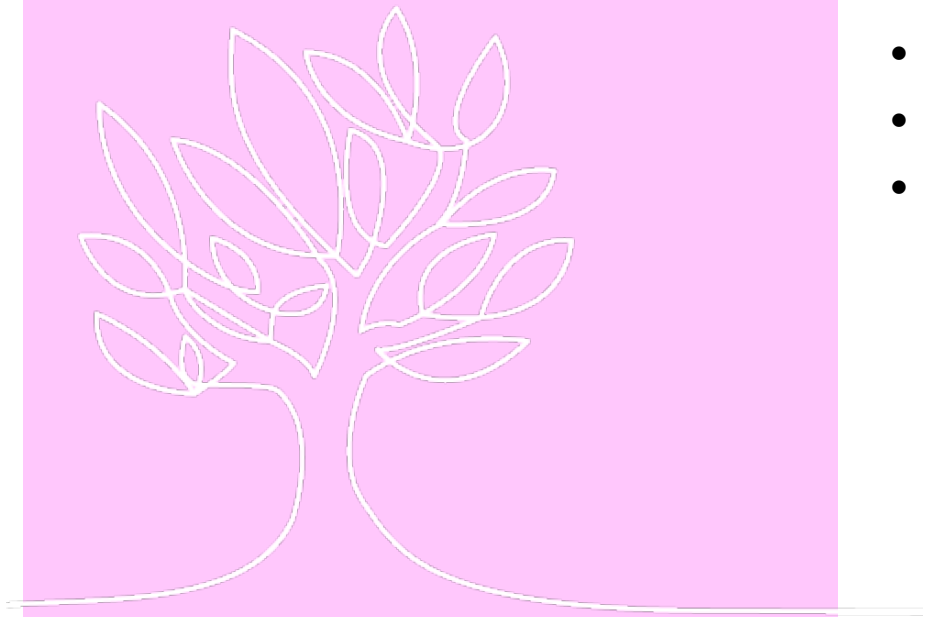
Learning themes emerging from Dual Diagnosis Learning Implementation Group December 2023 – May 2024

LEARNING FROM DEATHS - DUAL DIAGNOSIS LEARNING IMPLEMENTATION GROUP:

Three meetings of the newly formed LFD Dual Diagnosis Learning Implementation Sub-Group have been held since the Q2 report to the Board of Directors. This is chaired by the Trust's Dual Diagnosis Clinical Leads and comprises EPUT mental health representatives and all multi-agency partners in the Essex Drug and Alcohol Partnership (EDAP). Key learning opportunities to be taken forward include:

- Ensuring strengthened processes for patients transitioning between EPUT crisis and community mental health services are in place consistently across the Trust
- Continuing to strengthen collaborative and joint working (i.e. working towards joint care planning and risk assessment) between EPUT mental health and EDAP services including operational dual diagnosis groups in localities
- Exploring ways to strengthen communication between acute Trusts and mental health/EDAP services
- Raising awareness of the availability of specialist Personality Disorder Services and referral routes
- Exploring how families (and other services providing care) can be more closely involved / engaged in care particularly if clients have a history of poor engagement
- Involving EDAP partners in transformation work underway in ICB areas
- Exploring joint appointments between mental health worker, EDAP worker and client for clients who are being encouraged to seek support from EDAP services, rather than solely making a referral
- Exploring establishing strengthened formalised multi-agency forums across locality areas for planning and overseeing the transition of young people from Children and Young People's services to adult services.

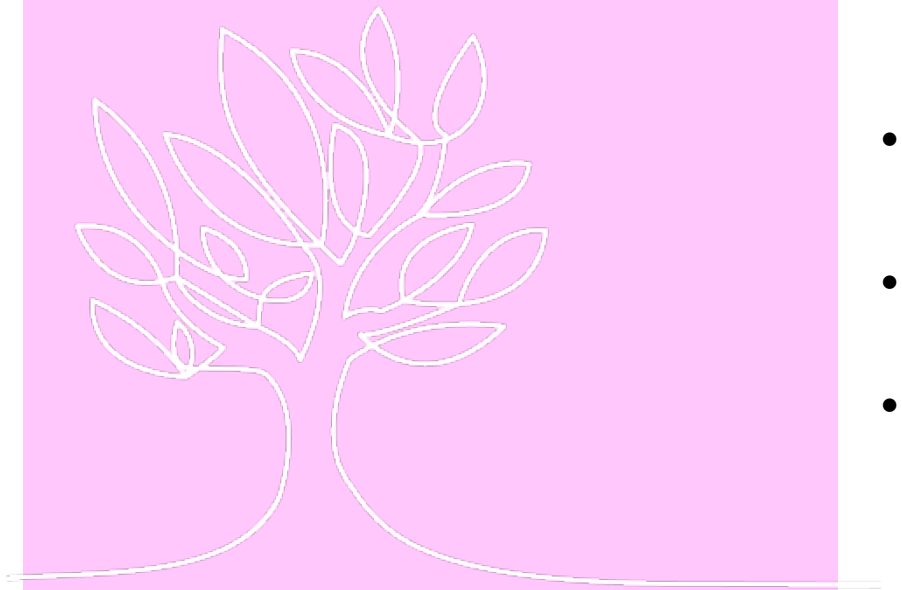
Learning themes emerging from PSIRF reviews approved December 2023 – May 2024



Similar themes continue to emerge from the review of deaths under the Patient Safety Incident Response Framework (PSIRF) as follows:

- Communication with / involvement of others – e.g. with patients, with other EPUT teams or partner agencies
- Record keeping
- Clinical care
- Referrals
- Training
- Disengagement
- Policy and Process
- Medications

Examples of actions being taken in response to learning from deaths – Stage 1 and 2 reviews [1]



- Local immediate actions by services – e.g. awareness raising undertaken with inpatient staff in terms of actions to take and contacts to make in the event of an expected death, awareness raising undertaken with staff in terms of timeliness of putting in place PEACE documentation and discharging patients from clinical systems when transferred to palliative care team, reminders given to staff to denote safeguarding incident on incident system if patient admitted with a pressure ulcer, all staff reminded to check with Care Homes what symbol they use to denote residents being at end of life to ensure e.g. family are not disturbed whilst sitting with dying loved ones, implementation of weekly zoning meetings

- Learning presented to and considered monthly by Learning Collaborative Partnership – included in Trust communications such as Lessons Learned Bulletin and 5 Key Messages as appropriate.

- Learning used to inform topic areas for "Learning Matters" MST development sessions – e.g. lessons learned from specific deaths.

- Thematic learning being used to inform the Trust's Safety Improvement Plans as they are developed.

- Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. The learning is also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

Examples of actions being taken in response to learning from deaths – Stage 1 and 2 reviews [2]

- Examples of specific actions arising from reviews that are being pursued include:
  - Work continues in terms of aiming to strengthen data flows to the Trust on confirmed causes of death – including liaison with the various Medical Examiners Offices covering the localities in which the Trust operates
  - The Trust's Nurse Consultant in Physical Health attended the Trust's Physical Healthcare Conference in January 2024 to present the initial findings of their thematic reviews of non-patient safety incident deaths of clients with Severe Mental Illness (SMI) and to explore actions that would strengthen holistic services.
- Multi-disciplinary work being facilitated to address Trust wide issues - e.g. :
  - Physical health – learning from deaths lead continues to link with Trust leads for physical health and the care of the deteriorating patient to ensure learning continually informs work in these areas – this has included feedback in terms of nutritional issues and physical health checks and recording
  - Terms of reference are now in place for the Quality Improvement Initiative to review and strengthen the pathways between prison healthcare and EPUT services and the multi-agency group to take this forward has been established
  - Review of Mental Health Liaison Team protocols to explore the facilitation of strengthened communication between the acute Trusts and mental health services

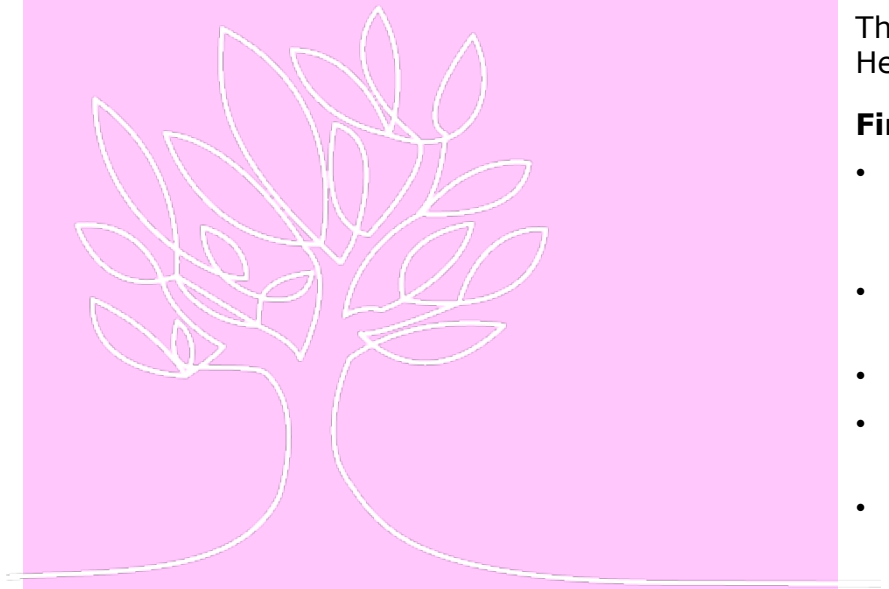
Examples of methods of sharing lessons from PSIRF reviews

The Patient Safety Team have introduced a robust measurable, qualitative Safety Action Plan that is developed as the learning emerges from the beginning of the PSIRF process through to the recommendations at the end report.

The following methods are used to ensure the findings from Patient Safety Incident investigations and reviews of deaths under PSIRF are shared:

- Sharing the report and learning with the patient's family: When the report has been approved, the patient's family are offered a copy to be shared with them.
- Push and Pull Communication: Development of policy and standard operating procedural documents taking account of learning, communicating learning via various Trust media including At a Glance, Safety Alerts and Team Briefing.
- Five Key Messages and Lessons Identified Newsletters: Key learning is shared in this format and published on the Trust Intranet page - EPUT Culture of Learning
- Lessons Identified Newsletters: These are shared at Quality and Safety meetings and stored on the Intranet, easily accessible via EPUT Culture of Learning desktop icon. A copy is also made available in the EPUT Culture of Learning hard copy folders on the wards.
- Attendance and representation at meetings: PSIM team representative attendance at Learning Collaborative Partnership and Learning Oversight Sub-Committee Meetings to share learning.
- Themed Learning Events: Introduction of quarterly Care Unit Leadership Learning Events.
- Live Learning Sessions: Introduction of the Learning Matters Monthly Insights MS Teams sessions delivered monthly and recording is accessible via the Trust Intranet.
- Safety Alert Learning Call (SALC): SALC calls stood up when there is significant opportunity for learning. There is a process in place for monitoring compliance for internal safety alerts issued in the Trust.
- System-wide Learning: The development of learning forums is a keen focus for the PSIM Team. This would be with the view to sharing learning across the systems. The multi-agency Patient Safety Specialist Forum presents a good opportunity for shared learning as well as the Integrated Care Board monthly assurance meetings.

Example of actions being taken in response to learning from deaths - PSIRF [1]



Incident Description

Patient presented at Acute Hospital - it was suspected that the patient had taken an overdose and patient sadly later passed away in Intensive Treatment Unit.

Findings - Good Practice

Patient had a team supporting her care in EPUT. Her community teams displayed compassionate care of a young woman with a complex diagnosis, the care was holistic and to a high standard.

The documentation was clear throughout the clinical notes and there appears to be no ambiguous information in clinical notes. However, the review identified that not all conversations regarding Patient's care were recorded on the Electronic Patient Record.

There is evidence of appropriate and proportionate escalation of concerns when Patient was deteriorating.

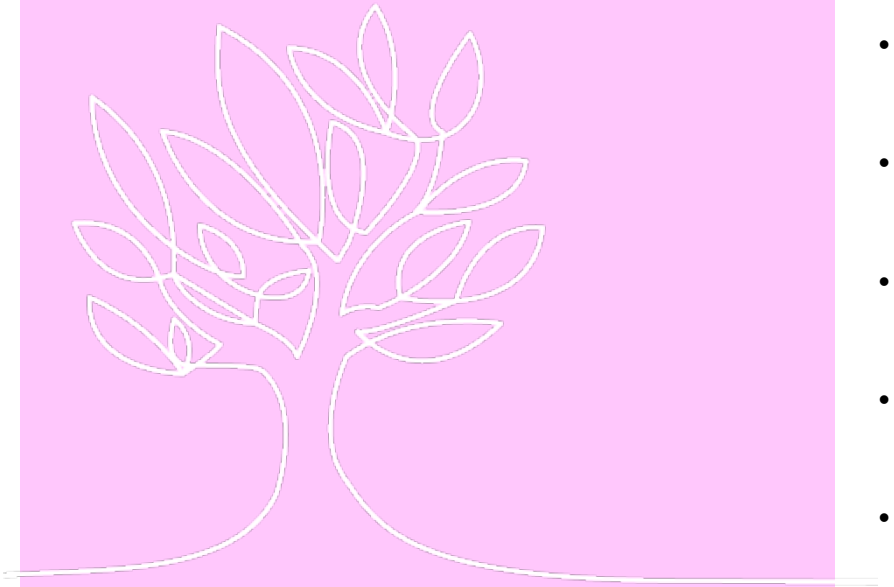
The referral to the Eating Disorder (ED) Specialist Unit was timely with the admission to Acute Hospital as an interim plan, before the ED Specialist Unit admission was possible.

There is evidence of regular face to face and telephone contact with Patient from both the Specialist Mental Health Team and Eating Disorder Team involved in her care.

Findings - Areas for Improvement

- The Learning Review discussion highlighted that continued Mental Health Liaison Team involvement throughout the acute admission would be best practice to promote the communication and joint working within both organisations.
- There is a need to consider a process of referral from community mental health teams to the mental health liaison team when referring to an acute hospital setting.
- Development of a Unified Electronic Patient Record was identified as relevant to this review
- When there is a Joint Learning Review under PSIRF, there should be assurance that meaningful family engagement is incorporated by all parties undertaking the review.
- Clinicians need to ensure that all discussions and conversations are recorded and reflected on the Electronic Patient Record. Medics must also ensure that information from telephone appointments is recorded within the notes and feedback in the Multi-Disciplinary Team meetings.

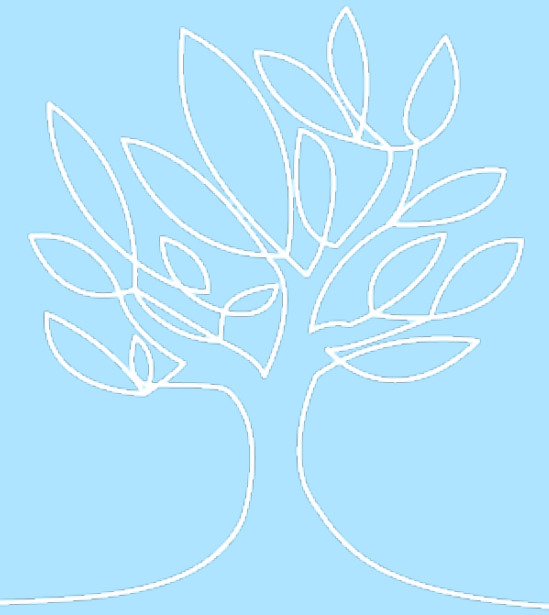
Example of actions being taken in response to learning from deaths – PSIRF [2]



Actions Taken:

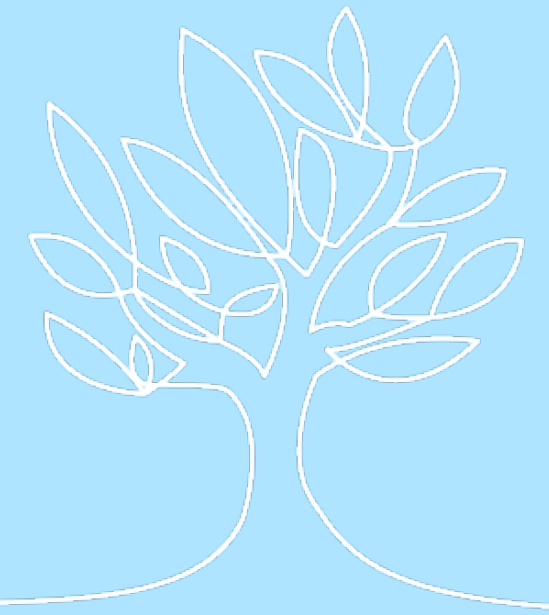
- Availability of the electronic Shared Care Record is being discussed in Business Meetings and Joint Working Meeting across EPUT and is improving patient pathways and better outcomes.
- Referral process from Specialist Mental Health Team to Acute Physical Services is being strengthened – this will include Medics completing such referrals ensuring the Patient's mental health services Care Coordinator is fully aware of plans and processes required in any planned interventions.
- Current policies and pathways in place for facilitating the admission of mental health patients with eating disorders to physical health ward's in acute hospitals are being reviewed.
- The need for a Standard Operating Procedure on joint working and multi-organisation working is being scoped.
- The development over the coming months of a Unified Electronic Patient Record for EPUT and other health providers will address learning related to shared records.
- All joint reviews/investigations will have a lead named Family Liaison Officer within EPUT.
- Trust Safety Alert Notices that include reference to record keeping and associated issues shared with staff.
- Learning Video relating to Record Keeping shared with staff.

Mortality Data – Context (1)



- From 1st April 2022, new arrangements for learning from deaths were implemented across the Trust. This included a new definition for deaths which would be in scope for consideration for **mandatory** individual mortality review in the Trust and thus report on Datix. This definition was based on the categories defined in the National Guidance on Learning from Deaths https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf and Royal College of Psychiatrists mortality review guidance https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych_mortality_review_guidance.pdf is outlined on the following page.
- Regardless of the mandatory requirements for report on Datix, services are also encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for Q1 – Q4 2022/23 and Q1 – Q4 2023/24.
- It should be noted that data in this report was extracted as at 15/02/24 (Q3 data) and 11/05/24 (Q4 data). Any updates to information after this date will be included in future reports.
- Mortality data is presented to the Learning from Deaths Oversight Group and Learning Oversight Sub-Committee monthly and quarterly for review and approval.
- Summary mortality data for Q1 – Q4 2023/24 is detailed in the following section with detail attached at **Appendix 1a (as at Q3) and Appendix 1b (as at Q4)**; and for previous years at **Appendix 2a (as at Q3) and Appendix 2b (as at Q4)**.

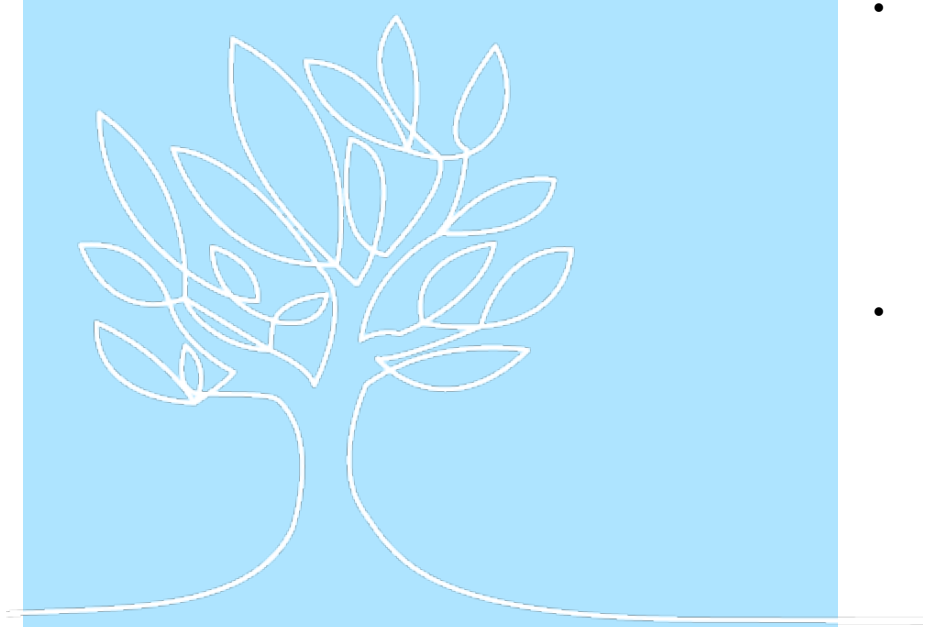
Mortality Data – Context (2)



Deaths in scope consideration for **mandatory** individual mortality review in the Trust and thus report on Datix are as follows:

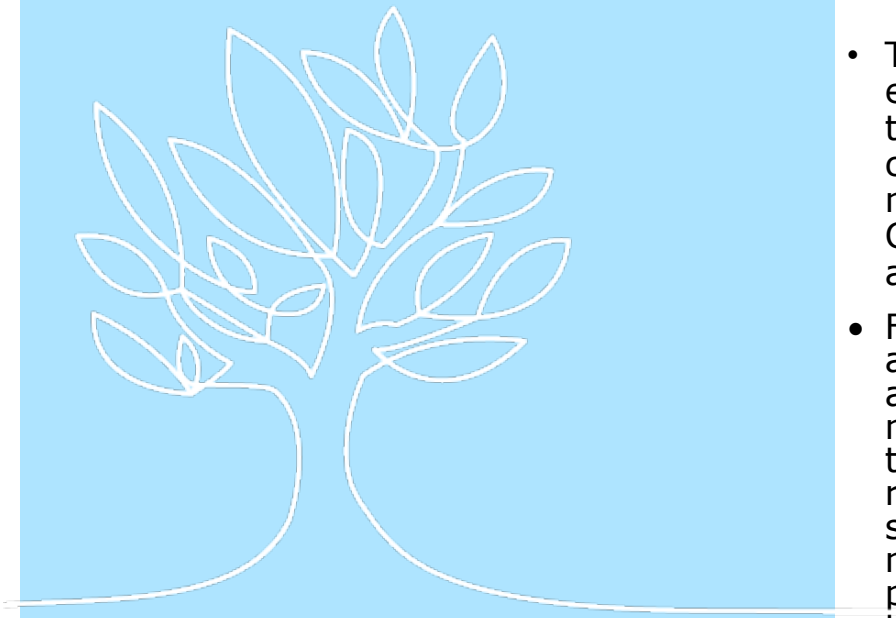
- All deaths that have occurred within Trust inpatient services (this includes mental health, community health and learning disability inpatient facilities).
- All deaths in a community setting of patients with recorded learning disabilities or autism. *All deaths of patients with recorded learning disabilities or autism, whether in an inpatient or community setting, will be referred into the national LeDeR programme and are thus subject to different review processes than other Trust deaths.*
- All deaths meeting the criteria for mandatory review under the Trust's Patient Safety Incident Response Framework (PSIRF) – both the nationally and locally determined categories. The review undertaken under the PSIRF constitutes the review of the death for the purposes of the Learning from Deaths Policy and Procedural Guidance.
- Any other deaths of patients in receipt of EPUT services not covered by the above that meet the national guidance criteria for a Stage 2 Clinical Case Note Review. These deaths will be any deaths where:
  - Family, carers or staff have raised concern about the care provided; or
  - The death was unexpected and the individual:
    - had a diagnosis of psychosis (including schizophrenia, bi-polar, episode of non-organic psychosis, personality disorder, complex and severe depression) or eating disorder during the last episode of care;
    - was an inpatient at the time of death or had been discharged from EPUT inpatient care within the last 30 days;
    - was under the care of a Crisis Resolution Home Treatment Team at the time of death.
- In addition, deaths of clients under the care of services provided by EPUT as part of the drug and alcohol services care pathway (EDAP) are subject to specific reporting and mortality review processes including a collaborative multi-agency review. These deaths are therefore also included within mortality surveillance data.

Mortality Data – Context (3)



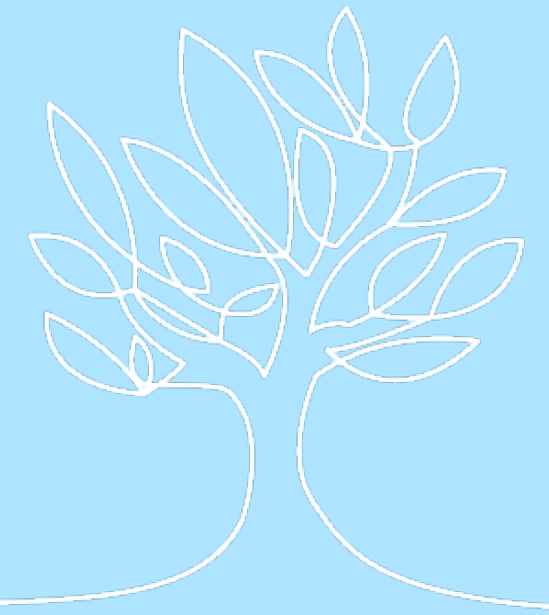
- Regardless of the above mandatory requirements for a formal review, services are encouraged to report on Datix all deaths that are brought to their attention. This increases the Trust's ability to identify potential learning opportunities. These additional reported deaths are also included in the data for 2022/23 and 2023/24. It should be noted that this will not reflect negatively on the Trust in terms of potential to appear as an "outlier" set against other Trusts mortality figures. The national guidance was clear that, given there is no standard national definition for deaths that should be included in Trust mortality data, no comparison or benchmarking should take place between Trusts – the data should be used solely internally to the organisation to support mortality surveillance and quality development. We are however exploring with other local mental health trusts their approach to reporting deaths and data provision to establish whether it is possible to locally determine a defined scope for reporting and benchmarks etc.
- This report includes mortality data mandated for report under the National Guidance on Learning from Deaths - i.e.:
  - the number of deaths in scope;
  - the number of these deaths subjected to review;
  - the level of review to which the deaths are being subjected; and
  - the determination of whether or not the deaths were more likely than not to have been due to problems in care.
- As the scope of deaths included has changed from the previous mortality review arrangements, there was no historic data prior to Q1 2022/23 against which to make comparisons. As a result, as well as analysing the data under the new arrangements, the data for 2022/23 and for Q1 – Q3 2023/24 was also analysed using previous scope arrangements in order to provide assurances that the Trust is not experiencing increases in death numbers across key services against historic data. Sufficient data had been collated under the current arrangements by the end of Q4 2023/24 to produce Statistical Process Control analysis under the current arrangements and this is included for the first time in this report.

Mortality Data – Context (4)



- Under the new Learning from Deaths arrangements, the previous 6 point scale for assessing problems in care has been replaced with the Royal College of Psychiatrists structured judgement review tool version which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. All deaths closed at Stage 1 are automatically deemed to be less likely than not to have resulted from problems in care. Deaths reviewed under the Patient Safety Incident Response Framework (PSIRF) from 01/05/21 were not subject to this determination as the methodology encourages focus on quality learning outcomes. A local methodology was initially put in place to make this determination for deaths reviews under PSIRF from 01/04/22; however this has been paused whilst further research is undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination for deaths reviewed under PSIRF given that the PSIRF methodology has not been designed for this purpose. This approach to PSIRF deaths is reflected in the data in Appendix 1 & 2. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will be reassessed.
- The Trust's established mortality data dashboard was amended from 1st April 2022 to enable recording of data in line with the new arrangements, whilst still retaining the ability to use the process as a validation exercise to ensure deaths are reported on both Datix and clinical information systems and that learning disability deaths have been reported to the national LeDeR mortality review programme. A validation exercise between Datix and Clinical Information Systems is undertaken each quarter to ensure deaths are reported appropriately on both systems.
- Further refinements to data processes were put in place last year to streamline and automate some previously manual processes, utilising more advanced technologies available to the Trust. This included the building of an additional section on Datix which is now completed for every death reported. This enables corporate oversight of progression of the death through the learning from deaths review processes and of the outcome of reviews, previously undertaken manually. The refinements made were intended to strengthen efficiency, accuracy and resilience in the production of meaningful data. These new processes have been utilised for the production of Q1 2023/24 data onwards. Data processes continue to be reviewed to establish opportunities for further strengthening of the Trust's approaches.

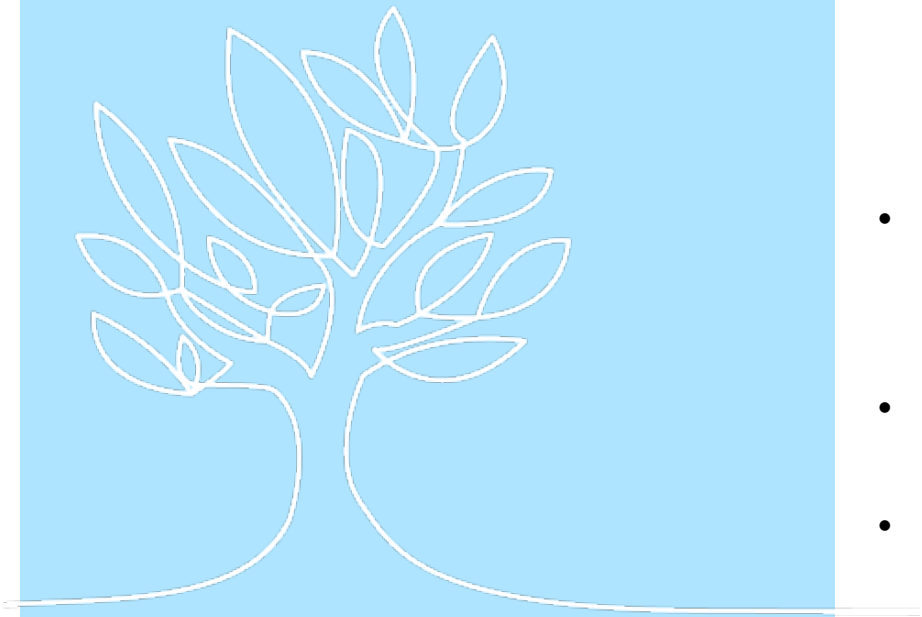
Mortality Data – Future developments



- The following bullet points summarise some key developments underway that it is anticipated will further strengthen the Trust's ability to report and provide assurance the deaths of patients under its care into the future.
- Currently Datix, the Trust's incident management system, is used as the primary source of information for production of the quarterly mortality data for these reports to the Board of Directors on the basis that all deaths within scope of the Trust's Learning from Deaths Policy are reported and tracked via Datix.
- The Trust is currently working on system enhancements whereby all patient deaths identified from the "National Spine", a central record essentially fed by GP clinical systems, will be automatically notified by the central Trust information team to the relevant service lead. The service lead will then undertake the initial screening of the death onto a newly built section of the relevant Electronic Patient Record for the patient which will identify and record whether the death falls within the scope of the Trust's Policy for report onto Datix and, even if not, any learning identified.
- This will enhance the ability for the Trust to be able to report data on all deaths of patients, not just those within the scope of the Policy for review, and provide documented assurance that all have been subject to an initial screening review. The timescale for completion of these system enhancement works is still being finalised but it is currently hoped that these arrangements will be in place by 1st October, enabling such reporting and data to be included in the Q3 2024/25 quarterly report onwards.
- The Trust is also liaising with local Medical Examiners Offices to explore opportunities for automatic data flows to the Trust on all confirmed causes of deaths for all patients under the care of the Trust. This is linked to the new statutory arrangements being implemented from 9th September 2024 that all deaths, including those occurring in a community setting, will be subject to Medical Examiner scrutiny from that date.
- Following implementation of the above processes, the Trust will move onto exploring possible enhancements to sophistication of analysis of the data by demographic factors to strengthen the ability to use the data to improve public health outcomes.

Summary of Quarter 3 2023/24 mortality data (1) (as at 15/02/24)

Refer Appendix 1a & 1c



- **Total number of deaths reported:** There were a total of 169 deaths reported on Datix for Q3 2023/24 (including those not falling within the scope for mandatory reporting). This is higher than Q2 2023/24 but in line with the figures for Q1 2023/24. The higher Q1 figures were impacted by the retrospective reporting exercise for Therapy for You deaths that informed a thematic review of those deaths and was subsequently stood down in July 2023. The higher numbers of reported deaths for Q3 predominantly relate to the Mid and South Essex and North East Essex community based mental health service areas. However it is important to note that the number of deaths in scope of the Policy have remained broadly consistent. Deep dives of data relating to reported deaths in both Mid and South Essex and North East Essex are underway to ensure there are no issues of concern requiring further investigation. Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 176 Datix reports made in respect of the 169 deaths.

- **Total number of deaths in scope for mandated reporting:** To date, a total of 40 deaths in Q3 2023/24 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 53 deaths which is required to determine whether they are in scope for mandated reporting). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 (Q1 – 62 Q2 – 61 Q3 – 55 Q4 – 58) and in Q1 and Q2 2023/24 which are 59 and 52 respectively. The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

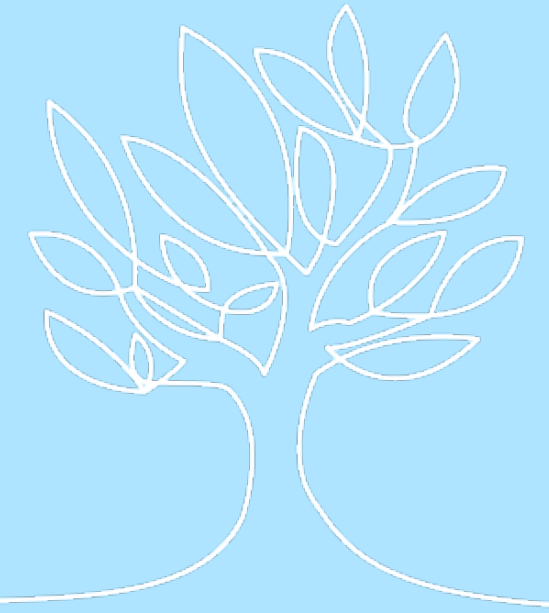
- **Inpatient / Nursing Homes deaths:** Of the 169 deaths reported in Q3, 5 were inpatient deaths and 6 were nursing home deaths. Four of the 5 inpatient deaths and all of the nursing homes deaths have been confirmed as due to natural causes. One inpatient death was not due to natural causes and a Patient Safety Incident Investigation is currently underway.

- **LeDeR reporting validation:** To date, all 8 reported Learning Disability deaths in Q3 2023/24 have been confirmed as reported to the national LeDeR programme.

- **Level of review:** Thus far, 45% of deaths in 2023/24 have been closed at Stage 1; 6% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 9% have been referred for Stage 3 full PSIRF review. The Table in Appendix 1c details how these proportions compare with previous years.

Summary of Quarter 3 2023/24 mortality data (2) [as at 15/02/24]

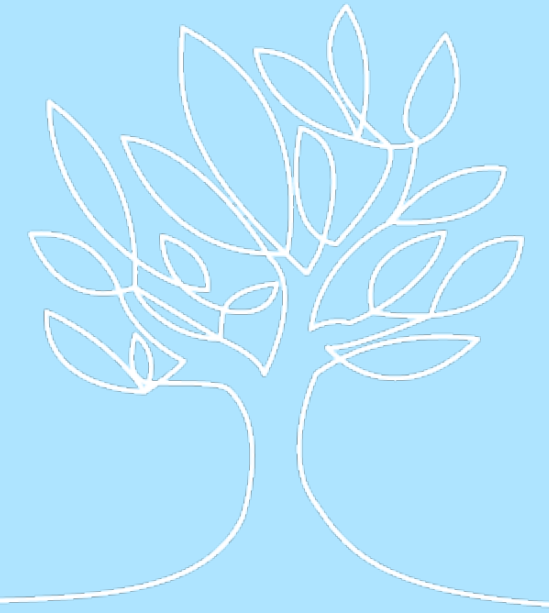
Refer Appendix 1a & 1c



- **Stage 1 reviews:** A total of 83 Stage 1 learning from deaths reviews have been conducted by a local service manager in respect of the 169 deaths in Q3. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 53 outstanding Stage 1 reviews for Q3 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 5 deaths in Q3 have been identified for Stage 2 mortality clinical case note review / thematic review thus far, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 7 deaths in Q3 have been identified for PSIRF review.
- **Completion of Stage 2 and Stage 3 (PSIRF) reviews:** Continued progress was made over the quarter with completion of Stage 2 and Stage 3 reviews relating to 2022/23 deaths, with 137 now completed set against a total of 100 completed in the Q2 report to the Board of Directors. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews. This is monitored by the Learning from Deaths Oversight Group and mitigating actions to ensure timeliness of review and learning identification are being pursued.
- **Problems in care assessment –** There are 0 deaths for Q3 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The assessment is still to be determined for 115 deaths in Q3. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 74 out of the total of 520 deaths for the full year. This includes deaths closed following PSIRF review as the assessment of problems in care has been paused whilst further research continues to be undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination given that the PSIRF methodology has not been designed for this purpose. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will need to be reassessed. This data will continue to be updated in future reports as reviews are completed and the likelihood is determined.

Summary of Quarter 4 2023/24 mortality data (1) [as at 11/05/24]

Refer Appendix 1b & 1d



- **Total number of deaths reported:** There were a total of 143 deaths reported on Datix for Q4 2023/24 (including those not falling within the scope for mandatory reporting). This is lower than Q3 2023/24 but in line with the figures for Q2 2023/24 and the same quarter last year. Deep dives of data relating to reported deaths in both Mid and South Essex and North East Essex were completed in Q4 to ensure there were no issues of concern requiring further investigation. Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 150 Datix reports made in respect of the 143 deaths.

- **Total number of deaths in scope for mandated reporting:** To date, a total of 45 deaths in Q4 2023/24 have been deemed in scope for mandated reporting (Stage 1 reviews are still awaited for 33 deaths which is required to determine whether they are in scope for mandated reporting). This total is broadly in line with the number of deaths confirmed as within the scope for mandated reporting in 2022/23 and in Q1 – Q3 2023/24. The deaths reported on Datix over and above these mandated deaths provide opportunities for the Trust to learn from deaths and staff will be encouraged to continue reporting.

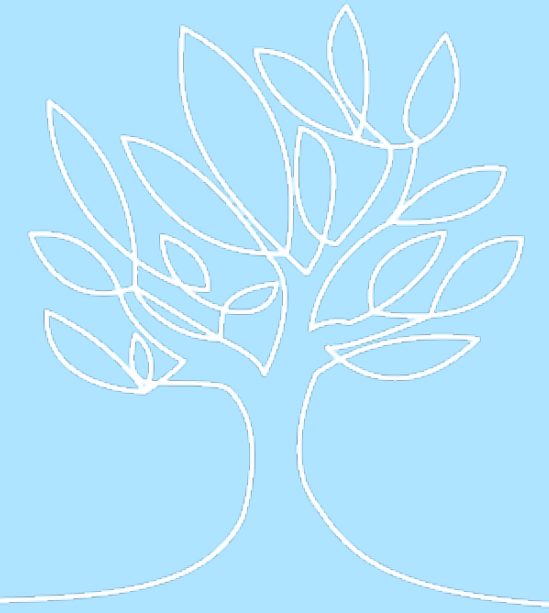
- **Inpatient / Nursing Homes deaths:** Of the 143 deaths reported in Q4, 9 were inpatient deaths and 6 were nursing home deaths. Eight of the 9 inpatient deaths and all of the nursing homes deaths have been confirmed as expected deaths due to natural causes. One inpatient death is currently under determination. Two additional inpatient deaths have been reported for Q3 since the last report, both of which were expected deaths due to natural causes.

- **LeDeR reporting validation:** All 5 reported Learning Disability deaths in Q4 2023/24 have been confirmed as reported to the national LeDeR programme. The additional Learning Disability death reported for Q3 since the last report has also been confirmed as reported to LeDeR.

- **Level of review:** Thus far, 52% of deaths in 2023/24 have been closed at Stage 1; 7% have been referred for Stage 2 Clinical Case Note Review or Stage 2 Thematic Review; and 8% have been referred for Stage 3 full PSIRF review. The Table in Appendix 1d details how these proportions compare with previous years.

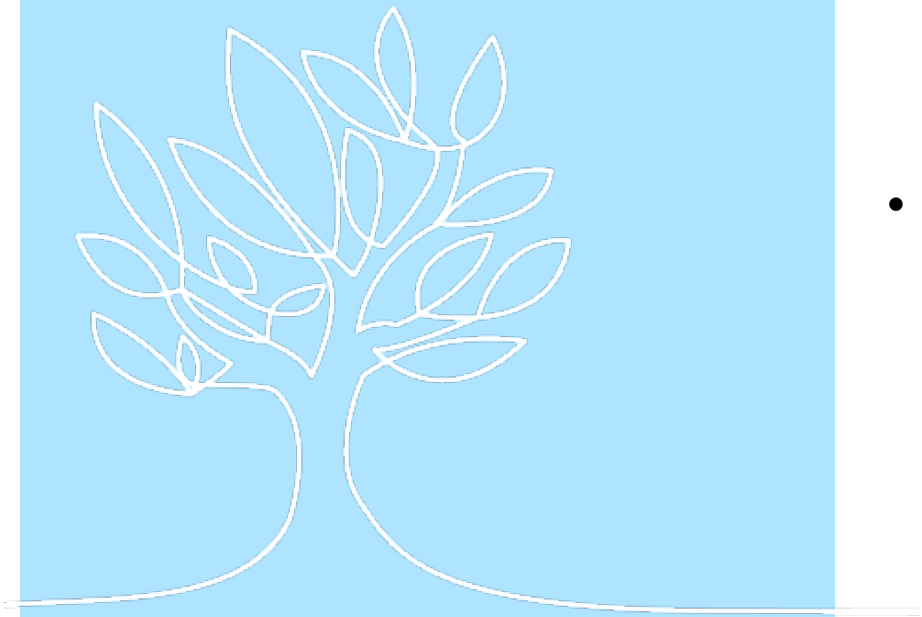
Summary of Quarter 4 2023/24 mortality data (2) [as at 11/05/24]

Refer Appendix 1b & 1d



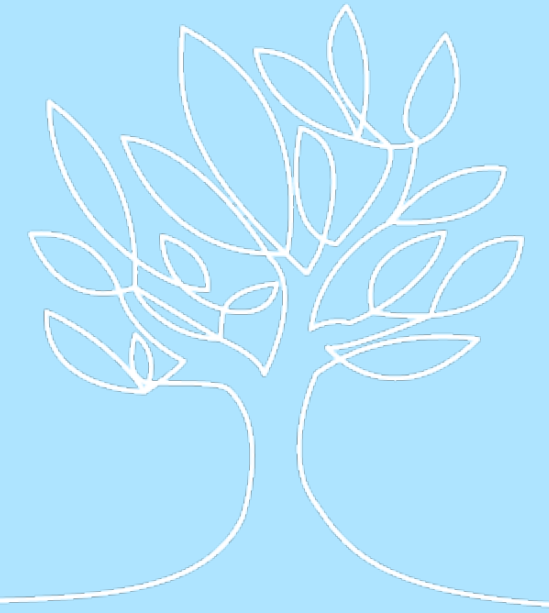
- **Stage 1 reviews:** A total of 88 Stage 1 learning from deaths reviews have been conducted by a local service manager to date in respect of the 143 deaths in Q4. This enables learning to be identified as well as identifying those deaths which should be subjected to a further detailed review. This is a review stage that did not form part of the previous Mortality Review arrangements and has thus increased reflective practice and the Trust's ability to identify learning locally. The timeliness of completion of Stage 1 reviews is monitored on a monthly basis by the Learning from Deaths Oversight Group and any concerns addressed. At the point of preparing data, there were a total of 33 outstanding Stage 1 reviews for Q4 deaths.
- **Stage 2 (clinical case note) reviews:** A total of 9 deaths in Q4 have been identified for Stage 2 mortality clinical case note review / thematic review thus far, and will be commissioned as capacity allows. None have yet been completed.
- **Stage 3 (PSIRF) reviews:** A total of 5 deaths in Q4 have been identified for PSIRF review to date.
- **Completion of Stage 2 and Stage 3 (PSIRF) reviews:** Continued progress was made over the quarter with completion of Stage 2 and Stage 3 reviews relating to 2022/23 deaths, with 139 now completed set against a total of 137 completed in the Q3 report to the Board of Directors. The completion of PSIRF reviews, due to their nature, is prioritised over completion of Stage 2 reviews. This is monitored by the Learning from Deaths Oversight Group and mitigating actions to ensure timeliness of review and learning identification are being pursued.
- **Problems in care assessment –** There are 0 deaths for Q4 thus far that have been assessed as being more likely than not due to problems in care by EPUT. The assessment is still to be determined for 93 deaths in Q4. For 2022/23, 3 deaths thus far have been assessed as being more likely than not due to problems in care by EPUT with the assessment still be to determined for 68 out of the total of 520 deaths for the full year. This includes deaths closed following PSIRF review as the assessment of problems in care has been paused whilst further research continues to be undertaken with relevant national / regional / ICB and neighbouring Trust colleagues in terms of an appropriate approach to making this determination given that the PSIRF methodology has not been designed for this purpose. Once the definitive local approach has been agreed, the closed PSIRF deaths that were assessed utilising the initial local methodology will need to be reassessed. This data will continue to be updated in future reports as reviews are completed and the likelihood is determined.

2023/24 Year End Commentary



- A year end audit / validation between deaths reported on Datix and deaths identified from clinical information systems as falling within scope of the Learning from Deaths arrangements is currently being undertaken and any necessary action identified is being taken forward. On completion this will provide assurance that all deaths in scope of the Policy have been reported on Datix and progressed through review processes; and that deaths reported on Datix have been appropriately updated onto clinical systems.
- The total number of death reports on Datix (n. 654) for the full year 2023/24 is higher than for 2022/23 (n. 520). However the number of deaths in scope of the Learning from Deaths Policy (n. 210) for the full year 2023/24 remains consistent with 2022/23 (n. 236). This potentially indicates that there has been an increasing awareness of the learning from deaths arrangements and reporting of non-mandated deaths that are not within the Policy scope - thereby increasing the Trust's ability to learn from deaths.
- There has been a significant improvement in the number of outstanding Stage 1 reviews being completed over the past quarter and we continue to pursue completion of those reviews awaited. Staff continue to be reminded via Bulletins and Quality and Safety meetings of the importance of timely completion of Stage 1 reviews.

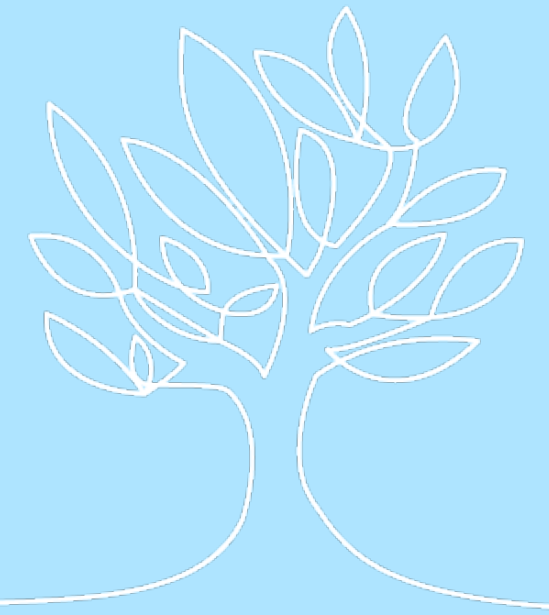
Assessment of Q3 2023/24 data against historic scope (for mortality surveillance) *Refer Appendix 1e*



- An analysis was undertaken of the Q3 2023/24 data using the previous "scope" categories and reporting groupings, in order to identify any trends of potential concern in relation to death numbers in established categories (as substantial historic data under the new groupings does not yet exist). This indicates that reported numbers of deaths are in line with numbers reported under the previous arrangements for periods not impacted by COVID-19 and that the category breakdown also remains broadly consistent with previous quarters.
- As at 15/02/24, when this was undertaken, the number of deaths in Q3 2023/24 falling within the previous scope (n. 28) was lower than for previous quarters. However this trend is observed every quarter and is related to the fact that there are a number of deaths for which a Stage 1 review requires completion and have thus not yet been assigned to a confirmed category. Figure 1 in Appendix 1 indicates that the number of deaths in scope in Q3, using the previous scope, fall within control limits.

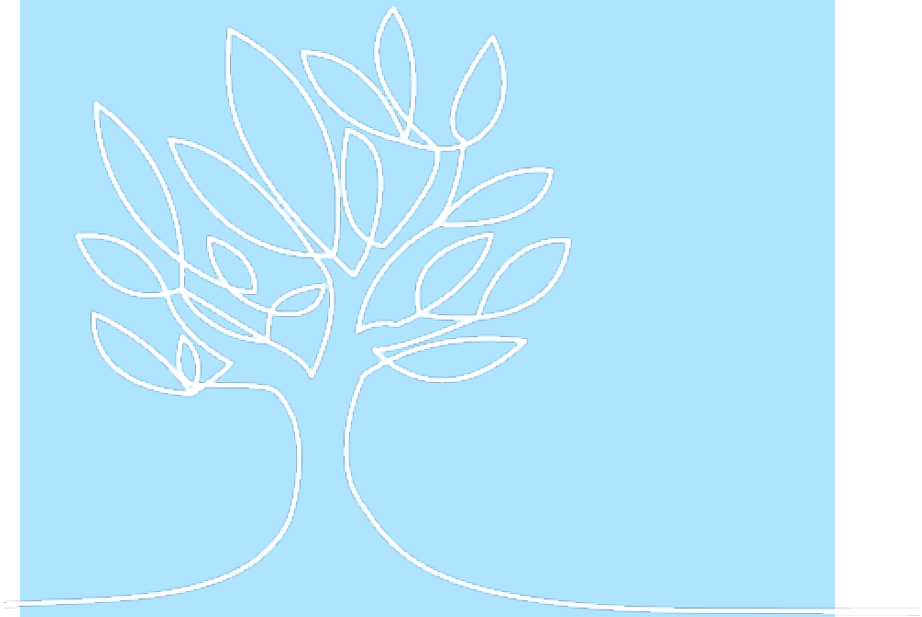
Production of statistical process control charts for 2022/23 and 2023/24 Datix reported deaths (for mortality surveillance)

Refer Appendix 1f



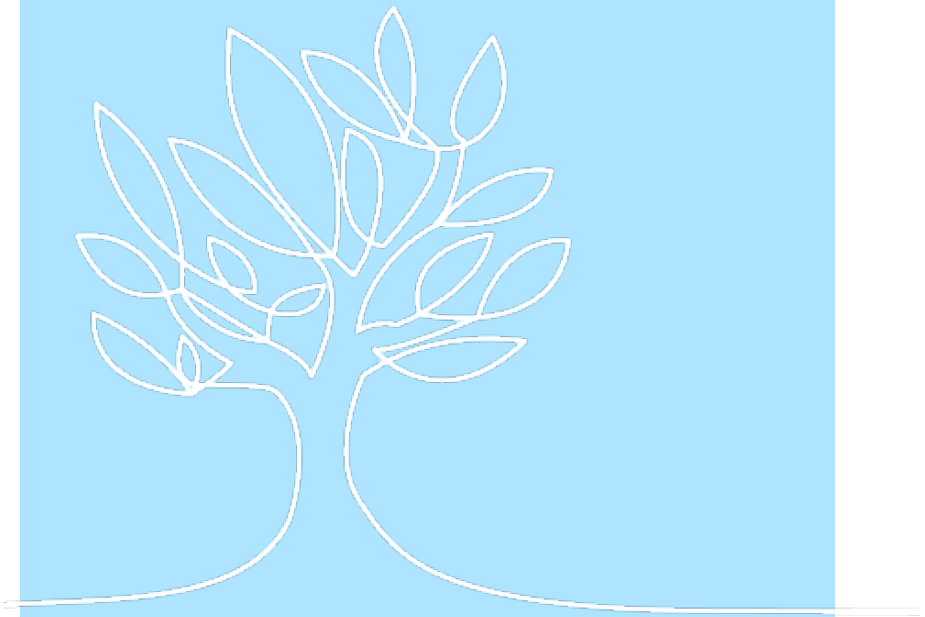
- The current data collection and analysis arrangements have been in place since the implementation of the current Learning from Deaths arrangements (01/04/22). In previous quarterly reports (up to the Q3 data – as per page 31 of this report), a comparison of deaths in scope was made against the previous data arrangements' scope categories whilst a sufficient time period of data was built up under the new arrangements. As there is now 24 months of data for the new arrangements (01/04/22 – 31/03/24), it has been possible to produce Statistical Process Control charts for the period, with control limits based on the first 20 months of data.
- The following Statistical Process Control charts are presented in Appendix 1f with commentary:
  - Deaths reported on Datix
  - Deaths reported on Datix within scope of the Learning from Deaths Policy
- Key points of note are as follows:
  - There has been a steady increase in the numbers of deaths reported on Datix since the start of the current Learning from Deaths arrangements. However, the number of deaths in scope of the Policy for review have remained broadly consistent. This therefore indicates an increasing awareness of the importance of reporting and reflecting on deaths and ascertaining learning.
  - The peaks had been identified at the time via monthly surveillance processes within the Trust and investigated further to ensure no issues of concern to address. This provides assurance that the monthly internal processes have been effective in identifying potential issues for follow up.
  - There are no monthly levels of reported deaths or deaths in scope that fall outside of the control limits.
  - Generally there appears to be a potential (but not significant) peak in deaths reported over the Winter months.

Summary of previous years' mortality data (2017/18 – 2022/23) as at Q3 2023/24 *Refer Appendix 2a*



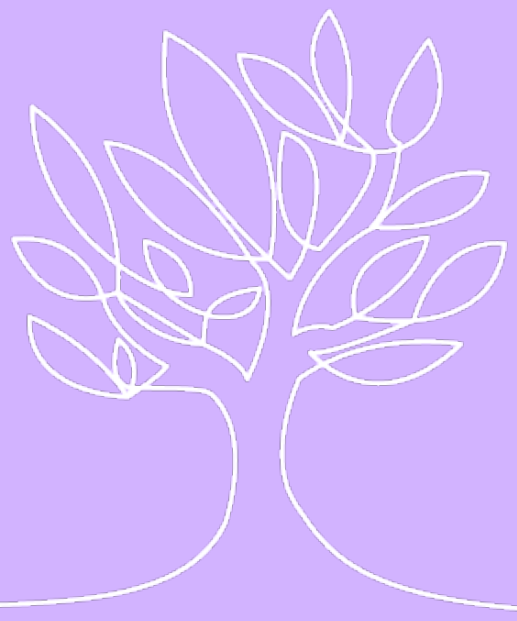
- Mortality data for previous years (2017/18 – 2022/23) as at 15/02/24 is attached at **Appendix 2a** detailing the mandated requirements of the National Learning from Deaths Guidance.
- In summary:
  - 2022/23 data is presented in the new format and indicates that, since the last report to the Board of Directors:
    - 8 deaths previously awaiting Stage 2 commission and re-assessed have been closed at Stage 1
    - 2 deaths previously awaiting Stage 2 commission and re-assessed have been referred for thematic review
    - 6 deaths have been closed at Stage 1 review
    - 37 deaths have been closed at Stage 2 (thematic review)
    - 1 death has had a Stage 3 (PSIRF) review approved
    - 1 death has been referred for Stage 2 (thematic review)
  - 4 reviews for deaths in 2021/22 remain open (3 x PSIRF reviews and 1 x under determination). These all continue to be actively progressed.
  - The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

Summary of previous years' mortality data (2017/18 – 2022/23) as at Q4 2023/24 *Refer Appendix 2b*



- Mortality data for previous years (2017/18 – 2022/23) as at 15/05/24 is attached at **Appendix 2b** detailing the mandated requirements of the National Learning from Deaths Guidance.
- In summary:
  - 2022/23 data is presented in the new format and indicates that, since the last report to the Board of Directors:
    - The number of Stage 1 reviews outstanding has reduced from 14 to 6 over the past quarter
    - 5 deaths, reviewed locally, have been reviewed by Care Unit leads and agreed for closure at Stage 1 over the past quarter
    - 2 Stage 2 clinical case note reviews have been approved in the past quarter
  - 3 reviews for deaths in 2021/22 remain open (2 x PSIRF reviews and 1 x under determination). These all continue to be actively progressed.
  - The significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death.

CONCLUSIONS AND ACTIONS REQUIRED



- This report provides information in relation to the learning emerging from reviews of deaths being undertaken under the learning from deaths arrangements; as well as mortality data mandated for report and data to support mortality surveillance.
- It also provides assurance that the learning emerging is being acted upon, with examples provided of actions taken in response to the learning identified.
- The analysis of the data indicates that there are no matters of concern in terms of mortality data surveillance for Q3 or Q4.
- Given the outcomes outlined, it provides the Trust Board of Directors with assurance that there are robust processes in place in line with national guidance to review deaths appropriately, forming part of the Trust's processes for continually reviewing and ensuring that patients are receiving safe, high quality care. It also highlights the work that has been undertaken, and continues, to strengthen mortality data reporting processes and implement refined processes.
- The Board of Directors is asked to note the information presented; and request any further information or action.

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APPENDICES

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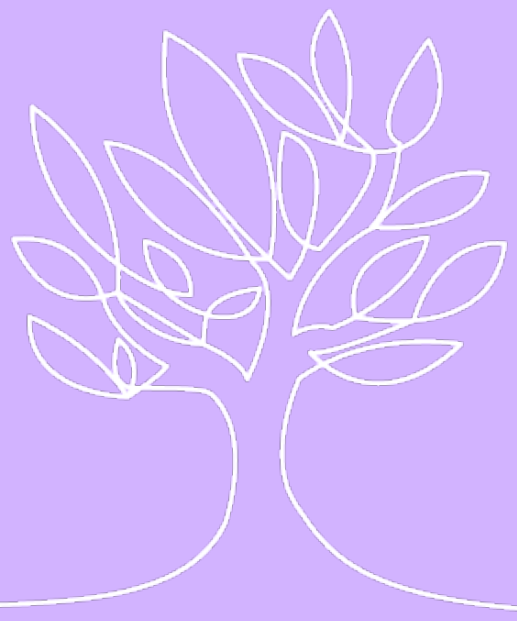
APPENDIX 1a Q3 2023/24 mortality data (as at 15/02/24)



The table on the following page provides a summary of mortality data for Q3 2023/24 (and updated Q1 & Q2 data). The following "Notes" are referenced in the left hand column of the table.

Notes:

1) There were a total of 169 deaths reported on Datix for Q3 2023/24 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 176 Datix reports made in respect of the 169 deaths.

2) 1 in Q1 and 3 in Q2 of these deaths occurred after transfer from EPUT inpatient unit to acute Trust

3) These figures denote the total number of Stage 1 reviews completed in full and the number that are actively awaited. When it is identified immediately that the death did not fall within the scope of the Trust's Learning from Deaths review arrangements as the patient had not been under the care of the Trust services within the 6 months leading up to the death or the death had immediately been identified for PSIRF review, it is not necessary to complete a full Stage 1 review.

4) 1 EDAP death included in the Q1 report has been deemed as out of scope as the client had only had historic contact with the service

5) All LD deaths have been confirmed as reported to LeDeR

Table 1: SUMMARY OF 2023/24 MORTALITY DATA (UPDATED AS AT 15/02/2024)	Q1 2023/24 (stated in Q2 report)	Q1 2023/24	Q2 2023/24 (stated in Q2 report)	Q2 2023/24	Q3 2023/24 (stated in Q3 report)	Q3 2023/24	Q4 2023/24 (stated in Q4 report)	Q4 2023/24	YTD (stated in Q2 report)	YTD
DATA ON NUMBER OF DEATHS										
Total death reports on Datix ***Note 1***	*181	*184	*133	*140	N/A	*176			*314	*500
Relating to x deaths ***Note 1***	*171	*172	*126	*134	N/A	*169			*297	*475
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	56	59	48	52	N/A	40			104	151
Total inpatient deaths ***Note 2***	**5	**5	**6	**6	N/A	5			**11	**16
Total nursing homes deaths	6	6	5	5	N/A	6			11	17
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes) ***Note 3***	***131	***137	72	84	N/A	83			***203	***304
Total deaths awaiting completion of Stage 1 review	13	10	30	22	N/A	53			43	85
Total deaths closed at Stage 1 and learning ascertained	110	117	40	65	N/A	45			150	227
Total deaths referred on for Stage 2 clinical case note review	2	2	4	3	N/A	2			6	7
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis)	11	12	5	7	N/A	3			16	22
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	23	22	16	14	N/A	7			39	44
Total deaths for which Stage 2 review complete and learning ascertained	0	0	0	0	N/A	0			0	0
Total deaths for which PSIRF review complete and learning ascertained	4	13	0	1	N/A	0			4	14
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes ***Note 4***	****6	****7	11	12	N/A	9			****17	****28
Total deaths undergoing LeDeR (national learning disability mortality review) processes ***Note 5***	*****5	*****5	*****5	*****6	N/A	8			*****10	*****19
Total deaths for which level of review under determination	7	7	5	4	N/A	22			12	33
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	0	0	0	0	N/A	0			0	0
Assessed as not more likely than not due to PIC	110	117	40	64	N/A	45			150	226
Assessment of likelihood of death being due to PIC still underway	60	55	77	57	N/A	115			137	227
Not applicable (EDAP and LeDeR reviews utilising different methodology)	11	12	16	19	N/A	16			27	47

APPENDIX 1b Q4 2023/24 mortality data (as at 11/05/24)

The table on the following page provides a summary of mortality data for Q4 2023/24 (and updated Q1 – Q3 data). The following "Notes" are referenced in the left hand column of the table.

Notes:

1) There were a total of 143 deaths reported on Datix for Q4 2023/24 (including those not falling within the scope for mandatory reporting). Some of the deceased clients had been in receipt of services from more than one service from EPUT and there were a total of 150 Datix reports made in respect of the 143 deaths.

2) 1 of these deaths in Q1 and 3 of these deaths in Q2 occurred after transfer from EPUT inpatient unit to acute Trust

3) These figures denote the total number of Stage 1 reviews completed in full and the number that are actively awaited. When it is identified immediately that the death did not fall within the scope of the Trust's Learning from Deaths review arrangements as the patient had not been under the care of the Trust services within the 6 months leading up to the death or the death had immediately been identified for PSIRF review, it is not necessary to complete a full Stage 1 review.

4) 1 EDAP death included in the Q1 report has since been deemed as out of scope as the client had only had historic contact with the service

5) All LD deaths in 2023/24 have been confirmed as reported to LeDeR.

Table 2: SUMMARY OF 2023/24 MORTALITY DATA (UPDATED AS AT 11/05/2024)	Q1 2023/24 (stated in Q3 report)	Q1 2023/24	Q2 2023/24 (stated in Q3 report)	Q2 2023/24	Q3 2023/24 (stated in Q3 report)	Q3 2023/24	Q4 2023/24 (stated in Q3 report)	Q4 2023/24	YTD (stated in Q3 report)	TOTAL 2023/24
DATA ON NUMBER OF DEATHS										
Total death reports on Datix ***Note 1***	184	183	140	139	176	182	N/A	150	500	654
Relating to x deaths ***Note 1***	172	172	134	135	169	173	N/A	143	475	623
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	59	62	52	53	40	50	N/A	45	151	210
Total inpatient deaths ***Note 2***	5	5	6	6	5	7	N/A	9	16	27
Total nursing homes deaths	6	6	5	5	6	6	N/A	6	17	23
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes) ***Note 3***	137	139	84	94	83	116	N/A	88	304	437
Total deaths awaiting completion of Stage 1 review	10	4	22	6	53	24	N/A	33	85	67
Total deaths closed at Stage 1 and learning ascertained	117	125	65	78	45	99	N/A	40	227	342
Total deaths referred on for Stage 2 clinical case note review	2	2	3	2	2	1	N/A	2	7	7
Total deaths referred on for Stage 2 thematic review	12	16	7	11	3	7	N/A	7	22	41
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	22	22	14	15	7	9	N/A	5	44	51
Total deaths for which Stage 2 review complete and learning ascertained	0	0	0	0	0	0	N/A	0	0	0
Total deaths for which PSIRF review complete and learning ascertained	13	14	1	3	0	0	N/A	0	14	17
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes ***Note 4***	7	7	12	12	9	9	N/A	12	28	40
Total deaths undergoing LeDeR (national learning disability mortality review) processes ***Note 5***	5	7	6	6	8	9	N/A	5	19	27
Total deaths for which level of review under determination	7	0	4	4	22	15	N/A	34	33	53
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC	0	0	0	0	0	0	N/A	0	0	0
Assessed as not more likely than not due to PIC	117	125	64	77	45	99	N/A	40	226	341
Assessment of likelihood of death being due to PIC still underway	55	44	57	43	115	65	N/A	93	227	245
Not applicable (EDAP and LeDeR reviews utilising different methodology)	12	13	19	19	16	17	N/A	17	47	66

APPENDIX 1c Q3 2023/24 mortality data – levels of review (as at 15/02/24)

Table 3: Confirmed levels of reviews under new Learning from Deaths arrangements compared to previous years (as at 15/02/24)

Level of review	Number of deaths 2022/23	As a % of total deaths 2022/23	Number of deaths 2023/24 YTD	As a % of total deaths 2023/24 YTD	Average % under previous arrangements
Total deaths	520	N/A	500	N/A	N/A
Closed at Stage 1 (to date)	303	58%	227	45%	65%
Being reviewed at Stage 2 Clinical Case Note Review / Thematic Review (to date)	75*	14%	29	6%	6%
Being reviewed at Stage 3 PSIRF (to date)	80	15%	44	9%	29%

** Note: the reduction in this figure from the Q2 report (n. 82) is due to a review undertaken of the latest circumstances of all Stage 2 reviews awaiting commission and agreement via the Learning from Deaths Oversight Group of proposals for closure at Stage 1 in light of updated information appertaining to each death since original decision to commission Stage 2 review (e.g. receipt of confirmed cause of death, no mandated criteria for Stage 2 review met etc.)*

APPENDIX 1d Q4 2023/24 mortality data – levels of review (as at 11/05/24)

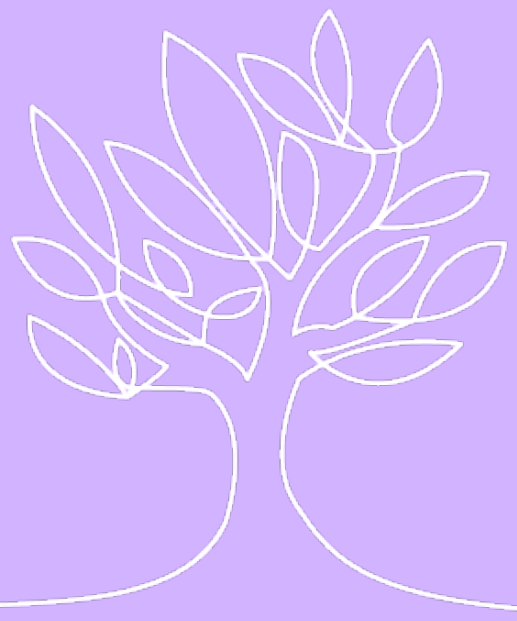
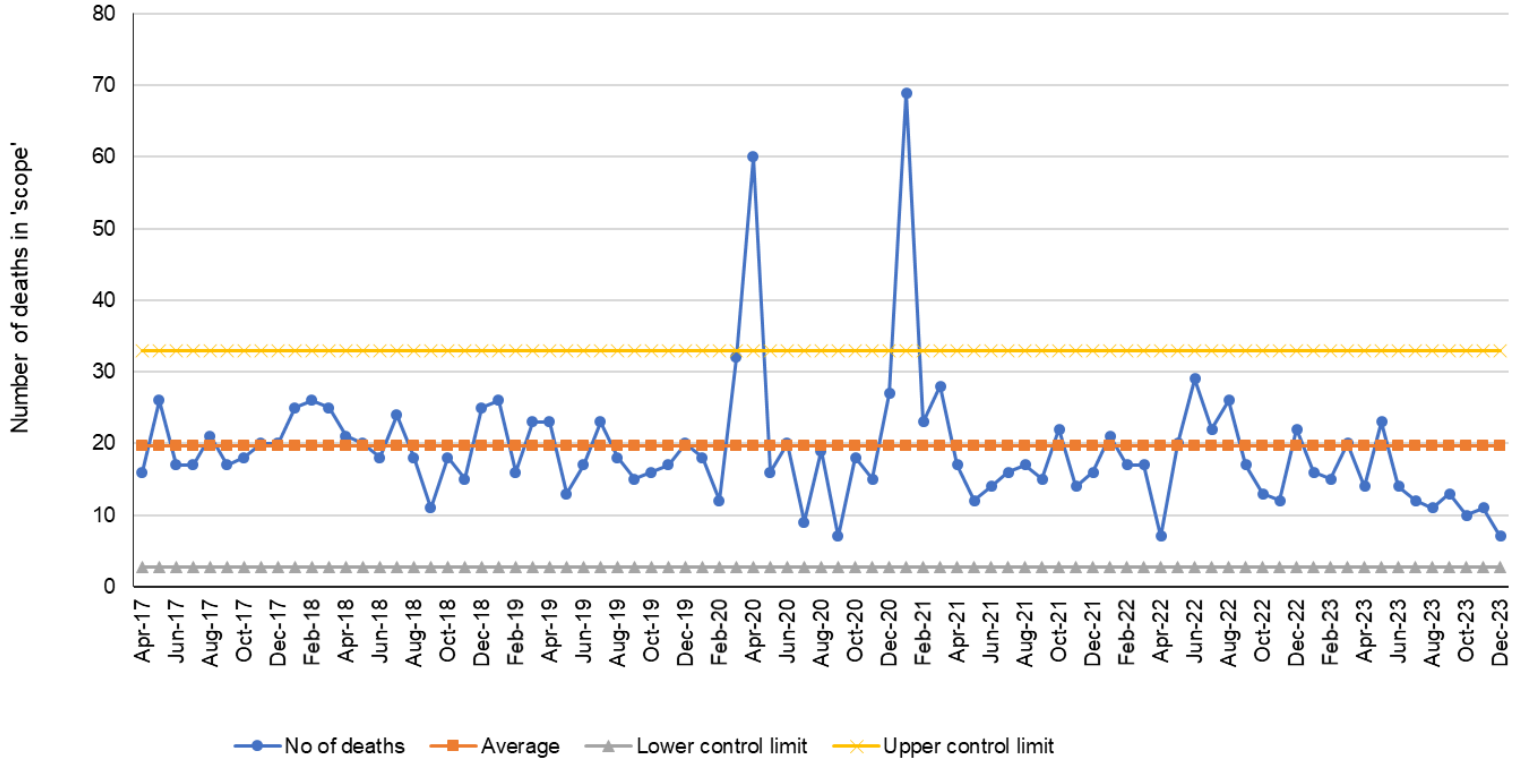


Table 4: Confirmed levels of reviews under new Learning from Deaths arrangements compared to previous years (as at 11/05/24)

Level of review	Number of deaths 2022/23	As a % of total deaths 2022/23	Number of deaths 2023/24 YTD	As a % of total deaths 2023/24 YTD	Average % under previous arrangements
Total deaths	520	N/A	654	N/A	N/A
Closed at Stage 1 (to date)	308	59%	342	52%	65%
Being reviewed at Stage 2 Clinical Case Note Review / Thematic Review (to date)	76	15%	48	7%	6%
Being reviewed at Stage 3 PSIRF (to date)	80	15%	51	8%	29%

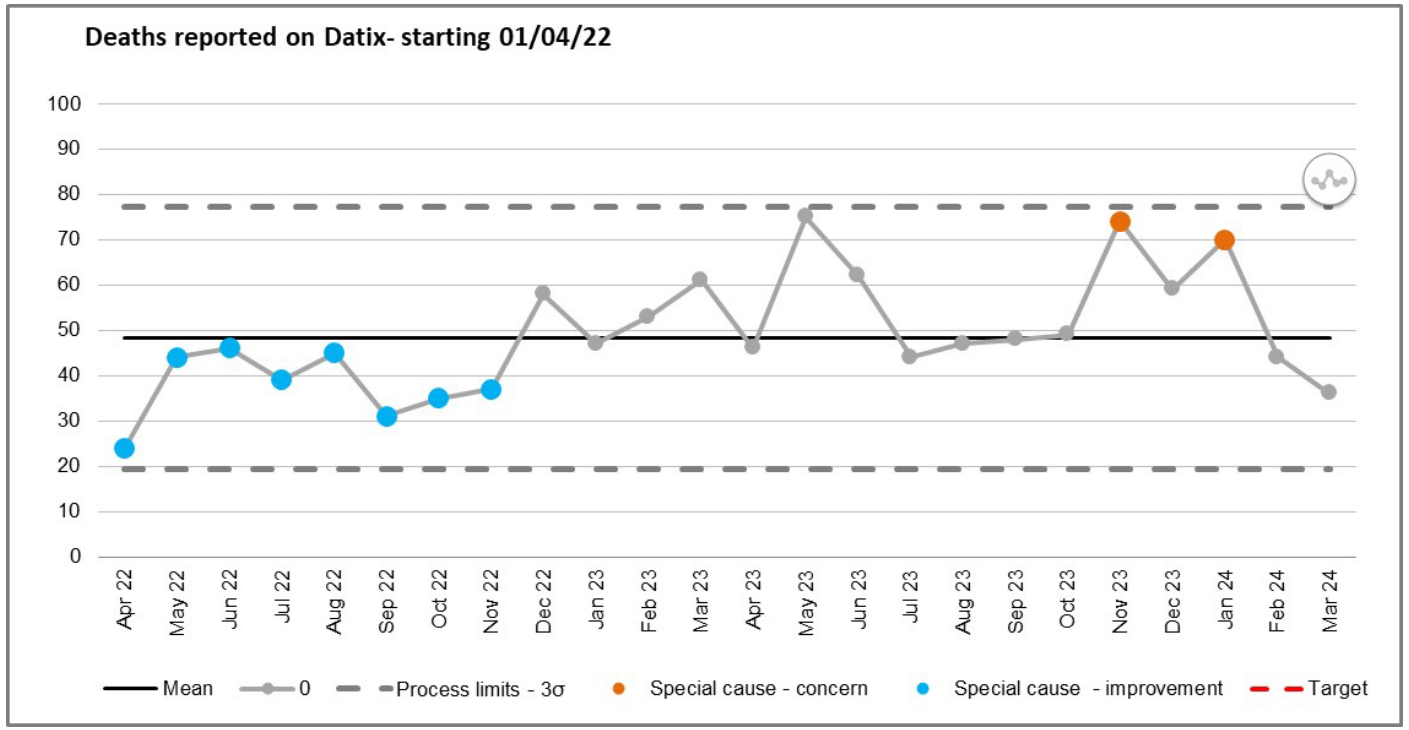
APPENDIX 1e Q3 2023/24 mortality data – comparison against historic scope

Figure 1 below shows the total number of deaths that fell within the scope of the previous Mortality Review Policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. The two months where the number of deaths fell above the upper control limit were peaks of COVID-19. Figure 1 below indicates that the number of deaths in scope in 2022/23 and in Q1 – Q3 2023/24 using the previous scope, fall within control limits.



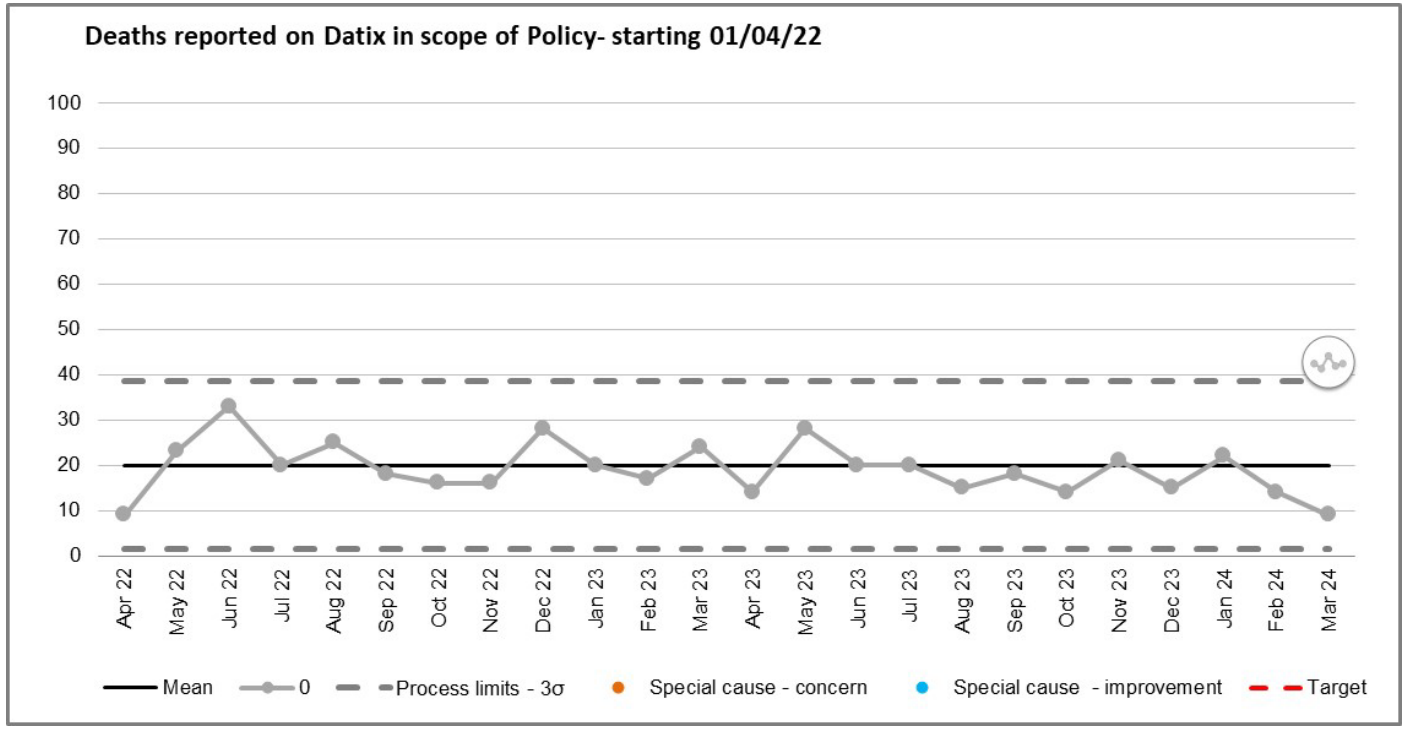
APPENDIX 1f Q4 2023/24 mortality data – Statistical Process Control - Deaths reported on Datix

Figure 2 below shows the total number of deaths reported on Datix for the period 01/04/22 – 31/03/24 in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2022 – November 2023). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 2 below indicates that the number of deaths reported on Datix fall within control limits for all months. Further commentary is provided on page 32 of this report.



APPENDIX 1g Q4 2023/24 mortality data – Statistical Process Control - Deaths reported on Datix within scope of Policy

Figure 3 below shows the total number of deaths reported on Datix for the period 01/04/22 – 31/03/24 that were within scope of the Trust's Learning from Deaths Policy in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2022 – November 2023). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 3 below indicates that the number of deaths reported on Datix in scope of the Policy fall within control limits for all months. Further commentary is provided on page 32 of this report.



APPENDIX 2a – Previous years' mortality data as at Q3 2023/24

The following two pages detail data (updated as at 15/02/24) for deaths as follows:

- **Table 5:** Deaths occurring in 2022/23 (reported and reviewed under the Trust's updated Learning from Deaths arrangements)
- **Table 6:** Deaths occurring in 2017/18 – 2021/22 (reported and reviewed under the Trust's previous Mortality Review arrangements)

Table 5: SUMMARY OF 2022/23 MORTALITY DATA (UPDATED AS AT 15/02/2024)	Q1 (stated in Q2 report)	Q1 Current	Q2 (stated in Q2 report)	Q2 current	Q3 (stated in Q2 report)	Q3 current	Q4 (stated in Q2 report)	Q4 current	TOTAL 2022/23 (stated in Q2 report)	TOTAL 2022/23 Current
DATA ON NUMBER OF DEATHS										
Total deaths reported on Datix	114	114	115	115	130	130	161	161	520	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	62	62	61	61	55	55	58	58	236	236
Total inpatient deaths ***Note 1***	4	4	6	6	9	9	4	4	23	23
Total nursing homes deaths ***Note 1***	6	6	6	6	3	3	4	4	19	19
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes)	111	111	113	115	123	123	153	156	500	505
Total deaths awaiting completion of Stage 1 review	2	2	2	2	7	5	8	5	19	14
Total deaths closed at Stage 1 and learning ascertained	55	56	58	60	76	80	100	107	289	303
Total deaths referred on for Stage 2 clinical case note review ***Note 2***	20	19	14	10	6	4	4	1	44	34
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis) ***Note 2***	7	7	5	7	15	15	11	11	38	40
Total deaths referred on for Stage 2 thematic review (other)	0	0	0	0	0	1	0	0	0	1
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	18	18	28	28	12	12	22	22	80	80
Total deaths for which Stage 2 review complete and learning ascertained ***Note 3***	14	21	7	11	2	17	0	11	23	60
Total deaths for which PSIRF review complete and learning ascertained ***Note 3***	19	18	27	27	12	12	19	20	77	77
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	11	4	4	9	9	11	11	35	35
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	3	4	4	5	5	5	5	17	17
Total deaths for which level of review under determination	2	2	2	2	7	6	10	9	21	19
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC * Note: methodology under review	*3	*3	0	0	0	0	0	0	*3	*3
Assessed as not more likely than not due to PIC	82	90	77	83	81	100	101	118	341	391
Assessment of likelihood of death being due to PIC still underway	15	7	30	24	35	16	45	27	125	74
Not applicable (EDAP and LeDeR reviews utilising different methodology)	14	14	8	8	14	14	16	16	52	52

APPENDIX 2a – Previous years' mortality data 2017/18 – 2021/22 as at Q3 2023/24

Table 6: Summary of deaths closed as at 15/02/24

Year	Number of deaths in scope *	Number closed	% closed at Grade 1 desktop review	% closed at Grade 2 clinical case note review	% closed at Grade 3 critical incident review	% closed at Grade 4 serious incident review	% deemed more likely than not due to PIC
2017/18	248	248	60%	5%	0.5%	35%	1%
2018/19	235	235	63%	8%	0%	29%	4%
2019/20	228	228	64%	7%	0.5%	29%	2.5%
2020/21	311	311	73%	4%	0%	23%	**0.3%
2021/22	195	191	67%	4%	0%	27%	**0%

* ***Note:*** Scope in place 2017/18 – 2021/22 under Mortality Review Policy was different to scope from 2022/23 onwards under Learning from Deaths Policy

** ***Note:*** From 01/05/21, on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements, the Trust did not undertake this determination for deaths reviewed via PSIRF arrangements as the focus of this methodology was on quality learning outcomes. The determination was made for all other deaths in scope.

The four death reviews open for 2021/22 deaths remain as follows:

- 1 death for which information is awaited from operational services in order to determine the level of review to which the death should be subjected prior to closure
- 3 deaths still undergoing PSIRF review – there are on-going Patient Safety Incident Investigations taking place in relation to these 3 deaths

APPENDIX 2b – Previous years' mortality data as at Q4 2023/24

The following two pages detail data (updated as at 15/05/24) for deaths as follows:

- **Table 7:** Deaths occurring in 2022/23 (reported and reviewed under the Trust's updated Learning from Deaths arrangements)
- **Table 8:** Deaths occurring in 2017/18 – 2021/22 (reported and reviewed under the Trust's previous Mortality Review arrangements)

Table 7: SUMMARY OF 2022/23 MORTALITY DATA (UPDATED AS AT 15/05/2024)	Q1 (stated in Q3 report)	Q1 Current	Q2 (stated in Q3 report)	Q2 current	Q3 (stated in Q3 report)	Q3 current	Q4 (stated in Q3 report)	Q4 current	TOTAL 2022/23 (stated in Q3 report)	TOTAL 2022/23 Current
DATA ON NUMBER OF DEATHS										
Total deaths reported on Datix	114	114	115	115	130	130	161	161	520	520
Total deaths reported on Datix confirmed in scope of learning from deaths policy to date	62	62	61	61	55	55	58	58	236	236
Total inpatient deaths Note 1	4	4	6	6	9	9	4	4	23	23
Total nursing homes deaths ***Note 1***	6	6	6	6	3	3	4	4	19	19
DATA ON LEVELS OF REVIEW										
Total deaths subjected to Stage 1 learning from deaths review on Datix (or equivalent under EDAP or LeDeR processes)	111	111	115	115	123	123	156	156	505	505
Total deaths awaiting completion of Stage 1 review	2	1	2	0	5	4	5	1	14	6
Total deaths closed at Stage 1 and learning ascertained	56	57	60	60	80	81	107	110	303	308
Total deaths referred on for Stage 2 clinical case note review ***Note 2***	19	19	10	10	4	4	1	1	34	34
Total deaths referred on for Stage 2 thematic review (diagnosis of psychosis) ***Note 2***	7	7	7	7	15	15	11	12	40	41
Total deaths referred on for Stage 2 thematic review (other)	0	0	0	0	1	1	0	0	1	1
Total deaths referred on for Patient Safety Incident Response Framework (PSRIF) review (Stage 3)	18	18	28	28	12	12	22	22	80	80
Total deaths for which Stage 2 review complete and learning ascertained ***Note 3***	21	21	11	12	17	18	11	11	60	62
Total deaths for which PSIRF review complete and learning ascertained ***Note 3***	18	18	27	27	12	12	20	20	77	77
Total deaths undergoing Essex Drug and Alcohol Partnership (EDAP) multi-agency collaborative review processes	11	11	4	4	9	9	11	11	35	35
Total deaths undergoing LeDeR (national learning disability mortality review) processes	3	3	4	4	5	5	5	5	17	17
Total deaths for which level of review under determination	2	2	2	4	6	6	9	9	19	21
DATA ON PROBLEMS IN CARE (PIC) DETERMINATION										
Assessed as more likely than not due to PIC * Note: methodology under review	*3	*3	0	0	0	0	0	0	*3	*3
Assessed as not more likely than not due to PIC	90	91	83	84	100	102	118	121	391	398
Assessment of likelihood of death being due to PIC still underway	7	6	24	23	16	14	27	24	74	68
Not applicable (EDAP and LeDeR reviews utilising different methodology)	14	14	8	8	14	14	16	16	52	52

APPENDIX 2b – Previous years' mortality data 2017/18 – 2021/22 as at Q4 2023/24

Table 8: Summary of deaths closed as at 15/05/24

Year	Number of deaths in scope *	Number closed	% closed at Grade 1 desktop review	% closed at Grade 2 clinical case note review	% closed at Grade 3 critical incident review	% closed at Grade 4 serious incident review	% deemed more likely than not due to PIC
2017/18	248	248	60%	5%	0.5%	35%	1%
2018/19	235	235	63%	8%	0%	29%	4%
2019/20	228	228	64%	7%	0.5%	29%	2.5%
2020/21	311	311	73%	4%	0%	23%	**0.3%
2021/22	195	192	67%	4%	0%	28%	**0%

* ***Note:*** Scope in place 2017/18 – 2021/22 under Mortality Review Policy was different to scope from 2022/23 onwards under Learning from Deaths Policy

** ***Note:*** From 01/05/21, on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements, the Trust did not undertake this determination for deaths reviewed via PSIRF arrangements as the focus of this methodology was on quality learning outcomes. The determination was made for all other deaths in scope.

The three death reviews remaining open for 2021/22 deaths are as follows:

- 1 death for which information is awaited from operational services in order to determine the level of review to which the death should be subjected prior to closure
- 2 deaths still undergoing PSIRF review – there are on-going Patient Safety Incident Investigations taking place in relation to these 2 deaths

9. STRATEGIC INITIATIVES

9.1 PHARMACY & MEDICINES OPTIMISATION STRATEGY

Decision Item | AG | 5

REFERENCES

Only PDFs are attached

Pharmacy and Meds Optimisation Strategy August 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	Pharmacy & Medicines Optimisation Strategy 2024 - 2028					
Executive Lead:	Alexandra Green, Executive Chief Operating Officer					
Report Author(s):	Dr Hilary Scott, Director of Pharmacy					
Report discussed previously at:	Executive Team, 5th March 2024 Medicines Management Group, 7th March 2024 Strategy Steering Group, 28th March 2024 Board Seminar, 1st May 2024					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report	Failure to recruit, develop and retain pharmacy staff to provide a comprehensive pharmacy service to Trust patients and support the provision of high quality, safe, cost-effective and clinically effective patient care. Failure to provide treatment of the highest quality, based on the latest evidence, is safe, clinically effective and cost-effective.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	
	SR4 Demand / Capacity	
	SR5 Lampard Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	✓
	SR9 Digital and Data Strategy	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No. Pharmacy Resources already included in corporate risk register as CRR98, although risk scores are improving over time.	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	Not applicable	
Describe what measures will you use to monitor mitigation of the risk	Audit, performance indicators, staff wellbeing, sickness and turnover. Quality of prescribing.	
Are you requesting approval of financial / other resources within the paper?	No, but some aspects of strategy delivery highlighted as linked to implementation of pharmacy elements of EPUT's Time to Care programme	

If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with the content of the EPUT Pharmacy and Medicines Optimisation Strategy 2024-2028 for approval.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the document.
2. Approve the Pharmacy and Medicines Optimisation Strategy 2024 - 2028

Summary of Key Points

The Trust's Pharmacy and Medicines Optimisation Strategy is identified in the EPUT Strategic Plan as one of the organisation's enabling strategies which will support its delivery. The Pharmacy and Medicines Optimisation Strategy has been updated to align with the timescale of and support delivery of the EPUT Strategic Plan.

A series of workshops and one-to-one meetings were held during December 2023 and January 2024, with the assistance of a facilitator from Enable East. These were attended by more than 60 EPUT senior leaders, ICB chief pharmacists, Lived Experience Ambassadors and pharmacy staff. The workshops considered a series of questions:

- **Diagnosis** – what are the problems that need to be solved?
- **Vision** – what does 'gold standard' pharmacy and medicines optimisation look like?
- **Must dos** - what are the priorities?
- **Risks and mitigations** – what are the risks to delivery of the vision? How does the vision help mitigate existing operational or strategic risks? What new risks could arise? What are the interdependencies?
- **Measures and KPIs**

The resulting input was consolidated and mapped to the Trust's four strategic objectives to produce the Pharmacy and Medicines Optimisation Strategy, the draft of which was circulated to several groups and individuals for comment and feedback. Some of the priorities identified contribute to more than one of the Trust's strategic objectives.

Unsurprisingly, many of the priorities set out in the strategy align with those already identified as part of the Trust's plans for the 'Time to Care' (TTC) inpatient transformation programme. The additional pharmacy staff identified as part of TTC (23 over the life of the programme with nine in year one) will be necessary to support implementation of many of the aspirations set out in this document.

At present professionally registered pharmacy staff are in high demand and short supply. This competitive market makes it important that the actions taken over the last 18 months to attract pharmacists and pharmacy technicians to EPUT are sustained, and the themes of '*train, retain and reform*', set out in the EPUT People and Education strategy are particularly relevant to this task. This is already being put in place with developmental programmes for newly registered pharmacists and pharmacy technicians as part of a 'grow your own' approach to staffing.

Of equal importance is a recognition of the contribution that pharmacists and pharmacy technicians can make to the care of our patients, as the experts on the clinical-effectiveness and cost-effectiveness of medicines. This requires greater acceptance of their contribution within ward rounds and MDT meetings than is currently experienced. This is important not only to ensuring medicines optimisation of individual patient's medication regimens, but also in challenging unwarranted variations in prescribing patterns where these exist and ensuring prescribing within EPUT is in line with the latest evidence-based guidance and of the highest standard.

The key priorities are set out below:

Strategic Objective 1: We will deliver safe, high quality, integrated services	Strategic Objective 2: We will enable each other to be the best we can be	Strategic Objective 3: We will work with our partners to make our services better	Strategic Objective 4: We will help our communities thrive
• Fill pharmacy team vacancies. • Ensure pharmacy presence at ward rounds, medication reviews and MDT meetings, so that patients will receive more timely access to the right medicines first time. • Champion evidence-based prescribing and best-practice handling of medicines. • Continue to drive the implementation of the electronic prescribing and medicines administration system (ePMA). • Make use of data from ePMA to inform day-to-day clinical practice and ensure prescribing is in line with evidence-based guidance. • Fully implement pharmacy referral so that patients can benefit from the Discharge Medicines Service (DMS) from their community pharmacist after discharge, reducing readmissions.	• Upskilling pharmacy support workers. • Providing dedicated development, training, experience and support for new pharmacy registrants and early career professionals. • Expansion of technician role. • Expansion of pharmacist role to include independent prescribing. • "Day in the life" videos and education sessions to raise understanding of pharmacy expertise. • Updated medicines management training for those involved in handling medicines. • Engagement of lived experience colleagues in training design and delivery. • Improve communication between wards and our dispensaries and explore a system of tracking. • Increase stock and staff numbers at our satellite dispensaries. • Ensure pharmacy service and medicines optimisation issues are considered during service and pathway redesign	• Implementation of ePMA. • Expanded number of referrals to the Discharge Medicines service. • Increase medication education sessions for patients, carers and relatives. • Face-to-face patient counselling about their medicines within wards. • Increase the number of advanced community mental health pharmacists. • Increase medicines education for primary care partners.	• Pre-discharge medicines counselling as standard. • Increase availability of community mental health and virtual ward pharmacy teams to primary care. • Increased referrals to the Discharge Medicines Service on discharge. • Provide complex case advice in the community. • Reduce medicines wastage through patient centred optimisation and recycling of medicines-related items.

The Pharmacy and Medicines Optimisation Strategy will contribute to the delivery of the Trust's overall vision by:

- Ensuring the consistent delivery of high-quality, digitally enabled, pharmaceutical care and pharmacy services.
- Pharmacy staff being valued members of ward clinical teams and MDTs able to fully contribute to quality patient care.
- Helping patients to receive safe, clinically effective, evidence-based and cost-effective medicines appropriate to their individual needs and be empowered as partners in medication treatment decisions through personalised care and shared decision making.
- Delivering medicines management training and education to members of the wider MDT to enhance their knowledge and understanding of the place of medicines within care pathways.
- Optimising medicines, including through deprescribing, to ensure that patients are prescribed the right medicines, at the right time, in the right doses.
- Making referrals to the Discharge Medicines Service provided by community pharmacists to review medication changes at discharge and reduce harm from medicines that can occur at transfers of care, ensuring better outcomes and reducing hospital readmissions.

The goal is to help patients to take their medicines correctly, avoid taking unnecessary medicines, reduce wastage, improve safety, and ultimately improve outcomes.

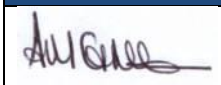
Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

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

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

Acronyms/Terms Used in the Report			
ACPT	Accredited Checking Pharmacy Technician	DMS	Discharge Medicines Service
ePMA	electronic Prescribing and Medicines Administration	HEI	Higher Education Institution
ICB	Integrated Care Board	MDT	Multi-disciplinary Team
PSW	Pharmacy Support Worker	TTC	Time to Care Workforce Programme

Supporting Reports
Pharmacy & Medicines Optimisation Strategy 2024 – 2028

Executive Lead:
 **Alexandra Green,** **Executive Chief Operating Officer**

NHS
Essex Partnership University
NHS Foundation Trust

PHARMACY & MEDICINES OPTIMISATION

Strategic Plan 2024 -2028

EPUT

CONTENTS

Foreword

To achieve our vision of being the leading health and well-being service in the provision of mental health and community care, it is essential that EPUT provides treatment that is of the highest quality, based on the latest evidence, is safe, clinically effective and cost-effective. Furthermore, that treatment should be personalised taking into account the views of patients and their carers through shared decision-making.

Medicines are the most common therapeutic intervention in healthcare and play a critical role in maintaining health, preventing illness, managing chronic conditions and curing disease. Over **two million doses** of medication are administered each year within EPUT inpatient wards alone, with more being taken by our patients in the community. 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.

Our pharmacy staff engage 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. The 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.

Dr Hilary Scott,
Director of Pharmacy

Our prescribers make hundreds of decisions each day about the treatment that patients are prescribed, and it is important that all strive to ensure that prescribing results in the best possible outcomes for patients. In line with our Research and Innovation strategies, prescribing practices need to be patient-centred, appropriately optimised and evidence-based, achieved through working closely with the pharmacy team who are experts in medicine use.

About our Service

Journey so far

The pharmacy and medicines optimisation team operates from multiple sites across the Trust. Our central dispensary is in Chelmsford, supported by two small satellite dispensaries in Basildon and Colchester. In addition to these sites, pharmacists and pharmacy technicians are based in Braintree, Brentwood, Epping, Grays, Harlow, Rayleigh, Rochford and Wickford, working as embedded members of multidisciplinary clinical teams.

Over the last two years, the pharmacy service has been restructured to reflect the Trust's new operating model and provide better alignment with our clinical Care Units. These structural changes will make integration with the work of Care Units easier. It is important that requirements for both the use of medicines and pharmacy services are considered at an early stage when changes to services and clinical pathways are being considered. From 2024/25 the team will move into the portfolio of the Executive Chief Operational Officer, making that easier to achieve.

The team helps patients and clinicians get the best possible results from medicines, ensuring that they are safe and effective. They regularly review the medication of patients on our inpatient wards, to make sure that patients receive optimal medication regimens and advise on the best medication choices to suit individual patient needs. They also have expertise in the treatment of physical health conditions and can offer a clinical sense check to colleagues on the wards or out of hours. The availability of an on-call pharmacist means that advice can be provided 24 hours a day, every day, even when the department is closed.

Every year the 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. On average the pharmacy dispenses 13,400 items of medicine per month, and the volume is increasing year on year (see Table 1). Each year around 700 EPUT staff attend education and training sessions organised and run by pharmacy staff.

The team helps patients and clinicians get the best possible results from medicines, ensuring that they are safe and effective.

Alongside the more general vaccination services provided by the Trust, we continue to support the Covid-19 vaccination programme for those living in Essex and Suffolk and have supplied nearly 385,000 doses of vaccine from our main pharmacy since 2021, as well as being involved in the development of policies and procedures, providing training for vaccinators and dealing with clinical queries.

Organisations with high incident reporting rates are considered to have a better and more effective safety culture because learning cannot be embedded unless incidents are reported and reviewed. Around one hundred medication incidents are reported on Datix each month and every incident is reviewed by a pharmacist to ensure that themes and trends are identified, and lessons can be learned.

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 programmes in adult community mental health and perinatal mental health services. The majority of these are now filled with pharmacists working as valued members of their local integrated teams. They offer patient consultations and provide expert advice to GPs and team colleagues, allowing complex cases to be managed in primary care.

Pharmacist and pharmacy technician posts have been created to support the development of a Virtual Ward in West Essex where patients are managed in the community rather than admitted to hospital, or discharged sooner than would otherwise be possible. Pharmacy staff also work as part of the South Essex care coordination team to help patients remain in their own homes rather than be admitted unnecessarily, reviewing their medication regimen at home, assessing whether they can take their medicines correctly and accessing support in the community to do so where that is necessary.

The pharmacy team currently consists of 42 pharmacists, 17 pharmacy technicians, 6 pharmacy support workers and 3 administrative assistants.

- Pharmacists undertake a four-year degree course and a year of supervised practice prior to registration. As experts on medicines, they carry out clinical review of patients' medication regimes to ensure safety, clinical- and cost-effectiveness and to optimise the use of medicines to promote recovery.
- Pharmacy technicians undertake two years of training prior to registration. Roles include medicines reconciliation for newly admitted patients, assessing patient's own drugs for use during admission, arranging for inpatient/ leave/discharge medicines supply, dispensing and supply of medicines within the Trust's pharmacy, support for self-administration. They are also involved in providing information to patients and staff about medicines and patient counselling.
- Pharmacy support workers ensure that adequate supplies of medicines held as ward stock are available on a 'top-up' basis and provide supplies of medicines from the Trust's main dispensary.

In addition, the team employs five pharmacists and pharmacy technicians undergoing their pre-registration training and provides placements for trainees who are employed in other settings, so that they can experience working in mental health and community health services.

Stakeholder engagement

As part of the development process for this strategic plan we have engaged with service users. People told us that they want:

- Clear, jargon free, information about the medicines they are taking to support shared decision making.
- Pharmacists, as the experts on medicines, involved in ward rounds, medicines reviews and multi-disciplinary team (MDT) meetings.
- Support to self-administer medicines in preparation for discharge.
- Communication between different parts of the NHS about their medicines, including with their community pharmacy.
- De-prescribing where medicines are no longer required.

Workshops and individual discussions also took place with more than 60 EPUT senior leaders, Integrated Care Board (ICB) chief pharmacists and pharmacy team members. They told us they want:

- Pharmacy team members able to spend more one-to-one time counselling patients about their medicines.
- Greater pharmacy presence on ward rounds and MDTs providing medicines expertise to staff and patients.
- Electronic Prescribing and Medicines Administration (ePMA) functional and in routine use.
- Information about medicines regimens communicated effectively with other partners in patients' care including use of the Discharge Medicines Service (DMS).

The contributions from these colleagues have helped shape this strategic plan which is carefully aligned with ICB plans for pharmacy and medicines management.

Challenges and opportunities

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 EPUT does everything possible to make it an employer of choice for pharmacy professionals.

Over the last two years the pharmacy service has experienced significant vacancies, but more than 35 new staff have been recruited to the team during that period. The challenge will now be to retain staff in a very competitive market. The EPUT People and Education strategy with its themes of 'train, retain and reform' are relevant to this task.

To meet the growing need, the *NHS Long Term Workforce Plan* proposes expanding the number of training places for pharmacists by around 50%, with increases in pharmacy technician training places as well. 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. Although the service has provided training places for some years, for the first time we have recruited pre-registration pharmacy technicians from within the ranks of our pharmacy support workers, and pharmacists who have undertaken their foundation year with us have gone on to secure permanent posts upon registration. It will be important to continue to provide training places for pharmacists and pharmacy technicians as well as developing staff from entry level into early career roles and on to become specialists with the knowledge and experience to work more autonomously.

Changes to the education and training of pharmacists and pharmacy technicians mean that they will, or already do, qualify with enhanced clinical and consultation skills. From mid-2026 all newly registered pharmacists will qualify as independent prescribers at the same time as registration. Pharmacy technicians are now registering with more clinical skills than previously, including qualification as accredited checking pharmacy technicians (ACPTs) on registration.

Implementation of electronic prescribing and medicines administration (ePMA) over the next two years, as part of our digital strategy, will provide the opportunity to streamline workflows relating to medicines, improve the safety of medicines use and quality of prescribing.

With appropriate support, the pharmacy team will support the Trust's aspirations to increase participation in clinical research involving medicines.

The Trust's Quality of Care Strategy provides a key opportunity for improving the quality of prescribing within the organisation in line with its ambitions around effectiveness and will actively participate in the Quality Senate.

Implementation of a future ePMA system as part of the new Mid & South Essex wide electronic Patient Record (ePR) will provide the opportunity for better integration of medicines information and improved care.

Vision, Purpose and Strategic Objectives

Vision

"To be the leading health and wellbeing service in the provision of mental health and community care."

Pharmacy and Medicines Optimisation Services will contribute to the delivery of the vision by:

- Ensuring the consistent delivery of high-quality, digitally enabled, pharmaceutical care and pharmacy services.
- Being valued members of ward clinical teams and multi-disciplinary teams (MDTs).
- Helping patients to receive safe, clinically effective, evidence-based and cost-effective medicines appropriate to their individual needs and be empowered as partners in medication treatment decisions through personalised care and shared decision making.
- Delivering medicines management training and education to members of the wider MDT to enhance their knowledge and understanding of the place of medicines within care pathways.
- Optimising medicines, including through deprescribing, to ensure that patients are prescribed the right medicines, at the right time, in the right doses.
- Making referrals to the Discharge Medicines Service provided by community pharmacists to review medication changes at discharge and reduce harm from medicines that can occur at transfers of care, ensuring better outcomes and reducing hospital readmissions.

The goal is to help patients to take their medicines correctly, avoid taking unnecessary medicines, reduce wastage, improve safety, and improve their outcomes.

Purpose

"We care for people every day. What we do together, matters."

Our vision for pharmacy services and medicines optimisation focuses on collaborating with our colleagues across EPUT, and our partners across the health economy, to ensure that patients can get the best possible outcomes from their medicines.

This requires medicines optimisation to be everyone's responsibility. Whilst medicines need to be managed, transported, and stored safely and securely, the most important aspect of medicines use is patient outcome. The greatest contribution to this is by ensuring prescribing is evidence-based and patient-centred, with reduction in inappropriate polyprescribing (also known as polypharmacy) which increases the risk of adverse effects without additional clinical benefit. Some variability in prescribing patterns is to be expected, but variation can often be unwarranted, resulting in unnecessary expense, poorer outcomes and wastage. As the experts on medicines our pharmacists will help clinicians to prescribe in line with the latest evidence-based guidance and identify and challenge prescribing which does not conform with these high standards.

Routine presence of pharmacists at the point that prescribing decisions are being made will help ensure that they are evidence-based and follow the Trust's recommended medicines choices contained in the EPUT formulary and prescribing guidelines. Pharmacy professionals' support to patients in terms of medicines counselling and information provision will facilitate shared decision making and improve adherence to medicines improving outcomes.

Medicines optimisation is everyone's business!

Strategic objectives

We have four strategic objectives to achieve our vision:

We will deliver safe, high quality integrated care services.

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

We will work with our partners to make our services better.

We will help our communities to thrive.

We have set out our key priorities to achieve these objectives in the next section.

Values

Our values underpin all that we do:
WE CARE • WE LEARN • WE EMPOWER

Members of the Specialist Services and Community Mental Health pharmacy teams discuss medication regimens

STRATEGIC OBJECTIVE 1:
WE WILL DELIVER, SAFE, HIGH QUALITY, INTEGRATED SERVICES

Introduction

Medicines optimisation has at its core a patient centred approach to delivering safe, high quality, integrated services. It is about ensuring that the right patients get the right choice of medicines, at the right time, to improve their outcomes and experience of care.

Medicines Optimisation: Helping patients to make the most of medicines. Royal Pharmaceutical Society, 2013

The impact of medicines optimisation is multiple and includes safe and patient-specific prescribing, improved adherence to treatment, better patient outcomes, reduced length of stay, reduced waiting times, fewer re-admissions, reduced errors, and less wastage. It may involve stopping medicines as well as starting them.

In line with the Trust's Quality of Care strategy, and its themes of safety effectiveness and patient experience, everyone plays a part in the optimal use of medicines. As the Trust's experts on medicines, pharmacy team priorities will continue to help embed optimisation as standard EPUT practice.

We will bring our specialist knowledge to inpatient ward rounds and multidisciplinary team meetings to help improve outcomes from medicines, by optimising doses, simplifying regimens where possible, reducing risks associated with medicine such as falls, serious adverse effects and antimicrobial resistance, and supporting deprescribing where appropriate. Medicines optimisation is the responsibility of everyone who prescribes, dispenses, and administers medicines. Access to the expert knowledge of pharmacy professionals will help to ensure that evidence-based choice of medicines has the highest priority within the Trust.

Within 10 days of starting a medicine, almost a third of patients are already non-adherent, and over half of them will be unaware that they are taking their medicines incorrectly. Only 16% of patients prescribed a new medicine take it as prescribed, experience no problems and have as much information as they need. We will improve adherence and help people have a positive experience of care by making information available about medicines and providing the opportunity to have a meaningful discussion with a pharmacy professional about their medication regimen.

We will support partners in the community, working alongside service users, their families, carers, and advocates, to produce the optimal care package for eligible individuals through referral of to the Discharge Medicines Service to minimise medication errors which commonly occur when patients transfer between care settings.

We will champion the use of the most effective evidence-based medicines and will engage with those involved in prescribing, dispensing and administration to ensure that medicines management, for all aspects of medicines handling, is of the highest possible quality.

The pharmacy team will continue its recruitment campaign to meet the demand for its services from patients, partners, and Trust ward-based and community teams.

Our key priorities

- Fill pharmacy team vacancies.
- Ensure pharmacy presence at ward rounds, medication reviews and MDT meetings, so that patients will receive more timely access to the right medicines first time.
- Champion evidence-based prescribing and best-practice handling of medicines.
- Continue to drive the implementation of the electronic prescribing and medicines administration system (ePMA).
- Make use of data from ePMA to inform day-to-day clinical practice and ensure prescribing is in line with evidence-based guidance.
- Fully implement pharmacy referral so that patients can benefit from the Discharge Medicines Service (DMS) from their community pharmacist after discharge, reducing readmissions.

We will continue to lead on the implementation of the electronic prescribing and medicines administration (ePMA) system to ensure safer and more effective prescribing, with more accurate patient data on medicines recorded for sharing with patients, staff, and partners across care settings. The advantages of ePMA include reduced

time spent re-writing and transcribing paper-based medicines charts, the ability to access information on a patient's medicines from anywhere, and greatly improved safe management of medicines including decision support in relation to contra-indications, cautions and allergies. Additionally, use of modern digital systems will aid the recruitment and retention of pharmacy and other clinical staff as well as freeing staff time for greater contact with patients.

The implementation of ePMA will inevitably see an increase in patients requiring reconciliation and optimisation support upon discharge from community pharmacists, and GPs and their pharmacy teams in primary care networks need timely and accurate information on a patient's medicines. The pharmacy team will champion referral to the Discharge Medicines Service when patients leave inpatient care.

Implementation of the Trust's inpatient workforce transformation programme 'Time to Care' will provide the additional staff necessary to support the aspirations set out in this document.

Immunisation services

The Trust is responsible for a growing service providing vaccinations for school-aged children in Essex and Bedfordshire. The pharmacy staff supporting the immunisation service include a pharmacist who provides advice about all aspects of immunisation and pharmacy support workers who coordinate schedules and deliveries to ensure that the immunisation teams can vaccinate in a timely manner. At peak times this can involve 35 temperature-controlled boxes, each containing hundreds of doses of vaccine being dispatched each day.

Vaccination against influenza and COVID-19 are now routinely provided to staff and patients, as well as to mothers-to-be who attend maternity services within local acute trusts. Hard to reach communities such as the housebound, the homeless, refugee populations and the travelling community are also supported.

The team often supports the ad hoc response to outbreaks, such as measles or hepatitis A, procuring vaccine, often in large quantities, at very short notice and providing dedicated clinical advice and bespoke training for vaccinators. The unprecedented success of the COVID-19 vaccination programme, in which the pharmacy team played a significant part, make this possible. The knowledge gained from setting up vaccination centres from scratch, at speed, and in unlikely venues has proved invaluable to supporting business as usual for this team.

How will we measure success?

- **Activity data showing pharmacy presence at ward rounds and MDT meetings as standard.**
- **Lower number of readmissions.**
- **Faster medicines reconciliation.**
- **All pharmacy posts filled, and retention rates high.**
- **Paper-based medicines charts replaced by ePMA records.**
- **DMS referrals occur for all patients requiring community pharmacy support on discharge.**
- **Pharmacy activity data reports.**
- **ePMA reports on medicines omissions.**
- **Evidence of embedded learning from medicines related incidents.**

What will be different?

Patients will have more access to pharmacy expertise with the opportunity for a meaningful discussion with a pharmacy professional about their medicines.

Medicines reconciliation will take place on admission and patients will receive counselling about their medicines on discharge as standard.

Patients will get the optimal medicine regime for their life circumstances and goals – as early in their treatment pathway as possible.

Patients will be empowered to manage their medicines more effectively and will therefore be more likely to comply with their prescribed medication regimes.

Higher numbers of patients will be able to self-administer prior to discharge increasing the chances of adherence to medicines once they return home.

Discharge referrals will result in timely medicine reconciliation and optimisation in the community.

STRATEGIC OBJECTIVE 2:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Introduction

The pharmacy team is committed to the growth, continuous professional development and progression of its staff to make EPUT an employer of choice for pharmacy professionals. As such we have implemented a "grow your own" approach which comprises a well-defined development pathway for newly registered/early career pharmacists and pharmacy technicians. This provides clear career progression, including access to appropriate post-graduate study and training of pharmacists as independent prescribers to ensure that our workforce can access high-quality professional development. New registrants, or those moving into mental health services for the first time, will be provided with the dedicated support required to develop their specialist knowledge and experience. A senior pharmacist post has been created to oversee this development pathway.

We will enhance the role of our pharmacy support workers (PSWs) so they can be more involved in facilitating patient care on the wards, particularly at our satellite dispensary sites. Upskilling PSWs will release time for pharmacy technicians to make more use of their clinical skills. Additionally, we will continue to promote progression to the Pre-registration Trainee Pharmacy Technician programme by encouraging existing PSWs through the apprenticeship route.

We will also develop pharmacy technicians to be able to work to their full potential, providing support and education to patients about the medicines they are receiving, and counselling patients prior to discharge so that they have the information they need to take their medicines safely and effectively. For appropriate patients this will include supporting self-administration of their medicines during their inpatient stay to improve their confidence and identify any problems so that they can be resolved prior to discharge.

As pharmacy technicians expand their role, in turn we will provide development that will enhance the contribution to patient care that pharmacists are able to make, particularly in relation to making use of their skills as independent prescribers.

A major workforce transformation programme ("Time to Care") for inpatient mental health services heralds the potential for a range of new posts. This plan will build on the new posts already created through the community mental health transformation programme and creation of virtual community wards and will increase the presence of pharmacy staff across care settings to provide holistic patient-facing care. It will also drive improvements in recruitment, wellbeing, and the retention of staff. The aim is to ensure daily senior pharmacist presence on-site for our main inpatient units. New pharmacy posts have been identified as part of the first-year implementation plan for this initiative. These posts will increase the provision of clinical advice and patient access to education about the medicines they need.

The pharmacy team will increase the support to, and development of, MDT colleagues and partners to achieve excellent quality in medicines management and optimisation. Following an overhaul of medicines management training, we will provide comprehensive sessions on the safe and effective handling of medicines, including high risk medicines and medicines for specific conditions, to all staff involved in medicines handling and administration.

To improve Trust-wide understanding of the contribution that the pharmacy team can make to patient care, we will create "day in the life" videos to promote greater understanding of the role of pharmacy staff and appreciation of the pharmacy team's expertise.

Our key priorities

- Upskilling pharmacy support workers.
- Providing dedicated development, training, experience and support for new pharmacy registrants and early career professionals.
- Expansion of technician role.
- Expansion of pharmacist role to include independent prescribing.
- "Day in the life" videos and education sessions to raise understanding of pharmacy expertise.
- Updated medicines management training for those involved in handling medicines.
- Engagement of lived experience colleagues in training design and delivery.
- Improve communication between wards and our dispensaries and explore a system of tracking.
- Increase stock and staff numbers at our satellite dispensaries.
- Ensure pharmacy service and medicines optimisation issues are considered during service and pathway redesign.

We will increase the range of stock held and numbers of staff within our satellite dispensaries to increase the timely supply of medicines to patients, particularly discharge medication. We will improve communication between wards and our dispensaries to increase the timely ordering, supply and dispensing of medicines, as well as explore a system for medicines tracking through that process.

Pharmacy Development Programme

With pharmacists and pharmacy technicians nationally in short supply, we have had to look carefully at how to attract and retain professionally registered pharmacy staff.

This has led to the creation of development programmes for newly registered pharmacists and pharmacy technicians which will support them from entry level into specialist posts. A workforce development pharmacist has been appointed to oversee this process for pharmacists, whilst the operational business manager will undertake a similar role for newly registered pharmacy technicians.

The programmes set out attributes which post-holders are expected to be able to demonstrate to progress, likely to take 12 – 24 months, depending on role. These include items contained in the nationally recognised development framework for pharmacists. Supporting material is provided in a clinical training manual and pharmacists are expected to undertake an appropriate postgraduate certificate or diploma in pharmacy practice. Staff must also successfully complete a competency workbook.

How will we measure success?

- **Activity data showing presence at ward rounds and MDT meetings as standard.**
- **Attendance numbers for medicines management training.**
- **Activity data showing number of medicine counselling sessions offered to patients.**
- **Activity data capturing pharmacists and technicians using their full skill set.**
- **Correlation of pharmacy activity data and readmission rates.**

What will be different?

A pharmacist's presence and expertise as standard at ward rounds and MDT meetings.

Patients will have more access to pharmacy expertise with the opportunity for a meaningful discussion with a pharmacy professional about their medicines.

Higher numbers of patients will be able to self-administer prior to discharge increasing the chances of adherence to medicines once they return home.

Patients are prescribed medicines holistically accounting for their physical, social, and mental health needs.

Patients, carers, and families have a clear understanding of their medicine regime and its impact.

Strategic Objective 3:
WE WILL WORK WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Introduction

The optimisation of medicines and the patient-centred approach that sits at its core, necessitates strong working relationships with service users, carers and their families, communities and other care provider organisations across the four integrated care systems we serve. Medicines optimisation requires a holistic view of each service user's circumstances and working collaboratively to find optimal treatment pathways that will achieve the best outcomes for mental and physical health.

Implementation of ePMA will increase the safety, quality and timeliness of medicines information exchange with partners. Additionally, ePMA will decrease the number of medicines charts and prescriptions which need to be handwritten, freeing up clinician time to spend working with our partners. Following successful roll out to inpatient wards, ePMA will be implemented for community mental health services.

We will expand referrals to the Discharge Medicines Service to ensure that our partners in community pharmacy can provide continuity of care in the community. This will help reduce problems with medication regimens where care transfers between settings ensuring that changes to medication made in hospital are not inadvertently reversed in the community.

To support and advise those working in primary care manage mental illness, we will recruit more advanced community mental health pharmacists. This partnership working at the interface will help ensure the pharmaceutical needs of patients with mental illness are met. This will include providing education to GPs, pharmacists, nurses and other health professionals to upskill their knowledge of mental health medicines and their use.

We will increase the provision of face-to-face medicines counselling, medication review, side effects monitoring and optimisation during the inpatient stay and at discharge.

Our key priorities

- Implementation of ePMA.
- Expanded number of referrals to the Discharge Medicines service.
- Increase medication education sessions for patients, carers and relatives.
- Face-to-face patient counselling about their medicines within wards.
- Increase the number of advanced community mental health pharmacists.
- Increase medicines education for primary care partners.

Advanced Community Mental Health Pharmacists

The Community Mental Health Framework highlighted as a key aim the evidence-based treatment of mental health problems through a full range of multidisciplinary staff available within each local community setting to delivery effective mental health care. *The NHS Mental Health Implementation Plan* identified a need for expansion of the number of mental health pharmacists working to support patients in the community.

West Essex was an early implementer for this model with pharmacists included as part of the roll out of community transformation since 2020. Over the last four years further such posts have been implemented across Essex. Ten advanced community mental health pharmacist posts have been created as part of community transformation, of which eight are filled, some on a part time basis.

Typically, each pharmacist reviews between 30 and 60 patients per month, providing advice to EPUT teams and primary care clinicians on medication regimens. They also respond to telephone queries, participate in MDT, locality, and primary care network meetings, undertake joint assessments with multidisciplinary colleagues, hold medicines-related consultations with patients, develop guidance and other documents, and provide support and training for nursing colleagues, especially those who are non-medical prescribers.

Our small community mental health and virtual ward pharmacy teams will support similar activities for community-based patients as part of their work with local clinicians.

As part of working towards an integrated and holistic care model for patients, we will provide or participate in education programmes for patients, relatives and carers to help them make informed choices about their medicines in the context of their personal life circumstances. We will continue to subscribe to the Choice and Medication website, making patient information about mental health conditions and treatment easily accessible to service users and promote its availability.

How will we measure success?

- **Number of referrals through the DMS.**
- **Pharmacy activity data showing more patient contact for counselling, advice, education, reconciliation, and optimisation.**
- **Pharmacy activity data showing increased collaboration with PCN partners in the community.**
- **Fewer readmissions.**
- **Reduction in the use of paper drug charts, paper prescriptions and medicines wastage.**
- **Less wastage of medicines.**

What will be different?

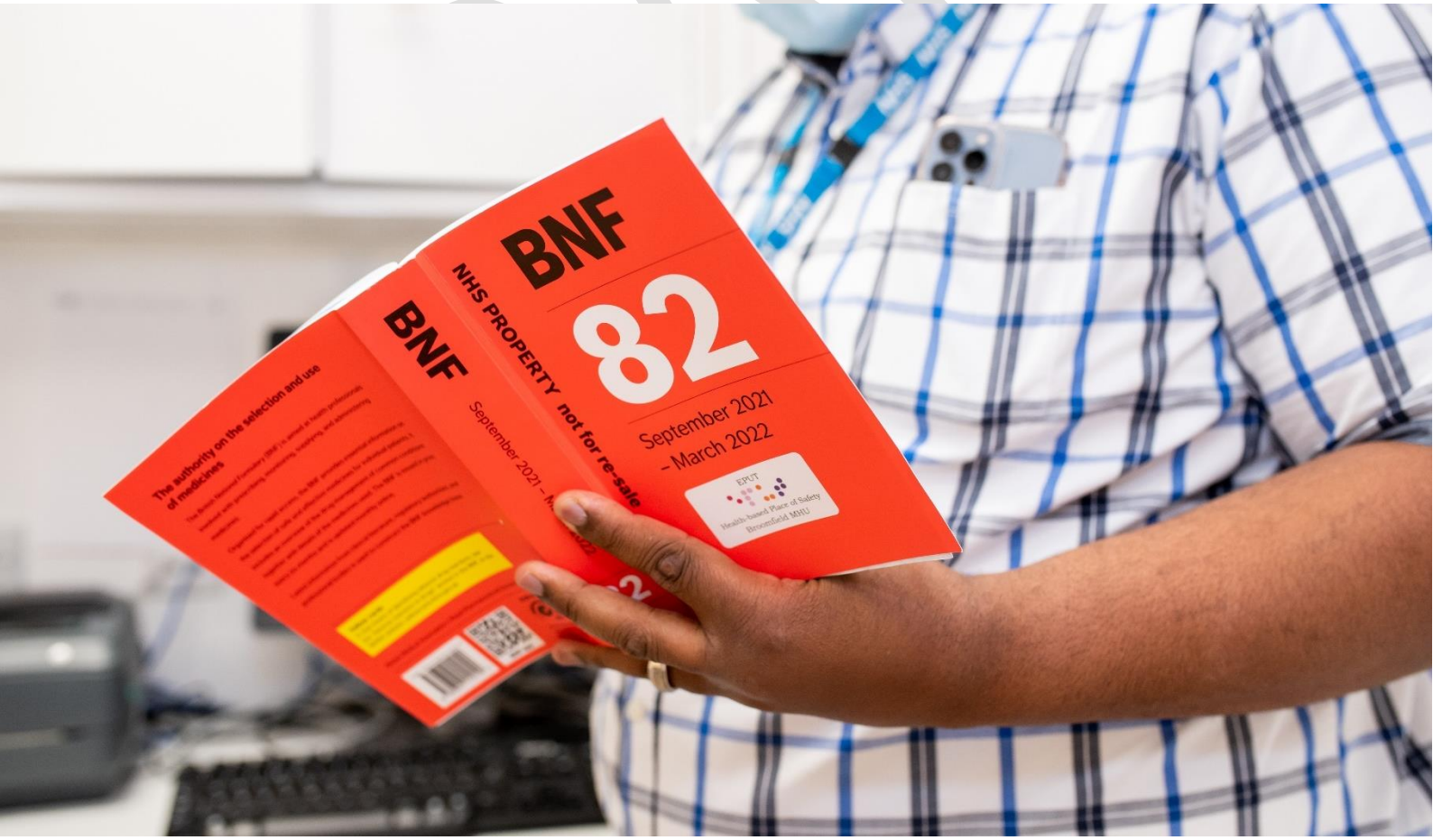
Patients will get more face-to-face pharmacy support.

Patients will have a better continuity of medicines support across care settings and care providers.

Patients will be more empowered to make decisions about their medicine regimes.

More patients will be confident to self-medicate.

MDT staff and PCN partners will have an understanding of and draw upon the leadership and expertise of the pharmacy team.



STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Introduction

Medicines optimisation at every stage of a patient's journey has an impact on service users, their families and the wider community. We will work with our patients to help them thrive as they move from inpatient wards to community settings and ensure that support continues in the community.

We will increase the number of patients who benefit from pre-discharge medicines counselling and offer medicines education sessions to maximise the successful transition of patients into the community. Medicines education sessions will also be offered in the community to include family members and carers.

We will increase the number of referrals to the Discharge Medicines Service to ensure that our partners in community pharmacy have the information they require to support patients requiring medicines reconcilliation and review after an episode of hospital care. This will minimise the risk of inadvertant discontinuation of medicines started during a hospital episode or continuation of treatment that has been stopped and maximise patient outcomes.

Our specialist community mental health and virtual wards pharmacy teams will help to assess complex cases and advise primary care colleagues on appropriate evidence-based medicines regimens.

Increasing patient support, including use of patient's own drugs during admission, will minimise the wastage of medicines which has both financial and environmental impact. We will continue to minimise our reliance on paper and plastics, with increased recycling of paper and cardboard at our dispensary sites. We will explore options for recycling medicines-related items such as blister packs and inhalers.

Our key priorities

- Pre-discharge medicines counselling as standard.
- Increase availability of community mental health and virtual ward pharmacy teams to primary care.
- Increased referrals to the Discharge Medicines Service on discharge.
- Provide complex case advice in the community.
- Reduce medicines wastage through patient centred optimisation and recycling of medicines-related items.

Discharge Medicines Referrals

The Discharge Medicines Service (DMS) is part of the core services provided by community pharmacies. By improving communication about changes to a patient's medication when they leave hospital, it aims to reduce the risk of medication errors. When a patient is discharged from a hospital into the community, the NHS trust makes a referral for follow-up to the patient's chosen community pharmacy.

Evidence shows that follow-up with their community pharmacist post-discharge is associated with reduced medication errors, reduced readmissions, improved adherence with medicines and improved patient experience. It has benefits for patients and health services alike.

At present, referrals to the DMS are on a relatively small scale, involving just patients discharged from community health services inpatient beds. During the last 12 months, 738 referrals were made to the service. Of these, follow-up has been completed for 65%, with most of the remainder awaiting acceptance by the community pharmacist or awaiting the patient to visit their pharmacy. Very few referrals were rejected.

Although from studies of referrals for patients discharged from acute hospital care rather than mental health or community health services, evidence suggests that patients who receive a community pharmacist follow-up consultation have lower rates of readmission and shorter hospital stays if readmission does occur than those without a follow-up consultation.

Whilst there are costs associated with making referrals to the discharge medicines service, including infrastructure and pharmacy staff time to identify patients requiring follow-up, capture potential issues and make the referral, evidence shows that the potential exists for significant savings to the local health economy because of DMS referrals.

Many of our team members already live within the communities that the Trust serves. We will recruit from local communities and support inclusive

recruitment where possible.
To help address the current shortage of pharmacists and pharmacy technicians we will work with, and support, local Higher Education Institutions (HEI) which are developing initial training and education programmes for pharmacy professionals. We aleady accept requests for work experience from young people considering a career in pharmacy and will explore working with HEIs to offer formal clinical placements for students undertaking a pharmacy degree. This will help raise awareness of working both with EPUT and in a mental health and community health service setting.

Where available, we will participate in community events run by voluntary organisations to help educate and inform patients, carers and their families about the medicines prescribed for them.

How will we measure success?

- **Medicines reconciliation and follow-up for patients discharged into the community.**
- **Fewer readmissions.**
- **Less wastage of medicines.**
- **Increased accuracy of medicines supply at the interface.**

SUMMARY OF KEY PRIORITIES AND MEASURES

Objective	Key Priority	What will be different	Measures*
1: WE WILL DELIVER SAFE, HIGH QUALITY, INTEGRATED SERVICES	Fill pharmacy team vacancies.	• Patients have more access to pharmacy expertise. • Medicines reconciliation on admission. • Optimal medicine regimes on admission. • Greater empowerment of patients and improved compliance with medicine regimes.	• All pharmacy posts filled and retention rates high. • Faster medicines reconciliation.
	Ensure pharmacy presence at ward rounds, medication reviews and MDT meetings.	• Patients will get more timely access to right medicines first time.	• Activity data showing pharmacy presence at ward rounds and MDTs.
	Champion evidence-based prescribing and best-practice handling of medicines.	• Patients will get the optimal medicine regime for their life circumstances and goals – as early in their treatment pathway as possible.	• High quality prescribing practices in line with evidence-based guidance. • Evidence of embedded learning from medicines related incidents.
	Continue to drive the implementation ePMA.	• Improved safe prescribing and management of medicines.	• Paper-based medicines charts replaced by ePMA records. • ePMA reports on medicines omissions.
	Fully implement pharmacy referral so that patients can benefit from the DMS from their community pharmacist after discharge, reducing readmissions.	• Discharge referrals will result in timely medicine reconciliation and optimisation in the community.	• DMS referrals occur for all patients requiring community pharmacy support on discharge. • Lower number of readmissions.
2: WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE	Upskilling pharmacy support workers. Expansion of technician role and expansion of pharmacist role to include independent prescribing.	• Patients will have more access to pharmacy expertise with the opportunity for a meaningful discussion with a pharmacy professional about their medicines. • Patients are prescribed medicines holistically accounting for their physical, social, and mental health needs. • Higher numbers of patients will be able to self-administer prior to discharge increasing the chances of adherence to medicines once they return home.	• Activity data capturing pharmacists and technicians using their full skill set. • Activity data showing number of medicine counselling sessions offered to patients.
	Providing dedicated development, training, experience and support for new pharmacy registrants and early career professionals.	• New registrants working autonomously with confidence.	• Activity data capturing pharmacists and technicians using their full skill set.

Objective	Key Priority	What will be different	Measures*
2: (Continued) WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE	"Day in the life" videos and education sessions to raise understanding of pharmacy expertise.	• A pharmacist's presence and expertise as standard at ward rounds and MDT meetings. • Patients, carers, and families have a clear understanding and impact of their medicine regime.	• Activity data showing pharmacy presence at MDTs and ward rounds as standard. • Correlation of pharmacy activity data and readmission rates.
	Updated medicines management training for those involved in handling medicines.	• Improved safe management of medicines.	• Attendance numbers for medicines management training.
	Engagement of lived experience colleagues in training design and delivery.	• Training is better focussed on patient needs and outcomes.	• Activity data showing lived experience colleagues in training design and delivery.
	Improve communication between wards and our dispensaries and explore a system of tracking.	• There will be an increase in the timely ordering, supply and dispensing of medicines.	• Medicines tracking data shows improved supply times.
	Increase stock and staff numbers at our satellite dispensaries.	• There will be an increase in the timely ordering, supply and dispensing of medicines (particularly discharge medicines).	• Staffing compliment at dispensaries. • Medicines tracking data shows improved supply times.
3: WE WILL WORK WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER	Implementation of ePMA.	• Patients will have a better continuity of medicines support across care settings and care providers.	• Reduction in the use of paper drug charts, paper prescriptions and medicines wastage.
	Expanded number of referrals to the Discharge Medicines service.	• Patients will have a better continuity of medicines support across care settings and care providers.	• Number of referrals through the DMS.
	Increase medication education sessions for patients, carers and relatives.	• More patients will be confident to self-medicate.	• Fewer readmissions. • Less wastage of medicines.
	Face-to-face patient counselling about their medicines within wards.	• Patients will get more face-to-face pharmacy support. • Patients will be more empowered to make decisions about their medicine regimes. • More patients will be confident to self-medicate.	• Pharmacy activity data showing more patient contact for counselling, advice, education, reconciliation, and optimisation.
	Increase the number of advanced community mental health pharmacists	• MDT staff and PCN partners will understand and draw upon the leadership and expertise of the pharmacy team.	• Pharmacy activity data showing increased collaboration with PCN partners in the community.
	Increase medicines education for primary care partners.	• MDT staff and PCN partners will understand and draw upon the leadership and expertise of the pharmacy team.	• Pharmacy activity data showing increased collaboration with PCN partners in the community.

Objective	Key Priority	What will be different	Measures*
4: WE WILL HELP OUR COMMUNITIES TO THRIVE	Pre-discharge medicines counselling as standard.	• Patients will receive pre-discharge medicines counselling as standard practice. • Patients will receive more timely access to the right medicines first time.	• Medicines reconciliation and follow-up for patients discharged into the community. • Fewer readmissions.
	Increase availability of community mental health and virtual ward pharmacy teams to primary care.	• Patients will get more support relating to medicines in the community.	• Medicines reconciliation and follow-up for patients discharged into the community. • Fewer readmissions.
	Increased referrals to the Discharge Medicines Service on discharge.	• Patient will receive follow-up by their community pharmacist where this is deemed appropriate.	• Increased accuracy of medicines supply at the interface.
	Provide complex case advice in the community.	• Patients will get more support relating to medicines in the community.	• Medicines reconciliation and follow-up for patients discharged into the community. • Fewer readmissions.
	Reduce medicines wastage through patient centred optimisation and recycling of medicines-related items.	• Patients will receive more timely access to the right medicines first time.	• Less wastage of medicines.

* metrics may need to be created to capture some of these measures.

9.2 TIME TO CARE - THERAPEUTIC ACUTE INPATIENT OPERATING MODEL FOR ADULTS AND OLDER ADULTS

Decision Item | AG | 10

Presentation

REFERENCES

Only PDFs are attached

Time to Care Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Time to Care - Therapeutic Acute Inpatient Operating Model for Adults and Older Adults**					
Executive/ Non-Executive Lead / Committee Lead:	Alex Green, Executive Chief Operating Officer					
Report Author(s):	Elizabeth Wells, Director & Care Unit Leads					
Report discussed previously at:	Executive Team					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report			
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	**Yes/** No		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	Yes/ **No**		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	Yes/**No**		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors on the new Inpatient Acute Operating Model as part of the Time to Care programme.	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents and key principles proposed within the new Inpatient Acute Operating Model, as part of the Time to Care Programme
2. Give final approval to proceed to mobilisation phase

Summary of Key Points

In Essex and nationally mental health services are striving to provide safe, quality care and support for people with mental health conditions, neurological differences and psychosocial disabilities who require mental health inpatient services.

The 'Time to Care Programme' has enabled the development of a new innovative therapeutic operating model that will enable quality and safety consistency across all wards; ensuring purposeful admission with an ambition of an average length of stay 30 days, equality, shared decision making, patient centred care, therapeutic benefit, trauma informed care, more integrated working with urgent care and community services to support safe local and effective discharge; therefore improving the experience for patients, families and carers. Better collaboration between health and care professionals, families, carers, and individuals is key.

The Trust is now very excited and motivated to mobilise the new EPUT Therapeutic Acute Inpatient Care Operating Model during 2024/25 which will be supported by the 2024/25 investment and recruitment of the Time to Care Workforce, training schedule, Standard Operating Policy, International Fundamentals of Care (ILC) and new EPUT Quality of Care Framework.

The Trust will embrace the NHS England Culture of Care Standards for mental health inpatient services (April, 2024) during mobilisation of the model - creating the conditions where patients and staff can flourish.

Aims and Objectives of Therapeutic Acute Inpatient Operating Model for Adults and Older Adults (see document /slides for full detail)

- This Operating model aims to set out the acute inpatient care operating model for adults and older adults.
- Current and incoming TTC staff will understand how care is to be delivered in our organisation and be empowered and equipped with the skills to deliver care in line with the operating model

Project Scope (see slides for full detail)

- **Plan and Design the operating model** for acute inpatient care for adults and older adults from admission, through inpatient stay and to discharge (joined up with Community Services / families & carers.).
- **Identify priority pathways**
- **Development of implementation plan** (yr. 1,2,3 priorities)
- **Communicate** the operating model to the organisation, working with relevant stakeholders
- **Work with stakeholders** to ensure change management activities are in place to enable to implementation of the operating model
- **Work with the Time to Care Programme** to ensure that the operating model is reflected in the work being delivered by the recruitment and marketing, communications, and initiative leads work streams
- **Commence implementation** in priority pathways
- **Review the success** of the operating model and make revisions as appropriate

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

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

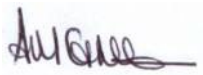
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			✓
Communication and consultation with stakeholders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

Acronyms/Terms Used in the Report			

Supporting Reports and/or Appendices

Therapeutic Acute Inpatient Operating Model for Adults and Older Adults Slide Pack

Executive/ Non-Executive Lead / Committee Lead:



Alex Green
Executive Chief Operating Officer

NHS
Essex Partnership University
NHS Foundation Trust

What We Do Together Matters.

Therapeutic Acute Inpatient Operating Model for Adults and Older Adults

Lizzy wells-Dir of MH Urgent Care & Inpatient Services
Joanne Pitt-Portfolio Lead: UEC, Inpatients & Pharm)

Aug 2024

Therapeutic Acute Inpatient Care Operating Model for Adults and Older Adults Inpatient Care Unit – STATUS UPDATE REPORT

OVERVIEW

G	Time	G	↔
	Cost	G	↔
	Quality	G	↔

Report Date	21/06/2024
Report Author	Joanne Pitt
Reporting Period	Monthly
Next Report Date	22/07/2024

PREVIOUS RAG STATUS

REPORTING DATE	18/12	20/02	20/03	22/04	22/05	21/06
PREVIOUS RAG	G	G	G	G	G	G

PROJECT BUDGET

Project Budget:	N/A-Summary
Spend forecast:	N/A
Actual Spend:	N/A

EXECUTIVE SUMMARY

STRATEGIC OVERVIEW:
The Programme has oversight and responsibility for the delivery of the new Therapeutic Acute Inpatient Care Operating Model. It will embed the NHS England Guidance for Adult and Older Adult Acute Inpatient Mental Health Services and be enabled by the Time To Care programme and GIRFT recommendations

VISION: "Create a new innovative operating model for all wards, which is the same quality of care 24/7 and that is integrated with place-based community model and the wide system"

PROGRAMME BRIEF: (includes aims, scope, objectives, outcomes)

Adobe Acrobat Document

Route to Green (Time, Cost, Quality): N/A

Decisions and escalations required: N/A.

ACHIEVEMENTS THIS REPORTING PERIOD

- **Operating model in final iteration** ready for internal signoff
- **Place based system meetings** continue to take place (SIG,MSE, NEE) and are planned for West Essex, to support buy in and system partnering
- **Quality and safety mapping** complete to support activities against the 9 trust priorities
- **NHSE Culture of Care Standards**-mapping to support alignment with standards
- **Culture of Care Funding Agreement** to take forward International Fundamentals of Care Post
- **MHLDA framework (NHSE Regional Programme)** submission of initial model plans
- **Process and principals continuing to be shared** with other areas (specialised services, NHSE Regional Team) to support progression and alignment for reporting

PLANNED FOR NEXT REPORTING PERIOD

- Completion and signoff of model (ET & Board)
- Performance/measure matrix-baseline and target for pre/post implementation agreed (alongside TTC)
- Alignment of model against Time to Care staffing post release (partially enabled)
- Agreement of yr. 1, 2 mobilisation/priority planning
- Culture change planning to support embedding the change (SOP, ambassadors etc.)

(please see slide 5 timeline)

KEY MILESTONES (phase One, review and redesign)

		COMPLETION	BASELINE	FORECAST	RAG
1	Agree membership, governance & TOR, roles and responsibilities and on-board all members	100%	11/05/23	11/05/23	C
2	Agree & define **vision design principles and operating** model objectives	100%	13/07/23	13/07/23	C
3	Identify and agree priority pathways to design the operating model around – including current state assessment, future state, design task small MDT groups with responsibility for a pathway	100%	10/08/23	10/08/23	C
4	Alignment of work completed by MDT pathway groups and agreement on onward development required (final draft report).	100%	28/02/24	28/02/24	C
5	Final Report/model signoff (ET)	95%	17/06/24	23/07/24	A

KEY RISKS AND ISSUES (top 3)

DESCRIPTION	MITIGATION	RISK/ISSUE SCORES PROB	IMP	SCORE	RISK / ISSUE OWNER
There is a risk that there isn't sufficient resource to deliver the work required on the operating model development due to operational demands and agreement of TTC funding to support additional resource.	There is a recruitment and retention strategy to support this Trust wide. The TTC funding will be regularly monitored through the TTC Steering Group and Operating Model Steering Group assessing what can be delivered within current capacity and with TTC funding. Funding has now been released	3	4	12	LW/AG
There is a risk that the current state of organisational culture and ways of working creates resistance to change.	A change task and finish group will be mobilised to work alongside the operating model workstream in order to support change management activities. As part of the operating model design, current state of provision of services will be considered.	3	4	12	LW
There is a risk that current reliance on agency workers impedes the ability to drive local change required for operating model implementation.	The staffing model is a key enabler to the operating model. working closely with recruitment and change leads as well as the staffing model initiative leads. The operating model will set out clear ways of working for current substantive and agency staff as well as for incoming staff.	3	4	12	LW

WORKSTREAM CHARTER: Operating Model (3/18)

SRO: Lizzy Wells

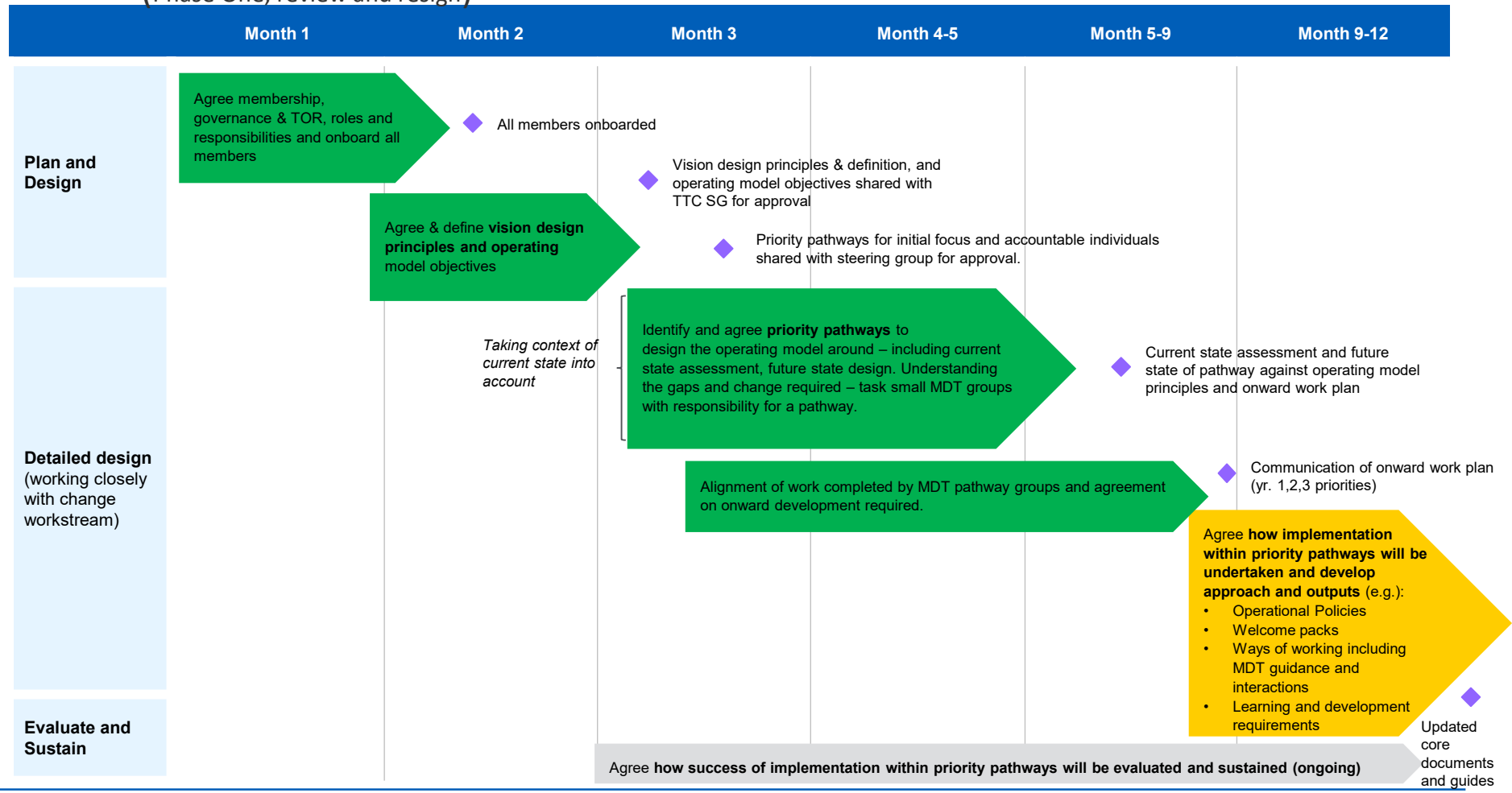
AIMS AND OBJECTIVES

- This workstream aims to set out the acute inpatient care operating model for adults and older adults.
- Current and incoming staff will understand how care is to be delivered in our organisation and be empowered and equipped with the skills to deliver care in line with the operating model

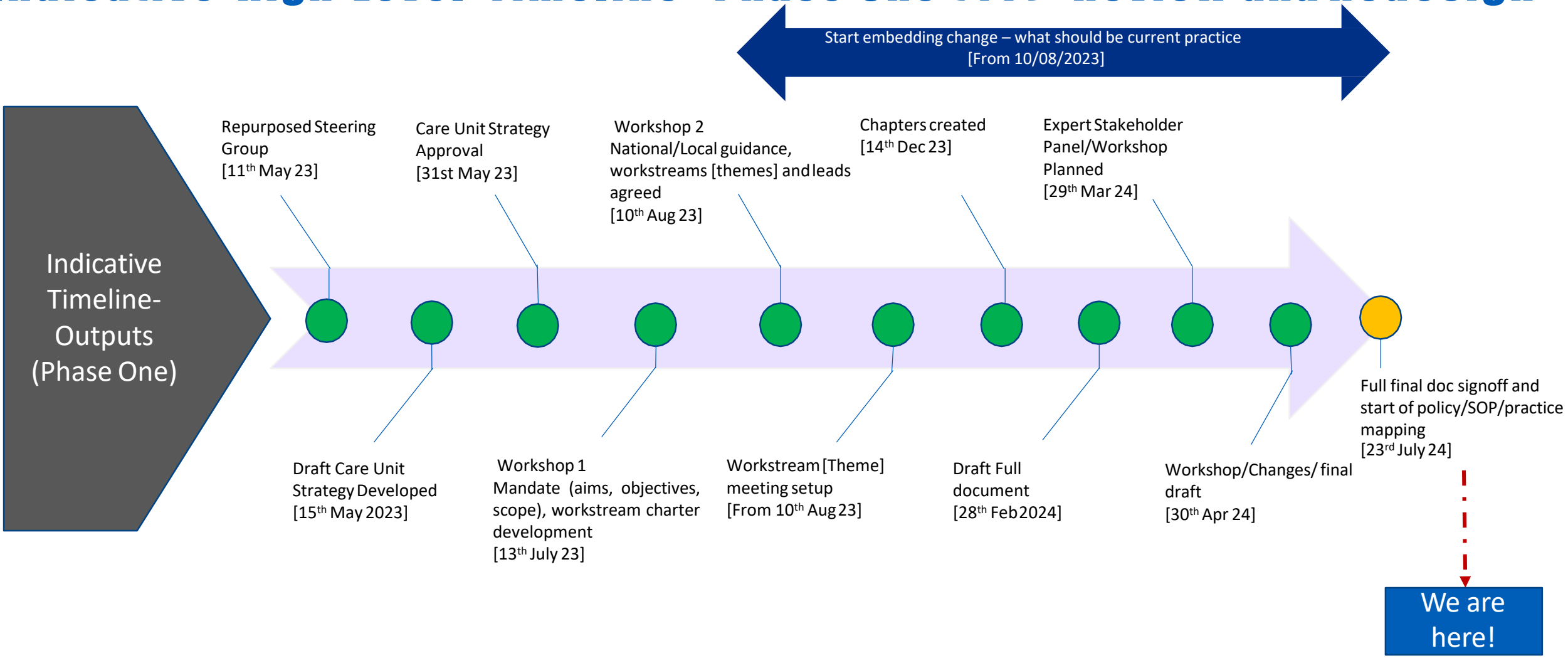
SCOPE

- **Plan and Design the operating model** for acute inpatient care for adults and older adults from admission, through inpatient stay and to discharge (joined up with Community Services / families & carers.).
- **Identify priority pathways**
- **Development of implementation plan** (yr. 1,2,3 priorities)
- **Communicate** the operating model to the organisation, working with relevant stakeholders
- **Work with stakeholders** to ensure change management activities are in place to enable to implementation of the operating model
- **Work with the Time to Care Programme** to ensure that the operating model is reflected in the work being delivered by the recruitment and marketing, communications, and initiative leads workstreams
- **Commence implementation** in priority pathways
- **Review the success** of the operating model and make revisions as appropriate

TIMELINE (Phase One, review and resign)



Indicative High Level Timeline- Phase One (Y1)- Review and Redesign



Indicative High Level Timeline- Phase Two (Y2,3)- Implementation

Communicate the operating model implementation to the organisation, working with relevant stakeholders

Indicative Timeline- Outputs Phase Two

Agreement of phase one (Year one priority-review and redesign stage) closure [End of July]

QI/Performance Indicator agreement ("as is" and "to be") [start Aug 24]

Time to Care workforce alignment to operating model and work being delivered by recruitment [mid/end Aug 24]

Start embedding change yr.2,3 priorities/plan [End Aug 24]

Agree year 1,2 mobilisation plan-priority pathways will be undertaken and develop approach and outputs (e.g.):

- Operational Policies (SOPs)
- Welcome packs
- Ways of working including MDT guidance and interactions
- Learning and development requirements

[end July/Aug 24]

Culture Change Ambassadors to ensure change management activities are sustained. [mid Aug 24 [partially complete]]

Interim Review (6 mths) of the operating model using QI tools and make revisions as appropriate [Feb 25]

We are here!

Check points to review, reflect on progress and ensure we are on plan to deliver the expected benefits of the model

Joint Vision Statement

Together we will:
‘Create a new innovative operating model for all wards, which is the same quality of care 24/7 and that is integrated with place-based community models and the wider system’.

KEY STAGES OF OUR OPERATING MODEL

PURPOSEFUL ADMISSION

Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient provision for the person's needs and there is a clearly stated purpose for the admission:

- Deciding whether an inpatient admission is required or the person could be supported in the community.
- Agreeing a purpose of admission
- Arranging prompt access to the most suitable available inpatient provision for the person's needs
- C(E)TR to have taken place pre admission and shortly after admission for people with a learning disability and autistic people

THERAPEUTIC INPATIENT CARE

Care is planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission including:

- Purposeful care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital. (Supported by the Red to Green approach)
- Care planning and formulation
- Delivering therapeutic activities and interventions
- Optimising medication regimes
- Reviewing and updating care plans. Meeting the purpose of admission

TRAUMA INFORMED CARE

Acknowledges the need to understand a patients life experience in order to provide and deliver the most effective care for their needs. This approach is expected to support better outcomes for patients and their carer/s.

PROACTIVE DISCHARGE PLANNING & EFFECTIVE DISCHARGE SUPPORT

The person's discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

- Proactive Discharge Planning and Effective Discharge Support
- Development of discharge plan from start of admission
- Regular review of discharge plan throughout admission including early action on any factors that may delay discharge
- Determine person is ready for discharge
- 48 hours' notice of decision to discharge
- 72 hour follow-up arranged
- Details of crisis support services provided
- 72 hour follow-up completed
- HTT support to facilitate discharge
- Ongoing support to maintain the person's wellbeing provided to agreed times

Key High-Level Components of the model-What will be different?

- Discharge planning from beginning
- Aim for four-week admission (where possible)
- Therapeutic programme
- Complimentary therapy
- Family/carer work
- 1 to 2 per week consultant ward rounds
- Structured MDTs
- Quality standards
- Regular 1to1s

02: PURPOSEFUL ADMISSION.

Lead Authors:

- Sarah Brazier, Associate Director - Flow and Operational Transformation
- Dr Andrew Biggs, Consultant Psychiatrist

Acute Inpatient Operating Model - Purposeful admission.

Ensuring that people are only admitted to inpatient care when they require assessments, interventions or treatment that can only be provided in hospital, and if admitted, it is to the most suitable available inpatient service provision for the person's needs, and there is a clearly stated purpose for the admission.

'Acute inpatient mental health care for adults and older adults', NHS England, 18 July 2023

- When people are in crisis, they require prompt access to the right support, in the best setting for their needs.
- Based on the assessment and taking the person's wishes into consideration as far as possible, a decision should be made about whether it would be better for the person to be admitted to hospital (including admission under the MHA) or whether it would be better for the person to be supported in the community.
- Given that long lengths of stay in hospital can in themselves be harmful, decision- making needs to explicitly consider whether a hospital admission is essential because the person requires assessments, interventions and/or treatment that can only be provided in hospital and could not be delivered through community-based acute services.

CHAPTER OBJECTIVES

- All alternatives to admission have been explored and exhausted with the individual and their support network.

- Each admission has a clearly defined purpose for assessment and/or treatment that can only be delivered in acute inpatient care and ensures that there is therapeutic benefit to each admission. All admissions are purposeful and timely

- The individual and their support network (family, carers) are fully involved in the decision making around their care (community and primary care teams)

- All admissions remain aligned with the key principles of personalised care; meeting the needs of the individual (i.e. Learning Disabilities (LD), Autism, Physical and Socio-economic….) and care is joined up across the health and social care system.

Maintaining focus on the purpose of admission.

The Red to Green approach is a helpful tool that can be used to support the allocation of tasks that are needed to deliver a person's care and to facilitate a timely and successful discharge from hospital. Under this approach, a 'red day' is recorded when a person receives little or no value-adding care, while a 'green day' is recorded where a person receives care that supports their progression towards discharge.

A green day does not mean the person is ready for discharge, it means that they are receiving the care and treatment that they need to progress their recovery and there are no barriers or delays to them accessing this support.

A Green day can only be recorded if all of these criteria are met.

- The person is receiving care that can only be provided in an acute inpatient setting
- The person receives value-adding care that day, e.g. assessments, interventions or treatment that supports their recovery and path towards discharge.
- All care that is planned or requested is completed by the end of the day.

Maintaining focus on the purpose of admission.

A Red day should be recorded if any of the criteria are met:

- The person is receiving care that could be provided in a non-acute inpatient setting.
- There are delays to discharging someone or transferring their care to a more appropriate service.
- The person does not receive active care or treatment that day
- Requested or planned assessments, interventions or treatments are not delivered.
- The person is on leave without a clear timeframe or rationale for what the leave is intended to achieve.

Maintaining focus on the purpose of admission.

The Patient Flow Bundle draws together **five principles** which when delivered together, support the smooth management of a patients care and timely discharge. This enables teams to ensure discharge planning is happening in parallel to the treatment/care plan.

Senior Review - before 11am daily

All patients to have expected date of discharge (EDD) based on individual needs.

Flow of patients from inpatient wards to home and community will commence at earliest opportunity

Early discharge. Patients due for discharge that day will be seen before midday.

Review. A systematic MDT review of patients with extended length of stay.

06: THERAPEUTIC BENEFITS.

Lead Authors:

- Doreen Mhone, Operational Service Manager
- Natasha Dominique, Operational Service Manger
- Diana Luckie, Head Occupational Therapist
- Marina Laing, Quality Matron -International Fundamentals of Care

Acute Inpatient Operating Model – Therapeutic Benefit.

Care is planned and regularly reviewed with the person and their chosen carer/s so that they receive the therapeutic activities, interventions and treatments they need each day to support their recovery and meet their purpose of admission including:

'Acute inpatient mental health care for adults and older adults', NHS England, 18 July 2023

- Purposeful care in a therapeutic environment supports people to recover more quickly and reduces avoidable time spent in hospital. (Supported by the Red to Green approach)
- Care planning and formulation
- Delivering therapeutic activities and interventions
- Optimising medication regimes
- Reviewing and updating care plans. Meeting the purpose of admission

Acute Inpatient Operating Model – Therapeutic Benefit.

CHAPTER OBJECTIVE

- Mobilise the co-produced therapeutic inpatient operation model enabled by Time to Care Staffing Model. Implement the clinical principles and operational actions within the Therapeutic Benefit and Trauma informed care chapters of the operating model

Acute Inpatient Operating Model –Delivery Therapeutic Activities and Interventions.

'Care is planned and regularly reviewed with the person and their chosen carer/s, so that they receive the therapeutic activities, interventions and treatments they need each day, to support their recovery and meet the purpose of their admission'. *(Acute inpatient mental health care for adults and older adults, NHA England, 2023)*

'Planning with patient & carers, community teams, including Crisis and Home Treatment, discharge coordinators and system partners. Review of support required and reduction of potential barriers to ensure safe discharge and transition of care.

ACTIVITIES :ADULTS

1-1 Interventions

- **Delivered by:** Medical & nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, peer support workers and external providers
- **Examples:** Acute Mental health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health support, short-term psychological interventions, managing emotions, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centered care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

Targeted therapeutic groups

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Managing emotions & coping skills (including reducing self-harm and suicidal ideation), arts psychotherapy, occupational skills development, DBT informed groups, physical health interventions, CBT, anxiety management and open talking groups.
- **Aim:** To promote self-management and coping strategies

Psychoeducation & information giving

- **Delivered by:** Psychological Services, AHPs, medical & nursing staff, pharmacists and pharmacy technicians, and external providers
- **Examples:** Carers' support, community meetings, drop in clinics, medication information, managing symptoms, physical health support, leaving hospital groups, advocacy, housing, benefits & employment support
- **Aim:** To provide ongoing information regarding treatment and reduce barriers to discharge.

Wellbeing groups

- **Delivered by:** CAPs, OTAs, HCAs, fitness instructors & volunteers
- **Examples:** Relaxation, sensory interventions, mindfulness, yoga, chaplaincy group
- **Aim:** To provide complementary coping strategies and therapies, for example, reflexology, essential oils, and others.

Activity programme

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** Creative crafts, board games, gardening, table tennis, gentle exercise, community meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities and groups help to improve people's physical and mental wellbeing. The activity programme should run daily on each ward, including at weekends and in the evenings in order to support maintenance of routine, rebuilding confidence, concentration and social skills.

ACTIVITIES: OLDER ADULTS

1-1 Interventions

- **Delivered by:** Medical & Nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, peer support workers and external providers.
- **Examples:** Acute Mental Health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health care, Falls prevention Tools and management, short-term psychological interventions, managing emotions, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centred care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

Targeted Therapeutic groups

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Maintaining & regaining ADLs, physical health interventions, social connectedness interventions, social and emotional modulation and regulation interventions, adherence to medication, rehabilitation and deconditioning prevention
- **Aim:** To promote self-management, coping strategies, minimizing distress and developing hope and meaning

Psycho-education & information giving

- **Delivered by:** AHPs, medical & nursing staff, pharmacists and pharmacy technicians, Psychological Services and external providers
- **Examples:** Community meetings, Life and coping skills, physical health support, utilization of aids and equipment, discharge planning, medication information, symptom management, sleep hygiene, carers education, social inclusion
- **Aim:** To provide ongoing information regarding treatment, reduce barriers to discharge and maximize least restrictive options

Wellbeing groups

- **Delivered by:** CAPs, OTAs, HCAs, & volunteers
- **Examples:** Relaxation, creative, exercises, sensory interventions, mindfulness, walking, chaplaincy group, reminiscence and topical discussions, social connectedness and inclusion groups, cognitive stimulation activities
- **Aim:** To provide complementary coping strategies, practical techniques and engagement in meaningful wellbeing approaches

Activity programme

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** Creative crafts, cooking, board games, gardening, gentle exercise, music, brain training, community meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities and groups help to improve people's physical, mental and emotional wellbeing. The activity programme should run daily on each ward, including at weekends and in the evenings in order to support maintenance of routine, rebuilding confidence, concentration and social connectedness

ACTIVITIES: DEMENTIA

1-1 Interventions

- **Delivered by:** Medical & Nursing staff, Psychological Services, AHPs, pharmacists and pharmacy technicians, care coordinators, Crisis & Home Treatment teams, discharge coordinators, social care, advocacy, hospice, end of life and external providers
- **Examples:** Acute Mental health interventions, including assessment, formulation, ward & medication reviews, nursing needs assessments, physical health assessment and care, falls prevention tools, short-term psychological interventions, managing emotions and behaviors, sensory modulation, discharge planning and targeted work on transition of care, including reducing barriers to discharge
- **Aim:** As part of person-centered care planning, the evidence-based interventions that the person will receive in hospital should be agreed with the person and their chosen carer/s and meet the person's holistic needs.

Targeted Therapeutic groups

- **Delivered by:** Psychological Services, AHPs, pharmacists and pharmacy technicians, and nursing staff
- **Examples:** Emotional, Behavioral or Sensory support activity, Maintaining ADLs, Regaining self-management, physical health interventions, social connectedness interventions, social and emotional modulation and sensory regulation interventions
- **Aim:** To promote self-management, coping strategies, minimizing distress and developing hope and meaning, Quality of Life

Skills maintenance & information giving

- **Delivered by:** AHPs, medical & nursing staff, pharmacists and pharmacy technicians, Psychological Services and external providers
- **Examples:** ADLs, Orientation meeting, Cognitive, Social, Physical and Sensory focused activities, carers information sessions, Medication and symptom management information
- **Aim:** To maintain skills and independence with least restrictive options, provide information to care givers to maximize independence and maintain dignity and respect

Wellbeing groups

- **Delivered by:** CAPs, OTAs, HCAs, & volunteers
- **Examples:** functional familiar, physical, sensory, cognitive and social activities, reminiscence, music and movement, relaxation, mindfulness, creative, chaplaincy group, reminiscence, topical discussions and Pet Therapy
- **Aim:** To provide structure to enable individuals to cope and engage in meaningful wellbeing approaches

Activity programme

- **Delivered by:** Activity coordinators, OTAs, HCAs, external providers (7 day programme)
- **Examples:** meaningful familiar activities, ball games, gardening, music & movement, games, creative crafts, gentle exercise, singing, orientation meetings, religious/spiritual groups, pet therapy, etc.
- **Aim:** To supplement the above interventions, this programme of activities helps to support people's physical, mental, sensory, cognitive and emotional wellbeing. The activity programme should run daily on each ward, including at weekends and evenings in order to support the maintenance of routine and structure, regulate the socio-emotional environment, managing complex behaviors, and provide opportunity for social connectedness

International Fundamentals of Care Framework

The Fundamentals of Care Framework outlines what is involved in the delivery of safe, effective, high-quality fundamental care, and what this care should look like in any healthcare setting and for any care recipient.

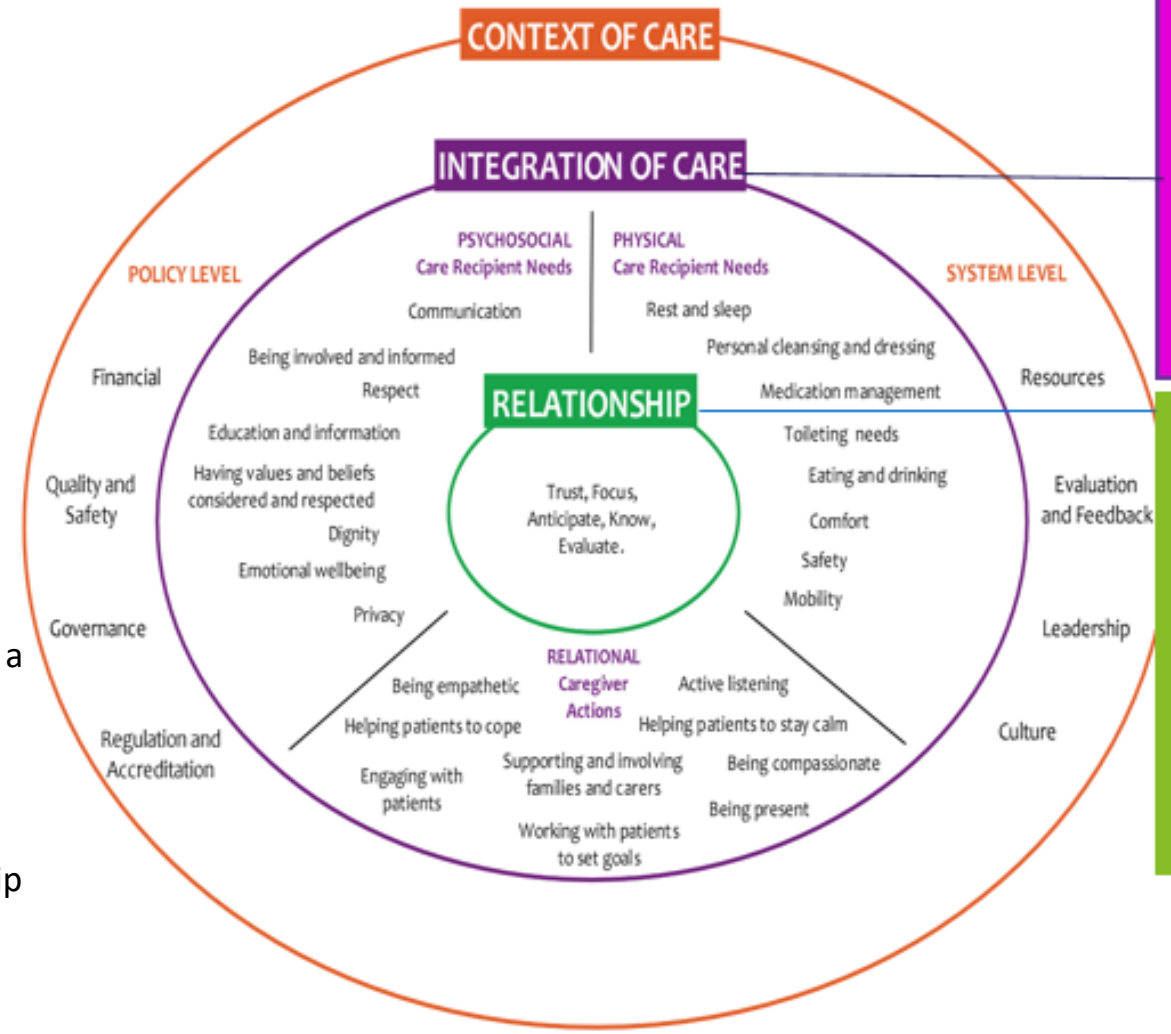
The Framework emphasises the importance of nurses and other healthcare professionals developing trusting therapeutic relationships with care recipients and their families/carers. It also emphasises the need to integrate people's different fundamental needs; namely their physical (e.g., nutrition, mobility) and psychosocial needs (e.g., communication, privacy, dignity), which are mediated through the nurses' relational actions (e.g., active listening, being empathic). The Framework also outlines that the context in which care is taking place must support care providers to develop relationships and integrate the needs of those for whom they are providing care.

The Fundamentals of Care Framework was created from the expertise and experience of ILC members. The Framework has continued to stand as the ILC's position paper and has been used in subsequent research and education activities by ILC members. The ILC continues to refine and improve the Framework to ensure it meets the needs of clinicians, consumers., educators, and researchers worldwide.

The International Fundamentals of Care Framework

The Fundamentals of Care Framework outlines three core dimensions for the delivery of high-quality fundamental care:

1. A trusting therapeutic relationship between care recipient and care provider
2. Integrating and meeting a persons' physical, psychosocial and relational needs
3. A context of care that is supportive of relationship development and care integration



- Personal cleansing (including oral/mouth care) and dressing
- Toileting needs
- Eating and drinking
- Rest and sleep
- Mobility
- Comfort (e.g., pain management, breathing easily, temperature control)
- Safety (e.g., risk assessment & management, infection prevention, minimising complications)
- Medication management.

- Developing and maintaining trust
- Focusing on the patient/person being cared for
- Anticipating the patient's/person's needs
- Getting to know the patient/person and how best to provide care for them
- Evaluating the quality, progress, and outcomes of the relationship

NHS
Essex Partnership University
NHS Foundation Trust

Physical Health in Mental Health

Purpose

- Individuals with severe mental illness have double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream) than the general population. Therefore people with severe mental illness require proactive assessment, investigation, treatment and ongoing review.
- To identify the health inequalities in mental health thereby to improve health outcomes and to reduce premature mortality.
- To expand the access to evidence based physical health care assessment and treatment .
- To ensure people with mental health illness had NICE recommended screening and a full annual physical health assessment and appropriate follow-up care.
- To developing more integrated services with primary care, tertiary care, social care and other agencies.
- To develop clear protocols outlining roles and responsibilities across primary and secondary care, communications and information sharing requirements, ensuring robust shared care arrangements are in place.
- To share the patient records between primary and secondary care in accordance with local information governance agreements and with due regard given to confidentiality issues as outlined within the Data Protection Act 1998 and human rights legislation.
- To increase patients' and carers' knowledge of physical health in order minimise secondary problems

Intervention

- On admission to offer timely holistic mental and physical health assessment, to recognize the historical physical health concerns and to offer intervention based on patient centred approach.
- To recognise the physical health care specialist needs such as referral to dietitian – diabetic management /SLT- dysphagia / Physiotherapy - MSK pain.
- To provide integrated assessment & physical health care plan

Example: MDT falls management

Example: AHP Integrated approach to enhance physical health and healthy life style

- Timely review
- To monitor and manage the risk of physical illness associated with long term use of anti-psychotic medication .
- Educating patients to understand the importance of physical activity and healthy living
- Promoting 150 minutes moderate activity / 75 minutes of vigorous aerobic activity spread across the week through graded individualised approach.
- MDT involvement in safe discharge planning and to ensure patient are referred back to primary care service to get appropriate support.
- Timely communication between professionals during step-up / step down transition between acute to MH inpatient units & vice versa.

Outcome

- Early diagnosis
- Improved access to heath care system
- Improved communication
- Reduce the risk of secondary complications
- Improved understanding about the importance of physical activity and healthy living
- Improved understanding to continue the physical activity and healthy lifestyle following discharge
- Improved social functioning
- Improved independence and quality of life
- Improved health outcomes and reduction in premature deaths

Acute Inpatient Operating Model – Therapeutic Environment.

The Therapeutic Environment

Therapeutic environment

Positive Health Outcomes

Offering opportunities for social interaction

Meeting sensory & cognitive needs

Promoting recovery & wellbeing

Physical Space

- Units should feel pleasant and comfortable, and feel safe but not institutional.
- Create spaces that encourage social interaction, which may range from small, quiet spaces, to larger, open-plan communal areas.
- A simple layout, with direct access and communication routes, identifiable focal points and clear signage.
- Appropriate choice of materials, furniture and fittings.

Light, colour and texture

- A focus on natural light or design solutions intended to increase or decrease the amount of light in the building in order to promote a pleasant and restful environment.
- Glare and shadow should be minimised.
- Colour and texture may help to differentiate spaces and support wayfinding.

Noise

- Minimise noise and promote a sense of calm and safety. For example, soft closing doors and consider whether alarms (fire and safety) could be linked to staff alarm pagers. This can avoid provoking anxiety reactions.
- Good sound insulation for areas where confidential discussions may take place.

External areas and landscaping

- Access to fresh air and outdoor spaces play a significant role in supporting well-being and recovery.
- Open grassy areas, herbs, textured plants and shrubs that attract wildlife can alleviate stress.
- Raised flower beds could incorporate seating areas and support therapeutic activities
- Incorporate space for outdoor activities, such as gardening, ball games, walking and resting.
- Level access from unit to external space and shading provided in external areas.

Acute Inpatient Operating Model – Therapeutic Environment.

Attractive & engaging shared spaces

Positive Health Outcomes

Involvement

Ensuring privacy, dignity & safety

Feels safe, inviting & accessible

Artwork

- Involve staff and service users in reviewing the ward environment and work with them using a co-production approach to improve the therapeutic spaces.
- The inclusion of artwork can be beneficial for service users, staff and visitors.
- It can provide a special identity to spaces and support wayfinding.
- Pieces can be created by anyone in the ward community. Artwork can include paintings, murals, prints, photographs and textiles.

Visiting

- A dedicated visiting area to be provided near the entrance and away from service user areas.
- This should be a private space for service users to meet with family and carers.

Food preparation

- With appropriate risk assessment, it is important that service users are able to carry out basic food and drink preparation themselves and that they are able to obtain a drink and snack at any time of the day or night.

The Health Building Note for adult acute mental health units
(https://www.england.nhs.uk/publication/adult-mentalhealth- units-planning-and-design-hbn-03-01/) .

Acute Inpatient Operating Model – Therapeutic Intervention.

Complementary Therapies

Complementary therapies are used alongside conventional medical treatments to enhance the overall well-being of an individual. They are not intended to replace standard medical care but are employed to complement it.

Alternative Therapies

Alternative therapies are used as a substitute for conventional medical treatments. These therapies are used in place of, rather than in addition to, standard medical care. They are chosen by individuals who prefer non-conventional approaches to healing and have scientific evidence supporting their effectiveness.

Acute Inpatient Operating Model – Therapeutic Intervention.

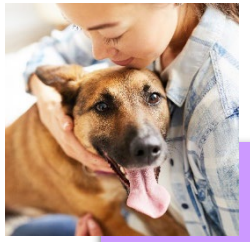
Examples of Complimentary Therapies

Essential Oils

A holistic practice that involves using concentrated plant extracts called essential oils, for therapeutic purposes.

The aroma of these oils is inhaled or absorbed through the skin to promote physical, emotional, and psychological well-being.

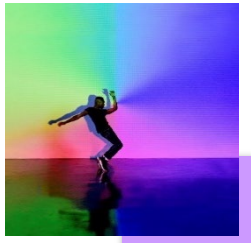
The olfactory system, linked to the brain's limbic system, is thought to influence emotions, memory, and certain physiological functions.



Pet Therapy

Pet therapy involves the use of trained animals to facilitate therapeutic interactions between individuals and the animal.

Emotional and Physical Benefits: Interactions with therapy animals have been shown to provide emotional and physical benefits. This can include reduced stress, anxiety, and depression, as well as improvements in mood, social interactions, and even physical health markers such as blood pressure.



Emotional Expression

Emotional expression healing refers to therapeutic processes or practices that focus on the healthy expression and processing of emotions to promote well-being.

The approach centres on acknowledging and expressing emotions as a vital step in emotional healing, encouraging individuals to confront and release pent-up feelings rather than suppressing them.

Emotional expression healing encompasses a range of therapeutic modalities, talk therapy, art therapy, music therapy, dance therapy, mindfulness, and yoga.

Acute Inpatient Operating Model – Therapeutic Intervention.

Alternative Therapies

Reflexology

Reflexology is a complementary therapy that involves applying pressure to specific points on the feet or hands.

Reflexology is rooted in the idea that energy flows through the body along specific pathways. By applying pressure to reflex points, practitioners aim to stimulate and balance energy flow, promoting overall well-being.

Reflexology often promotes relaxation, alleviates tension, and supports the body's natural healing processes.

Somatic Breathing

Deep and rhythmic breathing enhances oxygen flow to the brain, promoting alertness, concentration, and mental clarity.

Techniques like diaphragmatic and alternate nostril breathing are known for their positive impact on cognitive function

- **Please note:** We do not currently practice these therapies but aspire to

Acute Inpatient Operating Model – Therapeutic Intervention.

Peer Support

Peer support involves individuals with similar experiences providing emotional, informational, and experiential support to one another. Peers share common challenges, allowing for a unique understanding and connection based on firsthand experience.

Empowerment and Collaboration: Peer support fosters a sense of empowerment as individuals work together collaboratively. It emphasises mutual respect and shared decision-making, recognising that those with lived experiences can be crucial in supporting each other's journeys toward recovery or personal goals.

Acute Inpatient Operating Model – Therapeutic Intervention.

Meeting Sensory and Cognitive Needs

Environmental Design

- Seating to support engagement and social connectedness
- Optimum levels of stimulation and opportunity for engagement to aid recovery
- Quiet spaces with limited/no sensory stimulation
- Optimum lighting and visual contrasts
- Good visibility and visual access
- Supporting orientation, wayfinding and navigation
- Access to outdoors and nature
- Reduce impact of echoes, reflections, shadows etc.
- Non-triggering art and decoration
- Consider the level of auditory/visual stimulation from ALL sources – are they necessary?; therapeutic? constant?

Access Equality

- Does the person have / need a communication passport?
- Providing prompts and reminders
- Providing alternative opportunities and access
- Identify whether person has food insecurity or undernutrition
- Identity triggers/trauma that impact access to care/treatment/ ward.
- Provide alternative communication options and information giving
- Determine if the task requires vision? (short/long/colour recognition/depth perception)
- Determine if the task requires hearing? (sounds/tones/volume)
- Determine if the task requires taste discrimination?
- Determine if the task requires distinguishing between different smells?
- Determine if the task requires fine or gross motor skills / is the ability to recognise different shapes / textures or changes in temperature necessary?
- Determine if the task requires stereognosis / proprioceptive or vestibular skills?
- Are compensatory options available?
- Have aids/adaptations been considered?
- Has assistive technology been considered or implemented?

Sensory Diversity

- Person-focussed sensory environment review
- Creating a predictable environment and informing the person of what to expect
- Identify specific Sensory Diversity informed staff to support THAT individual to reduce need for restraints etc.
- Swap alarms for silent alarms (auditory sensitivity)
- Reduce noise and echo
- Access to noise free-zones, quiet spaces and outdoors
- Lighting – impact regarding individuals with hypersensitivity to lighting
- Impact of smells – food, cleaning products
- Consider impact of touch and texture – hyper or hypo sensitivity – bedding, towels, physical contact
- Identify specific requirements for the individual e.g. blankets, headphones, fidgets and their potential use/risk on the ward

Sensory Impairment

- Determine whether lifelong, recent, part of ageing or other?
- Ensure good communication skills
- Establish preferred communication method
- Utilise assistive technology - simple format, large print, and audio or screen reader
- Ensure person has access to aids including glasses and has had a recent test and update
- Transcription where appropriate
- Check with the person/family/ carers about communication styles.

Cognitive Impairment

- Familiar environment which is easy to recognise ?
- Identify specific Dementia informed staff to support individuals with cognitive impairments
- Completing 'this is me' to maintain personal identity
- Identify communication issues. To explain 'out of character' or challenging behaviour -Rule out hunger, thirst and pain, misunderstanding, feeling threatened, boredom or frustration.
- Speak slower with simple words and short phrases
- Maintain eye contact and be the person's visual area of focus
- Avoid body language, gestures, voice volume etc. that may be misinterpreted
- Give the person plenty of time to reply without environmental distractions
- As one things at a time and keep it simple

Acute Inpatient Operating Model – Pharmacy.

Pharmacy & Medicines Optimisation

Clinical Pharmacy

- Prompt pharmacy-led medicines reconciliation on admission with resolution of discrepancies.
- Timely access to medicines throughout to minimise missed and delayed doses.
- Pharmacy professionals routinely involved in ward rounds and MDT meetings to maximise outcomes from medicines, optimise doses, reduce risks associated with medicines (falls, adverse effects, antimicrobial resistance), encourage medicines use in line with national/local guidance, simplify regimens where possible and support de-prescribing where appropriate.
- Pharmacy involvement in discharge planning to provide clinical advice and facilitate timely supply.
- On-ward presence to improve accessibility to advice on choice, use and handling of medicines.

Enhanced Adherence

- Support the use of patient's own medicines where these are suitable.
- Support patients to self-administer medicines throughout their stay (e.g. insulin) and prior to discharge (all medicines) to identify and resolve problems with medicines-taking, provide practical support, and improve adherence.
- Referral to the Community Pharmacy Discharge Medicines Service to minimise medication errors involving transfers of care.

Patient Focused

- Provide regular group education sessions to improve understanding of the role of medicines in recovery and discuss beliefs, expectations and past experiences associated with medicines.
- Opportunity for 1:1 individualised discussion with a pharmacy professional about their medication regimen to support adherence.
- Provide information about side effects, interactions, and how to take medicines, to support shared decision making.
- Medication counselling shortly prior to discharge including advice on how to get information if needed post-discharge.
- Access to a pharmacy helpline to provide information post-discharge about medicines.

NHS
Essex Partnership University
NHS Foundation Trust

Acute Inpatient Operating Model – Reviews and Updating Care

1. The First Week Of Admission

On arrival, the patient is given a Welcome Pack and shown around the Ward. The Nurse in charge provides the patient with a "My Care, My Recovery" booklet, the patient is asked to complete this to inform their care plan. A 72 hour care plan will be completed in the interim, the patient is made aware of this and asked if they have any immediate needs. An initial risk assessment is completed within 4 hours of a patients arrival. Patients are allocated a named nurse. It is explained and encouraged to patients they can speak with an Independent Mental Health Advocate.

Within the first week, the MDT will meet to discuss the ongoing treatment plan. The patient will be seen by their Responsible Clinician in care review. The Named Nurse will re-visit the 'My Care, My Recovery', the patients views are documented in the care plan. The patient is also given the opportunity to ask any questions. The patient will be offered daily therapeutic engagement on a 1:1 basis with Psychology, Occupational Therapy (OT) and other AHPs. The patient would also be introduced to the Activity Coordinator who will provide a copy of the ward activity timetable and will be given the opportunity to discuss the activities on offer. The patient is allocated a named nurse for each shift, who will approach the patient to engage in a therapeutic 1.1 conversation. The rights of the section will be read to the patient, and will be re-visited at a later date if they do not understand them.

2. By The End Of The Second Week

The patient will be seen by their responsible clinician and the MDT in weekly Care Review, the patient's family is also invited with their consent. This continues throughout their stay on the ward. Observation levels are also adjusted accordingly. The treatment plan is reviewed and amended if necessary, the patient is provided with a copy of the treatment plan every time it is adjusted. The OT will meet with the patient once again to encourage them to attend activities (if they are not attending), and to enquire if there are any activities they would like to see take place. Patients are made their own personalised timetable which indicates which activities they have shown an interest in attending.

The patient is met with again to review and update their care plan and risk assessment. If the patient previously did not understand their rights they would be revisited at this time.

3. Towards The End Of The First Month

The patient will continue with their weekly Care Review. The patient is continued to be offered daily therapeutic engagement on a 1:1 basis along with 1:1 group offerings from OT, Psychology Services, AHP and Activity Coordinators, if indicated. Any therapeutic engagement (or attempt) is recorded on the electronic patient system in the patient file. If a patient is prescribed any medications they will be given the opportunity to discuss any concerns or side effects with the Pharmacy Team.
By this time the patient has been referred to their local community team, if the referral has been accepted they will be informed of their Care Coordinator who will visit the ward. It is explained to the patient the Care Coordinator will be involved in their care and will support them when they return to the community.

The patient's Named Nurse will meet with the patient on a weekly basis to review their care plan as the patients needs may change over time. During this time, the Nurse will revisit the 'My Care, My Recovery' booklet to help the patient complete this, this ensures the patient voice is included in their care plan. Any feedback from the patient or their family is reflected in the care plan. A copy is printed and provided to the patient for them to read and sign.

If it is appropriate, My Care My Safety (safety plan) will also be administered by ward staff.

4. Discharge Planning

The routine will stay the same for the patient, their Care Reviews continue weekly, care plan and treatment plan is reviewed on a weekly basis. Their therapeutic engagement opportunities also continues.

Discharge planning commences on admission. When the patient has improved to level pre-hospital a joint decision would be made If the patient still required hospital admission. If the patient is then discharged, they will be assessed on what their needs are post-discharge and if needed they will receive intensive support from the Home First Team for a brief intervention and continuous support from the Care Coordinator.

Acute Inpatient Operating Model – Principles-Expectation for Every Patient .

As part of this work, there is an expectation that a patient/individual will receive the minimum set of standards whilst in inpatient care.

- Individual Care Plan (underpinned by international fundamental of care principles)
- Dedicated 1to1 time with a MH professional
- Patient Safety Huddle
- Ward review by a Doctor
- Risk assessment/management planning
- My Care, My Recovery (patient family voice tool to support joint planning)
- Individual therapeutic programmes(activity/coordinator groups)
- Family/carer support meeting and daily conferencing
- Patient Centred with their involvement at all times
- MDT Meetings
- Tobacco Dependency Scheme to embed new behaviours – reduce smoking and support lifestyle change
- Making every contact count - supports physical health and optimises medical input
- Concerns regarding substance and alcohol use is covered, goals are agreed and are achievable, relevant signposting to services
- Optimising medication regimes

Acute Inpatient Operating Model – Next Steps

- Review and improvement of environment ensuring a therapeutic principles are integrated and implemented
- Safer Staffing and Time to Care
- Training for staff
- Implementation of International Fundamentals of Care Principles

04: TRAUMA INFORMED CARE.

Lead Authors:

- Dr Alison Fell - Consultant Clinical Psychologist & Associate, Clinical Director for Psychological Services (MH Urgent Care and Inpatient Services CCU)
- Dr Sophie Bellringer, Consultant Clinical Psychologist

Trauma Informed Care

Background: This is part of EPUT's Trust wide initiative to become a Trauma Informed Trust – and the Inpatient Initiative will be a part of this broader strategy.

What is it & why is EPUT aspiring to be Trauma Informed?
Trauma-informed practice is underpinned by a fundamental shift from thinking:

What is wrong with you?

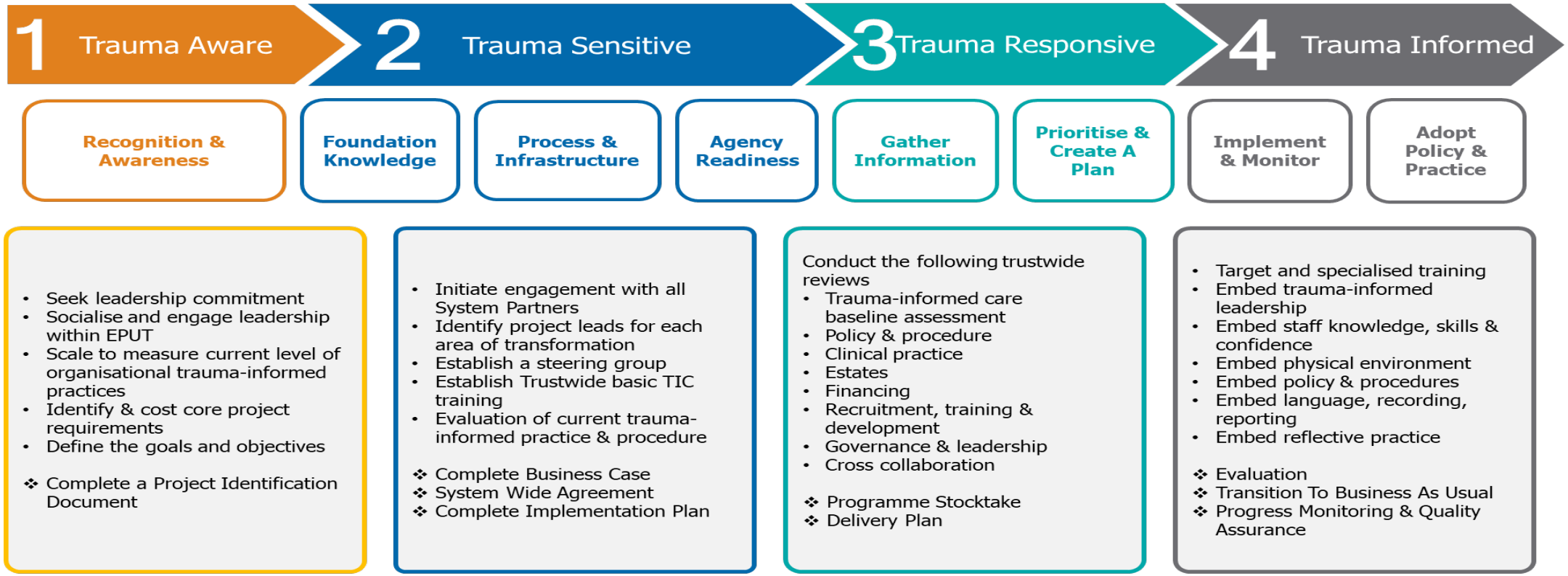
to considering

What happened to you?

It is not a specific service or set of rules, trauma-informed approaches are a culture
and it is not just about patient care, but staff care and a whole philosophy approach.

It is the future of mental health care – embracing the latest research and the directions this takes us in.

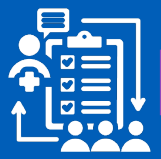
It is better for patients, better for staff, better for the community



Becoming a trauma-informed organisation is an ongoing process, not a one-off event.
The Oregon tool (shown above) shows how an organisation can move from being *Trauma Aware*, towards *Trauma Informed* and at any point a service/organisation can pause in its development.
The first challenge is to become Trauma Aware.

WHAT TRAUMA INFORMED CARE ISN'T

A draft of the 'Core Commitments and Standards to improve the Culture of Care in Mental Health LD and Autism Inpatient settings' (October 2023 v4.2), stated that: "*despite …enthusiasm for trauma-informed care*" there are concerns it can become "*a meaningless buzzword that reflects care delivered as normal*" or worse that people are "*seen as traumatised, and not mentally ill, and therefore denied access to services. This is not the intention for this paradigm shift*".



8.0: PROACTIVE DISCHARGE PLANNING AND EFFECTIVE DISCHARGE SUPPORT.

Lead Authors:

- Gbola Otun, Consultant Psychiatrist, Deputy Medical Director , Mental Health Inpatients and Urgent Care
- Tendai Ruwona, AD for Urgent Care and Inpatient Services (Mid & South)

Acute Inpatient Operating Model – Proactive Discharge Planning & Effective Discharge Support

The person's discharge is planned with the person and their chosen carer/s from the start of their inpatient stay, so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all planned post-discharge support provided promptly on leaving hospital.

'Acute inpatient mental health care for adults and older adults', NHS England, 18 July 2023

Principle 1: individuals should be regarded as partners in their own care throughout the discharge process and their choice and autonomy should be respected
Principle 2: chosen carers should be involved in the discharge process as early as possible
Principle 3: discharge planning should start on admission or before, and should take place throughout the time the person is in hospital
Principle 4: health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they are clinically ready to leave hospital
Principle 5: there should be ongoing communication between hospital teams and community services involved in onward care during the admission and post-discharge
Principle 6: information should be shared effectively across relevant health and care teams and organisations across the system to support the best outcomes for the person
Principle 7: local areas should build an infrastructure that supports safe and timely discharge, ensuring the right individualised support can be provided post-discharge
Principle 8: funding mechanisms for discharge should be agreed to achieve the best outcomes for people and their chosen carers and should align with existing statutory duties. (Discharge from mental health care: making it safe and patient-centred Feb 2024: Parliamentary and health Service Ombudsman)

Acute Inpatient Operating Model – Proactive Discharge Planning & Effective Discharge Support

CHAPTER OBJECTIVE

a) Mobilise the co-produced therapeutic inpatient operation model enabled by Time to Care Staffing Model. Implement the clinical principles and operational actions within the effective discharge and planning chapters of the operating model

a) In additional to the key drivers outlined in the programme brief and following the recent publication of the Parliamentary and Health Service Ombudsman Report this will inform the new inpatient model.

Care Formulation and Planning

George was detained by police under section 136 of the mental health act (MHA). He was assessed, agreed informal admission, and transferred to an Assessment Unit bed from the Health Based Place of Safety (HBPOS). Following admission, a further MHA assessment was required and he was subsequently detained under section 2 and identified for transfer to an EPUT Acute Inpatient ward.

72 hour care

A care plan identifying discharge need will be developed as part of the admission process.

Care plan

Within 72 hours of admission a comprehensive care plan will be completed which will include all the identified needs. Discharge coordinator assessment will feed into this multi-disciplinary care plan clearly identifying the barriers to discharge (if any and interventions required) or discharge destination.

For Action

Board is therefore asked to:

- Note the contents and key principles proposed within the new Inpatient Acute Operating Model, as part of the Time to Care Programme
- Give final approval to proceed to mobilisation phase

10. REGULATION AND COMPLIANCE

10.1 DUTY OF CANDOUR ANNUAL REPORT 2023-2024

Information Item | AS | 5

REFERENCES

Only PDFs are attached

Duty of Candour Annual Report August 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Duty of Candour Annual Report 2023-2024**					
Executive Lead:	Ann Sheridan - Executive Nurse					
Report Author(s):	Moriam Adekunle, Director of Safety & Patient Safety Specialist					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	If the Trust does not effectively engage with people who have experienced a degree of harm of moderate level and above during the use of our service and offer an apology, then the Trust will be at risk of not fulfilling the statutory requirement under the Duty of Candour.		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	Yes		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.	N/A		
Describe what measures will you use to monitor mitigation of the risk	N/A		
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
This report provides the Board of Directors with details of how the Duty of Candour has been implemented across the organisation and the number of times Duty of Candour has been triggered. The annual report also details how the organisation has fulfilled its' responsibilities in the triggering of Duty of Candour for adverse events which occurred between 1 April 2023 and 31 March 2024.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Request any further information or action

Summary of Key Points

- The Duty of Candour actively encourages transparency and openness; the Trust has a legal and contractual obligation to ensure compliance with the standard.
- A number of areas of work are in place to support staff in encouraging an open and transparent culture. This includes a training programme, family involvement in investigations and reviews under PSIRF.
- The Trust was compliant with Duty of Candour statutory timeframes and requirements for all applicable incidents during 2023/24.

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

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

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

Acronyms/Terms Used in the Report			
PSRIF	Patient Safety Incident Response Framework	PSIM	Patient Safety Incident Management
FLO	Family Liaison Officer	LRL	Learning Response Lead

Supporting Reports and/or Appendices

Duty of Candour Annual Report 2023-2024

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan
Executive Nurse

DUTY OF CANDOUR
ANNUAL REPORT
01 APRIL 2023 TO 31 MARCH 2024

Introduction

All health and social care services in England have a Duty of Candour (DoC). This is a legal requirement, which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. An important part of this duty is that we provide an annual report about how the implemented of Duty of Candour in our services. This report describes how Essex Partnership University NHS Foundation has operated the Duty of Candour during the time between 1 April 2023 and 31 March 2024.

Essex Partnership University NHS Foundation serves a population of around 3.2 million and employs in the region of 5,500 staff. The Trust provides a full range of clinical services covering the county of Essex and parts of Suffolk, Luton and Bedfordshire. The Trust operates over four acute hospital sites; Basildon Hospital, Broomfield Hospital, Colchester Hospital and Southend hospital, as well as over 200 community based healthcare settings including GP practices.

The Trust is committed to delivering high quality services with honesty, openness, transparency, accountability, and integrity. All staff are actively encouraged to contribute to an open and honest culture to support duty of candour, improvements in patient safety and the quality of the service user experience. The Trust considers 'being open' as fundamental to relationships between patients, the public, staff, and other healthcare organisations.

Number of Duty of Candour Incidents

Table 1: Patient Safety Incidents reported by financial year:

	April 2021 – March 2022	April 2022 – March 2023	April 2023 – March 2024
Total Patients incidents occurring in the year:	22523	24399	24111
Patients incidents with degree of harm of Moderate and above:	1986	2461	2722
Number of patient incidents noted to have initial Duty of Candour completed (Part 1) moderate harm and above)	813 (40.9%)	1251 (50.8%)	1272 (46.7%)
Number of confirmed ticked on Datix and aligned to the Patient Safety Incident Response Plan (PSIRP)	385	120	96
Number confirmed Patient Safety Incident with Duty of Candour Part 2 completed:	83 (21.6%)	90 (84%)	64 (86.5%)

It is important to note that the number of incidents reviewed, between April 2021 and March 2022, is attributed to impact of COVID 19, and the outstanding patient safety incidents that are due for review will potentially impact the data for April 2023 – March 2024.

It is important to note that it is not always possible to contact family and carers and in some incidences, next of kin information is not available. As early adopters, there were challenges in supporting and recording the process appropriately. The P*atient Safety Incident Management (*PSIM) team have Family Liaison Officer

(FLO) Leads who are taking the lead for Duty of Candour across the organisation. This is now showing improvements over the last year to involve families in incidents. Also note that the figures provided in the above table for duty of candour relates to the incidents that meets the threshold and where there has been family engagement managed through the FLO role.

There are a number of areas now being strengthened in the process, and the focus for the organisation are listed below:

1. **Improvements to Datix incident reporting form**
    a. Degree of harm captured at the time of reporting along with the requirements to complete the information to record that Duty of Candour process has been met or needs to be completed.
    b. Timeframes for completing the Duty of Candour recording will be set on Datix that will facilitate enhanced monitoring
    c. This will be monitored at a care unit level via the Datix Dashboard reported into the monthly Quality and Safety meetings in care units reporting up to Board.

2. **Duty of Candour Policy is being revised, specifically to address changes to Datix;**
    a. Requirements to record information on Datix incident record and patient records
    b. Role and responsibilities of all staff

3. **Duty of Candour awareness and implementation**
    a. Family Liaison Officer Leads reviewing the Duty of Candour online training and improve as appropriate
    b. Family Liaison Officer Leads will use data to monitor Trust's responses and put in quality improvement as required, linking in with the Patient Safety Partners and Patient Experience team.
    c. Family Liaison Officer Leads will lead on improving communication that will keep patient/families central to the reviews/investigation, especially where system partners, with significant input from the care unit Patient Safety Partners, lead investigations.

To what extent did EPUT follow Duty of Candour Procedures

Essex Partnership University NHS Foundation Trust has a robust process for the identification and management of adverse events with the Duty of Candour integrated within the Adverse Events Policy.

When applying Duty of Candour, all necessary action is in accordance with the Duty of Candour Procedure. The key stages of the procedure include the following requirements:

- Notify the person affected (or family/relative where appropriate);
- Provide a verbal apology with follow up in writing;
- Carry out a review into the circumstances leading to the patient ;
- Offer and arrange a meeting with the person affected and/or their family, where appropriate;
- Provide the person affected with detail of the review findings;
- Provide information about improvement actions; and
- Make available, or provide information about, support to persons affected by the adverse event.

On reporting a safety incident, the relevant team will review the incident and add the degree of harm. The recording of this information is on Datix and the patient clinical records including compliance with Duty of Candour. The leadership team in care units determine the requirement for further review as per PSIRF process. They agree with their PSIM lead the type of review to be completed based on Patient Safety Incident Response Plan, other learning response or investigation review methods used with the Trust Chief Medical Officer, Chief Operating Officer and Chief Nurse having the ability review these decisions.

Information about our process

The process involves a review of each patient safety incident to understand what happened and learning takes place to improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. The commissioning of reviews and investigations comply with the Patient Safety Incident Response Framework (PSIRF). All review and investigations have an allocated a FLO. The FLO will provide regular contact with the patient / family / carer to provide updates on progress of the review / investigation. All FLOs have received appropriate training and have the skills to respectfully disclose sensitive information and answer questions / concerns the patient / family / carer may have.

There is a register of FLOs in the Trust and they regularly undertake training. There is a regular support forum for all FLOs chaired by the Safety & Quality Director to support their role. The Trust trained 30 FLOs in the last financial year.

Duty of Candour training is part of Trust Induction. Staff who are responsible for reviewing incidents must complete Duty of Candour training.

The Trust recognises patient safety incidents can be distressing for staff also and support is provided for all staff through line management structures, Occupational Health and the Trust's employee support, Here for You.

The Duty of Candour process is part of the following policies:

- CP3 Adverse Incident Policy CP3
- CP36 Being Open and Duty of Candour Policy
- Patient Safety Incident Response Framework Policy (in approval stage)
- Patient Safety Incident Response Plan

What have we learnt

Further to the review of the events that triggered the Duty of Candour, various learning points were identified as follows:

Some of the learning that has been completed includes:

1. Supporting family members and carers to access specialist psychological support for bereavement and trauma.
2. Development of a bereavement information pack
3. Setting up of a FLO forum to better support these staff especially on trauma
4. Development of training for patients with neurological disorders on impact on their mental health
5. Ensure consistent communication approach with care units that involves speaking with colleagues in addition to using emails
6. Timely multi-disciplinary approach to reviewing patients in Health Based Place of Safety who require further assessment and treatment.
7. Commissioning of case note reviews and monitoring via the Learning from Deaths Group, and presentation of learning to the Mortality Review Sub-Committee.
8. Contact sheet for communication with family members and significant others now maintained and stored on Datix.

Some of learning currently being implemented includes:

1. Teams to be reminded that patient and family concerns must be taken on board at the time of discussion.
2. Supporting Policy / guidance / pathway on a page to support easy access.
3. Guidance for managing patients safely at home who are awaiting admission to hospital.
4. Support for acute trusts in terms of mental illness recognising the role of the Mental Capacity Act.

5. The importance of including patient when completing care plans, maintaining an open dialogue, particularly for people with complex emotional needs.
6. Promote the MHUCD Pathway Trust-wide.
7. A survey, of families and carers to obtain feedback from the engagement process, working collaborative with our Patient Safety Partners is under development and due for implementation in August 2024.

Conclusion

This is the Trust third year of presenting its Duty of Candour being in operation. The organisation continues to learn and refine processes to ensure adherence to the Duty of Candour process. The embedding of the PSIRF process with the right infrastructure and systems at a care unit level with reporting and oversight from ward to board will ensure greater compliance with the Duty of Candour especially the changes to the Datix System. The PSIM team and other key corporate teams have been working closely with the Care Unit Leadership Teams to progress action points in a timelier manner.

This report will be shared via the Safety of Care Group reporting structure for internal information and will be shared with the Quality Committee before being published on our public website as per the Duty of Candour legislation. NHSE will be made aware of the publication of this report and we are aware that they may for the purposes of compliance with the Duty of Candour provision, request information regarding the content of this report

The Board of Directors is asked to:

1. Note the contents of the report
2. Request any further information or action

10.2 SAFE WORKING OF JUNIOR DOCTORS QUARTERLY REPORT

Information Item | MK | 5

REFERENCES

Only PDFs are attached

Safe Working of Junior Doctors Q1 Report August 2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Safe Working Hours for Junior Doctors, Annual Report**					
Executive/ Non-Executive Lead / Committee Lead:	Dr Milind Karale, Executive Medical Director					
Report Author(s):	Dr P Sethi, Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	✓
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Lampard Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital and Data Strategy	
Does this report mitigate the Strategic risk(s)?	Yes/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk	Trainees escalate any issues to their Clinical Supervisor and Clinical Tutor. If unresolved they escalate at Junior Doctors Forum, any unresolved issues is further escalated to Dr Karale. Medical Staffing ensures that the Junior doctors working hours are in line with the Junior Doctors contract 2016.	
Are you requesting approval of financial / other resources within the paper?	No	

If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1. Note the contents of the report.

Summary of Key Points

1. The National recruitment of trainees is an ongoing issue.
2. The Board to note that there are no specific concerns related to recruitment within the Trust. There has been a significant improvement in the intake of trainees in the last year.
3. Trust has employed international Doctors, LAS and MTI and this helps to cover the service provision.
4. The Trust does not use agency locums.
5. The Junior Doctors participated in the industrial action from 27 June 2024 until 2 July 2024. The Trust were supportive of Doctors. The gaps in the rota, ward cover and emergency cover were all filled in by internal locum doctors so that safety of patients are not compromised. The total amount spent to cover the shadow rota during this period will be included in the next Board report.
6. Trainees have raised 6 Exception reports from 1 April 2024 until 30 June 2024. All the issues have been resolved.
7. The Trust was fined on two occasions. Details are in the main report.
8. Bi-monthly junior Doctors forum (JDF) is well attended by Junior Doctors representatives from all sites of the Trust. All matters discussed in this meeting are resolved timely and escalated to Clinical Tutors/DME/Senior Managers where necessary

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

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

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

Acronyms/Terms Used in the Report			
JDF	Junior Doctors Forum	DME	Director of Medical Education
LAS	Locum Appointment for Service	JDF	Junior Doctors Forum
MTI	Medical Training Initiative		

Supporting Reports and/or Appendices
Quarterly Report on Safe Working of Junior Doctors

Executive/ Non-Executive Lead / Committee Lead:
 **Dr Milind Karale** **Executive Medical Director**

QUARTERLY REPORT ON SAFE WORKING OF JUNIOR DOCTORS

1 PURPOSE OF REPORT

The purpose of this report is to provide assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the terms & conditions of their contract.

2 EXECUTIVE SUMMARY

This is the twenty eighth quarterly report submitted to the Board on Safe Working of Junior Doctors for the period 1 April to the 30 June 2024. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reports:

A total of 6 exception reports were raised in this quarter.

1. 21 May 2024: Foundation trainee worked extra hours on the ward to complete urgent tasks. Time off in lieu was given.
2. 29 May 2024: Trainee raised an immediate safety concern as she was the only doctor on ward, had to conduct ward reviews, complete admin tasks etc. The clinical supervisor conducted a review and time off in lieu was given.
3. 2 and 3 April 2024: Trainee stayed extra hours on the ward on both days to complete the admission process. Trainee was given time off in lieu.
4. 7 April 2024: Higher trainee had to work 6 hours on site to help the CT trainee due to a huge surge in the workload during an on call shift. This was a breach of contractual working hours and Trust was fined £566.76. Trainee preferred time off in lieu rather than extra payment and this was agreed.
5. 11 April 2024: Trainee worked extra hours during an on call shift as the night duty doctor did not arrive. Trainee was paid the locum rate for the extra hours and Trust was fined £188.92 as this was a breach of contractual working hours.

Work Schedule Report

Work schedules were sent out to all trainees who commenced their placements on 3 April 2024

Doctors in Training Data

Total number of posts EPUT Training Scheme inclusive of foundation and GP	**154**
Total number of psychiatry training posts	**97**
Total number of doctors in psychiatry training on 2016 Terms and Conditions	**86**
Total number of foundation posts	**35**
Total number of GP posts	**22**
Total number of vacancies across all grades	**19**
Total vacancies covered LAS/ MTI/Agency	**9**
Total gaps	**10**

Agency

The Trust did not use any agency locums during this reporting period but relies on the medical workforce to cover at internal locum rates as follows.

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancy/Maternity/ sick	102	102	0	1053.5	1053.5
Total	102	102	0	1053.5	1053.5

Junior Doctors Industrial Action:

Junior doctors took part in the industrial action held from 27 June 2024 until 2 July 2024. The Trust ensured that patient safety was not compromised and a shadow rota was set up to cover both day and night shift across all five areas of the Trust. The cost for covering the shadow rota will be included in the next quarterly report to the Board.

Actions taken to resolve issues:

The Trust has taken the following steps to resolve the gaps in the rota:

1. Rolling adverts on the NHS jobs website. Few International doctors who were appointed have started their posts.
2. Emails are sent to former GP and FY trainees if they would like to join the bank to do on-calls, this is now part of the termination process for GP's and FY's so they can express an interest in covering extra shifts when they leave EPUT.

Fines: Trust was fined for 2 exception reports raised in April 2024, the amount was £188.92 and £566.76. Both fines were incurred as there was a breach in contractual working hours.

Issues Arising:

1. Trainees reported increased workload during their on-call, particularly in the North part of the Trust as trainees have to travel long distances to cover the wards. Medical staffing, Medical Director and HR are aware. It was agreed to monitor their on-call for a period of time to obtain exact data to identify service need.
2. Higher trainees are unable to get enough experience in conducting Mental Health Act assessments. Senior managers are aware and an outcome to manage this issue is awaited.
3. Trainees in the North part of the Trust reported that seclusion reviews are not held by Consultants over the weekend. This matter was escalated to Medical Director.

3 ACTION REQUIRED

The Board of Directors is asked to:

1. Note the contents of the report.

Report prepared by

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours

10.3 SAFETY FIRST, SAFETY ALWAYS STRATEGY YEAR 3 REPORT

Information Item | AS | 10

REFERENCES

Only PDFs are attached

Safety First Safety Always Report 07.08.2024.pdf

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	7 August 2024

Report Title:	**Safety First Safety Always Year 3 Report**					
Executive/ Non-Executive Lead / Committee Lead:	Ann Sheridan, Executive Nurse					
Report Author(s):	Rebecca Pulford, Director of Nursing Anna Bokobza, Director of Strategy Chris Rollinson, PMO & Analytics Lead Moriam Adekunle, Director of Patient Safety					
Report discussed previously at:	Executive Committee and Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report			
Summary of risks highlighted in this report	No risks associated with this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety		✓
	SR2 People (workforce)		✓
	SR3 Finance and Resources Infrastructure		
	SR4 Demand/ Capacity		✓
	SR5 Lampard Inquiry		✓
	SR6 Cyber Attack		
	SR7 Capital		
	SR8 Use of Resources		
	SR9 Digital and Data Strategy		
Does this report mitigate the Strategic risk(s)?	N/A		
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	No		
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.			
Describe what measures will you use to monitor mitigation of the risk			
Are you requesting approval of financial / other resources within the paper?	No		
If Yes, confirm that you have had sign off from the relevant functions (e.g. Finance, Estates etc.) and the Executive Director with SRO function accountability.	Area	Who	When
	Executive Director		
	Finance		
	Estates		
	Other		

Purpose of the Report		
To provide the Board of Directors with a final (year 3) Safety First Safety Always strategy report, as we transition to the new Quality of Care strategy.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and approve the report for assurance and transition from the Safety First Safety Always strategy to the new Quality of Care strategy.

Summary of Key Points

Board members are asked to note:

- That significant progress and improvements have been made across the key indicators of patient safety, while recognising that EPUT still has more to do to build and maintain the confidence of patients, their families and carers and partners.
- The particular successes in ensuring the patient voice is listened to, understood and acted on supported by the doubling of Lived Experience Ambassador Team to 250 who have been integral to supporting the delivery of good care.
- That stakeholders have confidence that EPUT is a safe organisation.
- Since September 2022, there have been no preventable acute adult inpatient deaths associated with incidents of self-harm.
- The Trust has seen a reduction in Patient Safety Incidents for Investigation (PSII) reflecting the embedding of PSIRF process within our services.
- That the proportion of reported self-harm incidents resulting in moderate or above harm has been maintained at or below 2.7% since November 2022 despite reported self-harm incidents showing a rising trend over the three years of the strategy.

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

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

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

Acronyms/Terms Used in the Report			
PSII	Patient Safety Incidents for Investigation		
PSIRF	Patient Safety Incident Response Framework		

Supporting Reports and/or Appendices
Safety First, Safety Always Year-Three Report

Executive/ Non-Executive Lead / Committee Lead:

Ann Sheridan

Ann Sheridan
Executive Nurse

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NHS Foundation Trust

Safety First, Safety Always

Essex Partnership University NHS Foundation Trust

Three year report

EPUT

Foreword from our Chief Executive

Paul Scott
Chief Executive

Essex Partnership University NHS Foundation Trust

We launched our patient safety strategy, *Safety First, Safety Always*, in 2021 with **an ambition to provide the safest possible care for our patients**. **This commitment applies in all our services, however and wherever people receive our care**. The year 1 and year 2 reports consolidated this ambition.

Our first and most vital priority was to **set out and deliver improvements in inpatient care** so that patients and their families can feel assured that they will be well looked after and kept safe, whenever they are in our care. **Our Executive Team and local leadership teams remain wholly committed to delivering a vision of making Essex Partnership University NHS Foundation Trust (EPUT) the safest possible organisation**. This is the agenda that drives everything we do and the evidence shows that is still having a real, visible and measurable effect in the organisation.

At the end of the third and final year of the Strategy we must recognise that, while there has been significant progress, **we still have more to do to build and maintain the confidence of our patients, their families and carers and our partners.** Although feedback from our patients, their families and carers tells us that many people get excellent care and support from EPUT, there are still too many instances where this is not the case and where people feel we have failed them or have not treated them with the kindness and understanding they should expect. I am very clear that one person who has a bad experience in our care is one person too many, and I am determined that we will continue to improve. **It must be our number one priority to provide the safest and best possible care for everyone who needs our services -** and at the same time give them confidence in our services, without concern for their safety or the standards of their care.

As we continue to improve our services and evaluate that improvement, we do so in the context of the relaunched Lampard Inquiry into deaths in Essex mental health services across an almost 24-year period, which will bring additional intense scrutiny and will revisit incidents and learnings that have already taken place. We are completely committed to supporting the Inquiry to deliver on the scope and terms of reference that are now established - **it is vital that patients, families and carers get the answers they deserve and that we act decisively on the Inquiry's recommendations**.

It is also important that we reflect on the successes we have achieved with our staff, patients, communities and partners in the last three years. **Staff across the Trust have shown extraordinary commitment**. Against a backdrop of both unprecedented demand and workforce challenges, our people have truly embraced the *Safety First, Safety Always* message.

Our work has gained national recognition in key areas - for example, our national award-winning apprenticeship in Clinical Psychology (which is helping to address the workforce challenges of the present and future) and our Mental Health Urgent Care Department have both been recognised as examples of best practice by NHS England.

As the *Safety First Safety Always S*trategy comes to an end, **our new Quality of Care Framework takes forward a significant legacy of improvements and gives us an incredibly strong foundation on which to continue building**. We look forward to doing this in collaboration with patients, carers, families and partners to make EPUT the safest possible organisation for delivering patient care.

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Executive summary

The strategy's key ambitions

EPUT

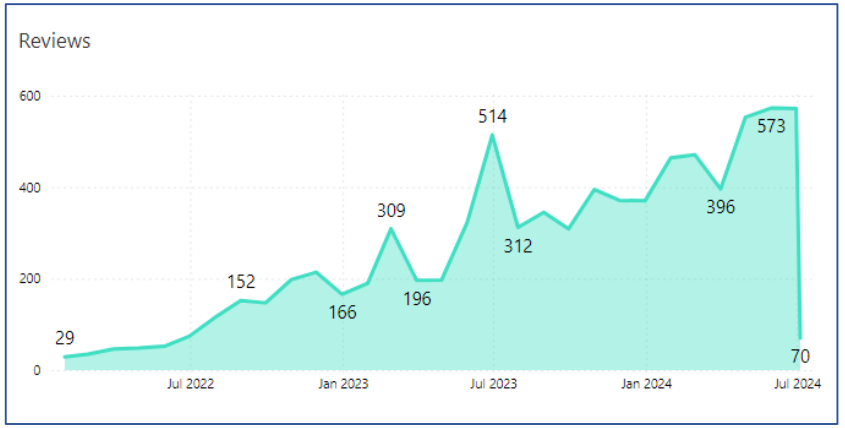
Summary of the strategy's impact

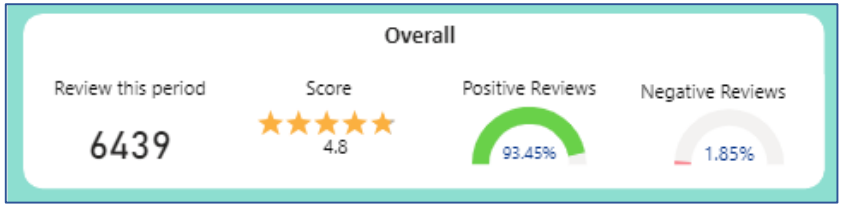
Safety First, Safety Always laid out **five key ambitions and outcomes for delivery over three years.** The combination of actions we have taken to improve safety of care at EPUT in the last three years has driven improvements demonstrable against each.

1 Patients and families feel safe in EPUT's care

- Since its implementation in October 2022, patients have shared their experience of EPUT's care via I Want Great Care
- Through five consecutive quarters, EPUT has seen a rising trend, achieving 98.2% positive response that patients and families feel safe in our care in December 2023, representing a 6.3% increase from December 2021
- This is in the context of a rising trend in overall numbers of patients using iWGC to feed back to us. We received 82% more feedback in December 2023 than in October 2022

Reviews over time





Summary of the strategy's impact

2

Stakeholders have confidence that EPUT is a safe organisation

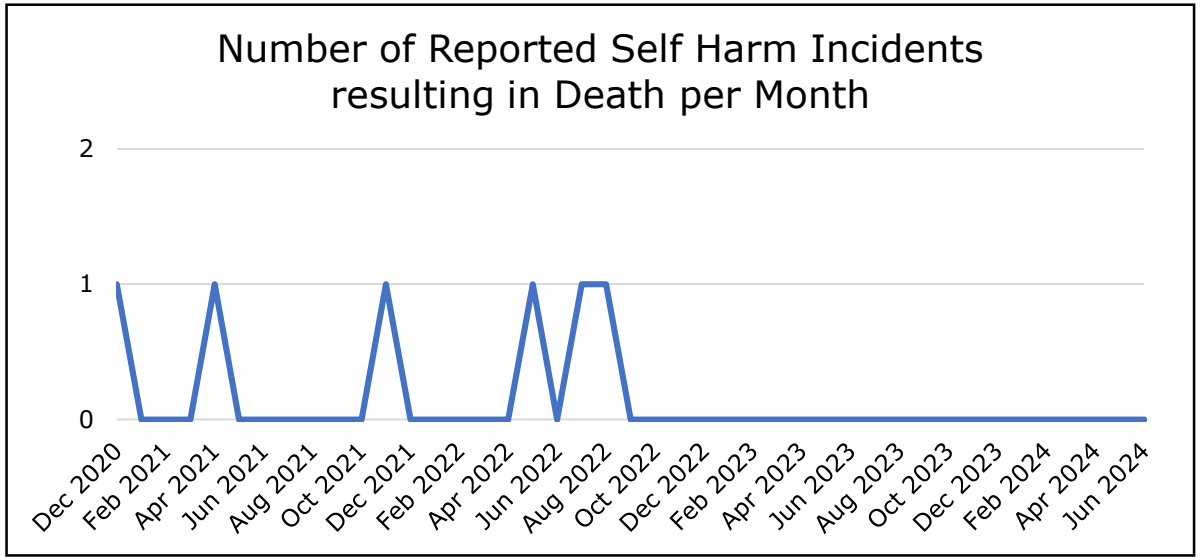
- Feedback from stakeholders and partners indicates that other organisations are starting to see EPUT as a more transparent and open system partner
- Closer working relationships developed with MPs and local council scrutiny committees,
- Whilst MPs and scrutiny committees report fewer complaints, we continue to work with them to address concerns and share our challenges
- EPUT services shortlisted in several national award schemes
- Education centre rated *Outstanding* by Ofsted

Summary of the strategy's impact

3

No preventable inpatient acute adult deaths attributable to self-harm

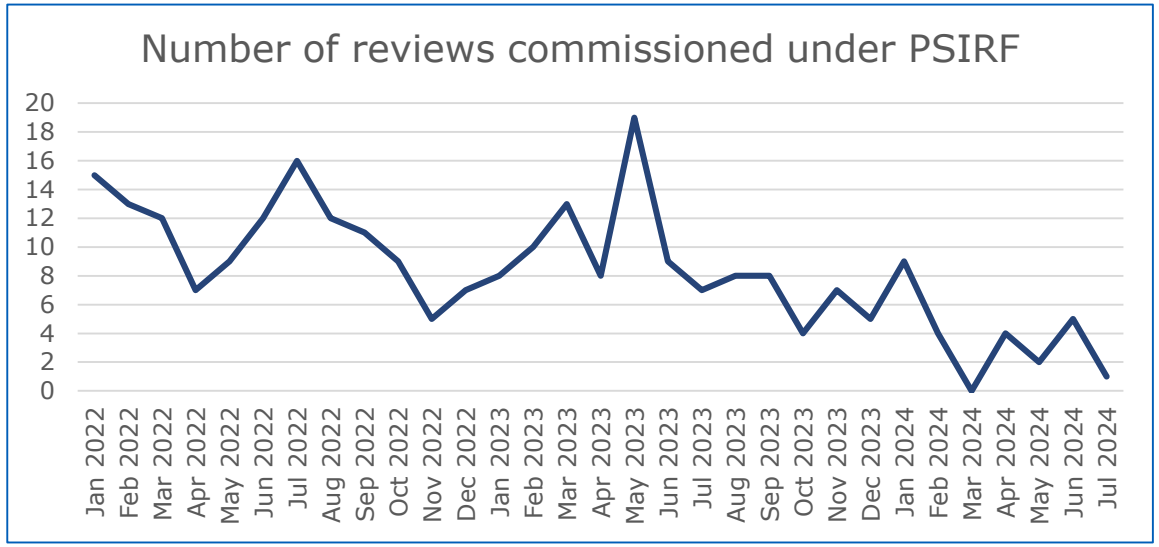
- There were no reported acute adult inpatient deaths attributed to self harm reported in adult inpatient services in 2023/24
- Since September 2022, there have been no deaths associated with incidents of self-harm



Summary of the strategy's impact

4 A reduction in Patient Safety Incidents for Investigation (PSII)

- We were an **early adopter of the NHS's Patient Safety Incident Response Framework (PSIRF)**, introducing it in May 2021 – this replaced the previous serious incident framework (SIF)
- PSIRF investigates incidents thematically rather than in isolation, providing a clearer picture of the underlying issues affecting safety and effectiveness of care
- We have seen a reduction in the number of incidents requiring investigation (PSII)
- Analysing PSIRF data over the last three years shows **improvements in key areas of patient safety**, including:
  - Inpatient deaths from self-harm – see slide 7
  - Self-harm by fixed ligature
  - Restraints – including use of prone restraint
  - Grade 3 and 4 pressure ulcers - those causing the most harm
  - Patient falls



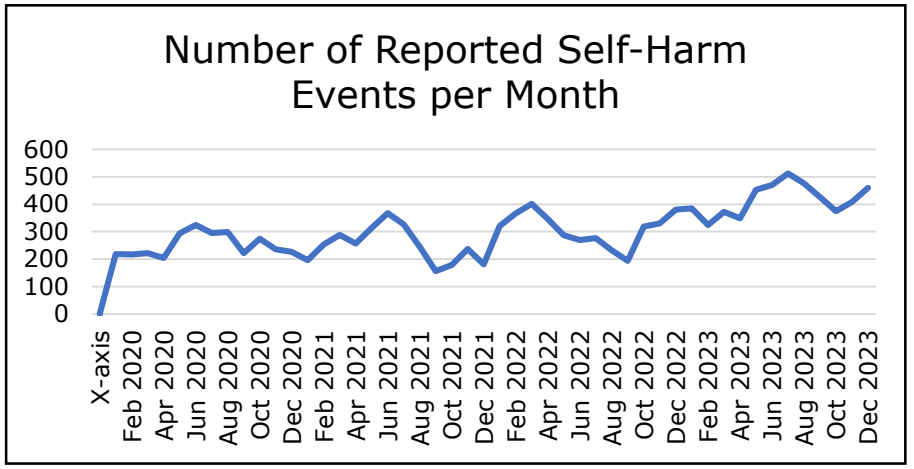
We are still on an improvement trajectory, including addressing those areas where we still need to improve

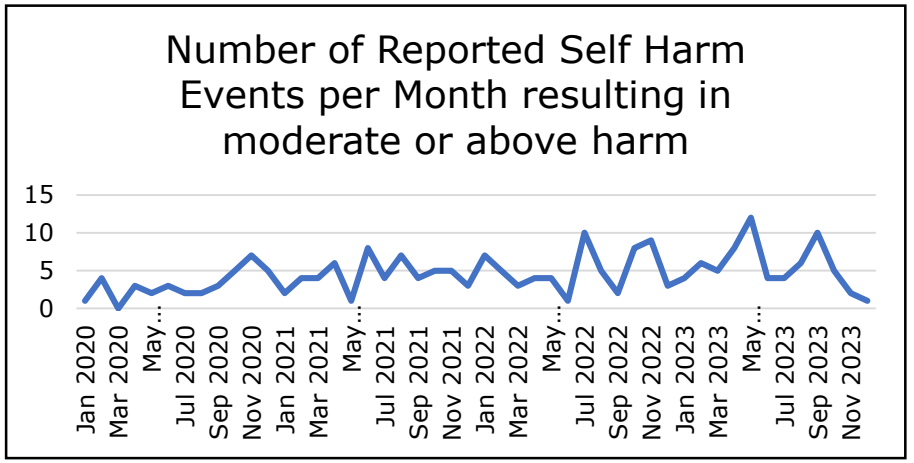
Summary of the strategy's impact

5

A reduction in self-harm

- Reported self harm incidents show a rising trend over the three years of the strategy
- Over the same three year period, EPUT has been building a culture of increased incident reporting as an enabler of learning and continuous improvement, so the increase in self harm reports is expected
- The proportion of reported self harm incidents resulting in moderate or above harm has been maintained at or below 2.7% since November 2022





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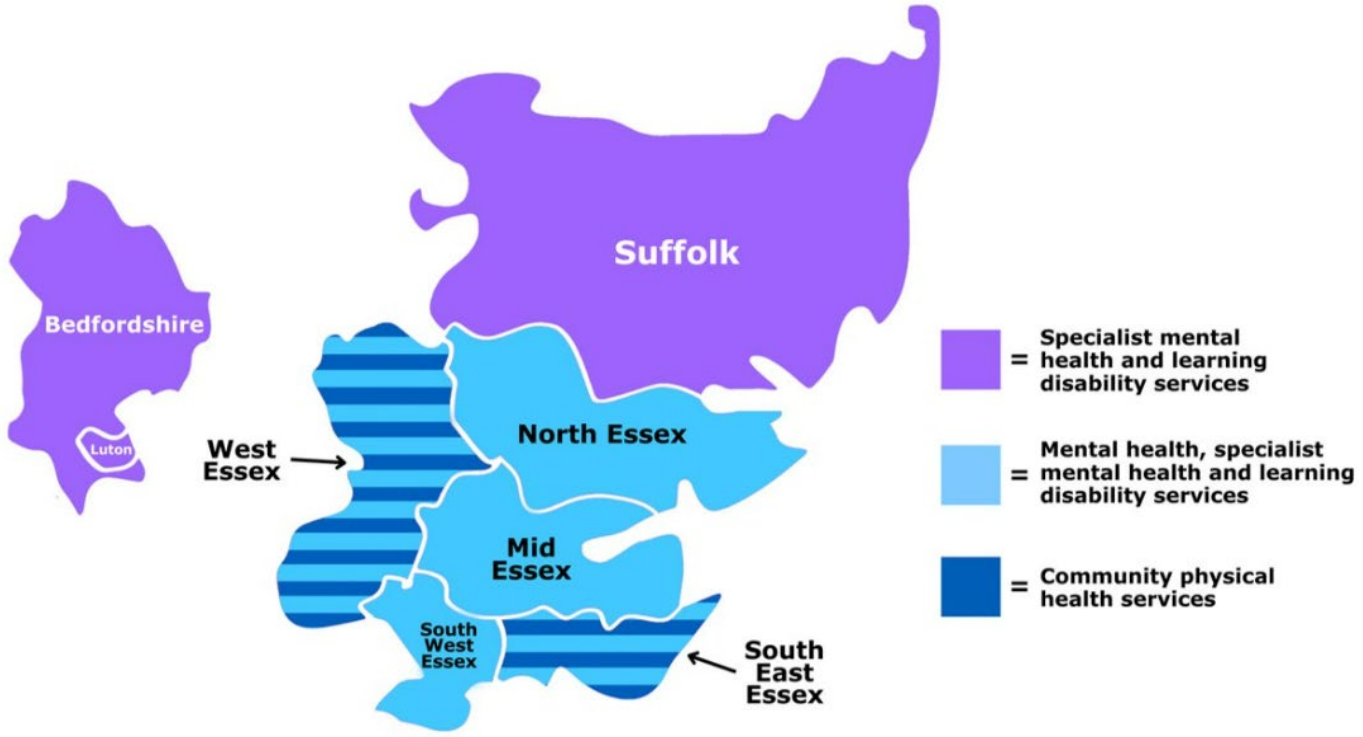
Establishing the context

Background to the Strategy and what we set out to achieve

EPUT

Who are we?

- We provide **community physical and mental health services to over 3.2million people** living across Essex, Thurrock and Southend as well as in Luton, Bedfordshire and Suffolk
- EPUT was formed in 2017 after the merger of the former South Essex Partnership and North Essex Partnership trusts
- **EPUT operates across three Integrated Care Systems**: Hertfordshire & West Essex, Mid & South Essex and Suffolk & North East Essex
- We are a large employer, with **around 7,500** staff working across **over 200 sites**
- We also provide services in people's homes and in community settings, including schools, GP practices and health clinics
- Around 100,000 people are in our care at any one time



The wider picture

Mental health services in context

- Demand for mental health services is increasing, whilst the population of the county of Essex is growing at one of the fastest rates in England – predicted to increase by 2.9% between 2022 and 2027
- The population is also ageing, with increasingly complex health and social care needs
- People who need our help are increasingly more unwell, with more complex needs
- All health and care organisations face additional pressures to recruit and retain staff and to meet demand within stricter budgetary requirements

Working together to care for people when they need us most

- We work closely with local system partners to help people get the care they need more quickly when they are experiencing a mental health crisis
- Introducing innovative new services such as our mental health urgent care department in Basildon helps free up capacity in the wider emergency care system, helping many other people get the care they need

Our strategy for ensuring patient safety

The **Safety First, Safety Always strategy** was agreed by the Trust Board in February 2021, following widespread engagement with Trust staff, Non-Executive Directors, Governors and partners. **It set out our ambition to be an organisation that consistently places patient/families' safety at the heart of everything it does.**

The strategy recognised the need for a change in culture and an organisation-wide mindset of *Safety First, Safety Always*. It reflects learnings from the past and themes from incidents over the preceding 20+ years.

We set out five key ambitions and outcomes:

- ☑ **Patients and families feel safe in EPUT's care**
- ☑ **Stakeholders have confidence that EPUT is a safe organisation**
- ☑ **No preventable deaths**
- ☑ **A reduction in Patient Safety Incidents for Investigation (PSII)**
- ☑ **A reduction in self-harm**

This report highlights the progress we have made against the priorities within this three year strategy and against the four priority areas for quality improvement in NHS England's Mental Health Safety Improvement Programme, now incorporated into NHS England's Culture of Care Standards for Mental Health Inpatient Services. It also sets out the context for our Quality of Care Strategy which launched at the end of April 2024 and builds on the work of the safety strategy to ensure that EPUT is a leader in providing outstanding patient safety and care.

Programme roadmap

THE JOURNEY

7 Themes for Improvement

Leadership	Culture	Continuous Learning	Wellbeing	Innovation	Enhancing Environments	Governance and Information
Ensuring there is buy-in, ownership and accountability across the Trust for putting *Safety First, Safety Always* and delivery this through leadership at all levels – from ward to board	Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility	Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff	Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care	Facilitating and inspiring patient safety initiatives through new ways of working	Ensuring our buildings and estates support the *Safety First, Safety Always* agenda	Building the foundations for safety through governance, processes and availability of information that put safety first

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Reviewing our progress

What we've delivered for our patients and communities

EPUT

PATIENT VOICE IN SAFETY

Ensuring the patient voice is listened to, understood and acted on is key to embedding safe, good quality care throughout the organisation in all our care settings.

Priority initiatives

- Further development of *I Want Great Care* to enhance the quality, quantity and application of patient feedback to care practices
- Instil a culture of systematically capturing and embedding patient feedback in everything we do
- Further increasing the number of people with lived experience engaged in our improvement work
- Increasing the number of our Patient Safety Partners, strengthening their voice and enhancing their role in safety and quality improvement

Highlights

- **22% year on year increase in *I Want Great Care* responses**, with a consistent trend of improvement since launch
- **Changes to practice are slowly driving an improving trend** in the proportion of patients and families who say they feel safe in EPUT's care
- **Patient experience dashboard created for each Care Unit**, supported by data insight to drive quality improvement; oversight via Care Unit quality and safety meetings and Accountability Framework meetings for executive assurance
- **Doubling of Lived Experience Ambassador team to 250** - ambassadors have been integral to the creation of the Quality of Care Framework
- **Doubling of Patient Safety Partners to 11**, focusing on establishing the Safewards programme and safety walkabout visits

PATIENT VOICE IN SAFETY - HIGHLIGHTS

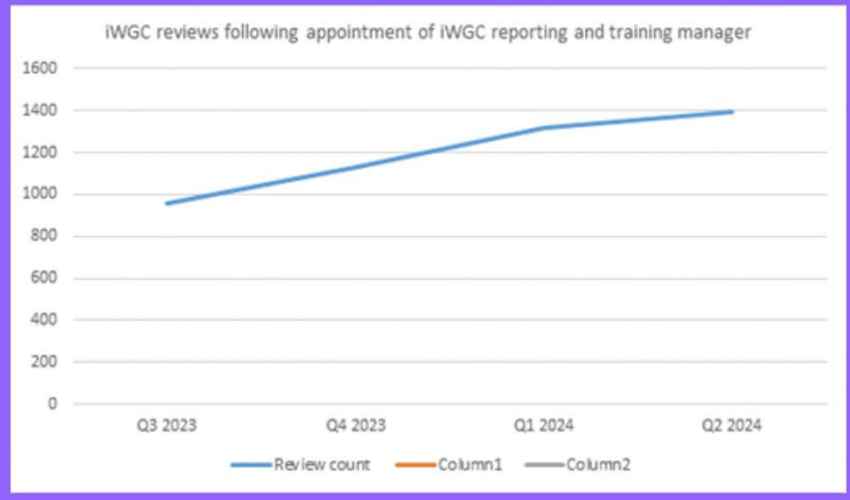
IWGC Development

IWGC OLM training module created

IWGC is now part of all staff induction

Grown an IWGC volunteer workforce

Safety question added to core data set



FEEDBACK CULTURE

IWGC feedback included in staff supervision

IWGC feedback utilised to improve support and discharge plans

IWGC feedback utilised to improve support and discharge plans

PATIENT INVOLVEMENT FOR QI

Growing pool of LEA's (approx. 250) with family or direct experience that our supporting improvements to our services

Lived Experience Framework has been developed

Peer support team has doubled in size

TTC LEA lead assigned and involvement group of LEA's have shaped the new staffing model

Three active coproduction leads facilitate and monitor progress of trust wide projects which feed into corporate work streams and steering groups

LEA's increasingly being utilised as members of key decision-making groups and committees

PATIENT SAFETY PARTNER DEVELOPMENT

PSP team has doubled in size.

People Participation Group feeds into Experience Executive Oversight Group

Time to Care involvement group has helped design the new staffing model for inpatient mental health wards

PSPs leading coproduction in development of UPER

Mandated requirement for LEA's to sit on interview panels for bands 8a and above

CULTURE OF SAFETY

Embedding the highest professional standards to become a Patient First organisation

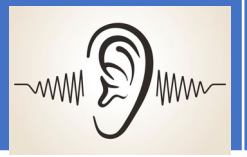
Priority initiatives

- Creation and embedding of the Trust's People Charter
- Continuing to foster a culture of reporting and speaking up
- Instilling a sense of empowered leadership throughout the wards
- Identify any learning or recommendations emerging from the Lampard Inquiry
- Rolling out Quality Together to ensure a shared culture of accountability, working with system partners and patients
- Truly embedding our process and practice improvements at ward level and throughout every care setting
- Enhancing the outcomes of our work using Quality Improvement methodologies

Highlights

- **Scoped development of People Charter** to be taken forward as part of our new People & Education strategy
- **Created just, learning and caring culture principles**
- **Continued to develop Freedom to Speak Up processes** and encourage colleagues to raise issues
- **Committed to supporting and learning from the Lampard Inquiry** as it develops
- **Held seven Quality Together meetings with ICBs and NHSE**, focusing on safety deep dives and related actions
- **Utilising a "single front door" approach for all quality improvement work**, developing knowledge and skills to improve standards of care delivery

Culture of Safety

Continuing to foster a culture of reporting and speaking up 	Instilling a sense of empowered leadership throughout the wards 	Rolling out Quality Together to ensure a shared culture of accountability, working with system partners and patients 	Utilising a "single front door" approach for all quality improvement work, to improve standards of care delivery 
254 Freedom to Speak Up (FTSU) contacts received Established three FTSU principles to align with Trust values: Speak Up – We Care Listen Up – We Learn Follow Up – We Empower Over 400 Trust managers attended one of 11 manager listening events Information from staff around sexual safety has led to: • Review of Trust policies and procedures • Creation of a 24/7 dedicated sexual	Coproduced Ward Manager Development Programme has five modules: • Foundations/learning from lived experience • Being great leaders • Workforce development • Professional practice and leadership enabling skills • High performing teams 31 ward managers have completed the programme to date Introduced new site manager roles on two sites to provide 24/7 senior oversight for inpatient wards	Seven Quality Together meetings held with system partners which discussed 'deep dives' undertaken on: • Workforce • Mixed sex wards • Sleeping on duty • Patient racism towards staff • Successful roll-out of safewards initiative • Health checks for people with severe mental illness • Coroners' Prevention of Future Deaths reports • Pharmacy workforce • Safeguarding • Workforce quality impact • Out of area placements • ADHD Services • Early Intervention Psychosis service	Quality Improvement (QI) methodology has utilised the 'Single Front Door' route to capture all improvement work. A QI programme has been designed to develop the knowledge and skills needed to improve and sustain standards of care

Established new structures that support a culture of reporting and speaking up, part of improvements made to meet our objective to embed the highest professional standards to become a Patient First organisation.

Increase in numbers of staff speaking up via the FTSU process. Further work ongoing to create a timely, supportive, responsive environment by demonstrating our ability to 'listen up' and to 'follow up'.

Created a bespoke Ward Manager Development programme with support from our lived experience ambassadors, senior nursing and quality leaders. All ward managers were offered a place on the programme over the past year. Feedback has been positive and led to new quality improvement projects being established by participants.

Established the Quality Together forum with the ethos of partnership across our systems to achieve quality assurance in collaboration with partners. Areas of focus are now informing continuous improvement programmes in 2024/25.

DATA-INFORMED STRATEGY

Making the best use of data to inform decision making, oversight and continuous improvement

Priority initiatives

- Review our Business Intelligence capability and develop a new future-state model
- Continue to develop the data that is collected and turn our data into insight to improve the quality of prioritisation and decision making
- Embedding use of Safety Dashboard data from ward to board, ensuring robust communication with and understanding of staff across the organisation
- Development of ward-level quality assurance framework that provides oversight and evidence on safety of care

Highlights

- **Agreed the Trust's data strategy with a five-year plan to level up data intelligence capability**, quality and maturity via a Microsoft Cloud data platform
- **Developed a target operating model for business intelligence and data analytics**, laying the foundation for using data to drive quality and capability
- **Developed a new data quality assurance framework** to improve data quality and availability to inform clinical and corporate services
- **Launched a managers' insight dashboard to inform delivery of safe care** and quality improvement
- **Put in place new quality assurance framework** to support the Quality of Care framework

Data-informed strategy - highlights

Review our Business Intelligence capability and develop a new future-state model

- Board approved data strategy setting out vision of EPUT as a data insight driven organisation with a 5 year plan to level up data intelligence capability, quality and maturity
- New Microsoft Cloud hosted data platform as single source of truth for data intelligence, leading to automation of self-serve, data driven decision making
- Significantly progressed new target operating model for business intelligence and analytics to modernise data analytics to drive efficiencies and new capabilities
- New data quality assurance framework based on best practice from national guidance to support improved data quality and availability
- Continued development of Microsoft Power BI

Continue to develop the data that is collected and turn our data into insight to improve the quality of prioritisation and decision making

- Launched monthly integrated performance report on Power BI with safety KPIs part of the Quality domain. Trends reviewed monthly through care unit governance, Accountability Framework and Executive and Board Quality Governance structures
- Developed safety dashboard and managers' insight reports
- Working on triangulation of different sources of safety data to ensure monthly scrutiny of trends, learning and oversight of actions to embed this in maturing Quality Governance structures
- In the second half of 2023, we saw a positive increase in reported incidents (64 in July to 71 in December) which we see as more valuable opportunities to analyse what happened and improve ways of working to avoid reoccurrence.

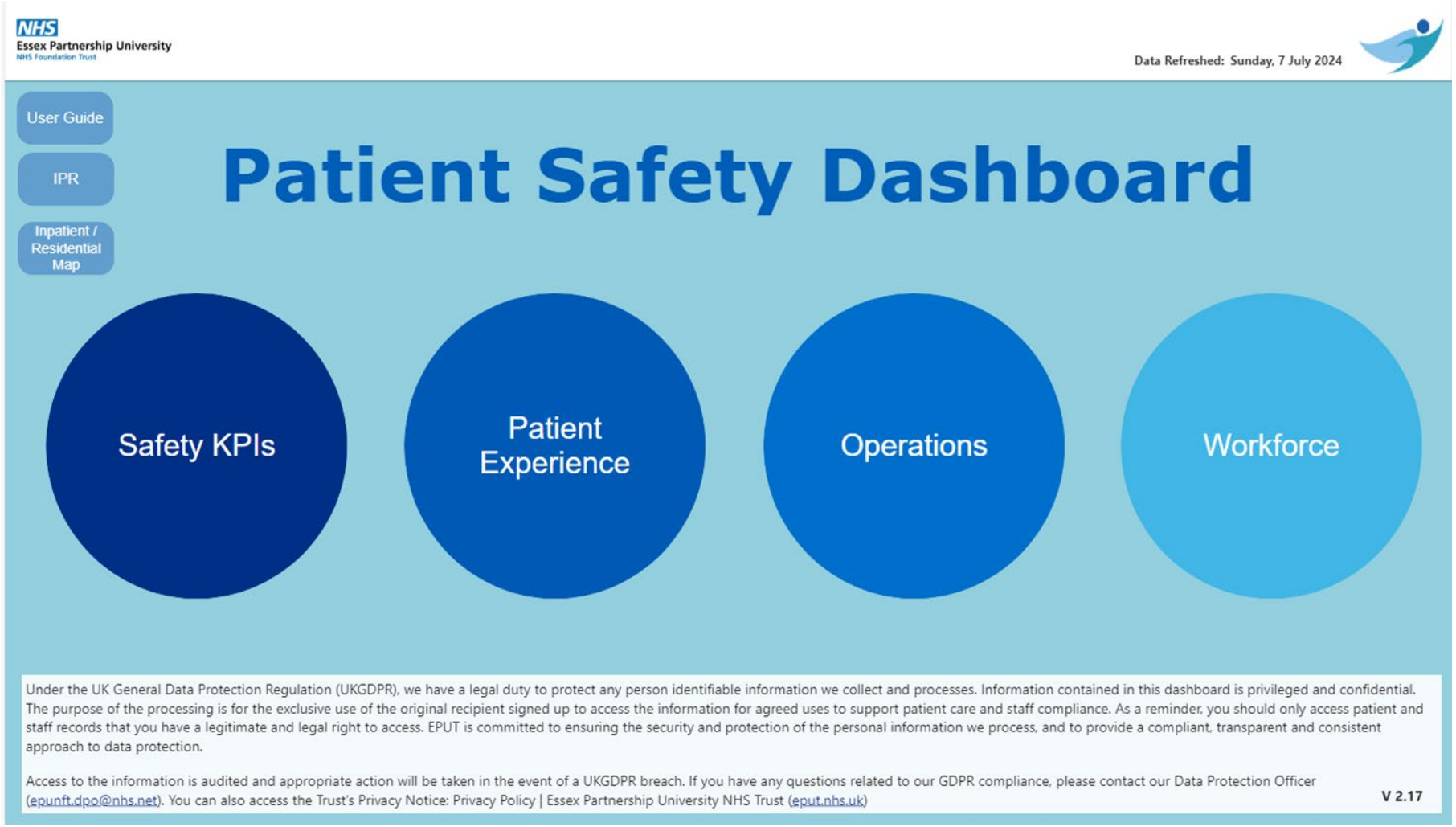
Embedding use of Safety Dashboard data from ward to board, ensuring robust communication with and understanding of staff across the organisation

- Over the past year, we have witnessed a significant surge in the utilisation of the Patient Safety Dashboard. The number of users has grown from 77 to 220, reflecting increasing value and demand for the tool.
- To further enhance the dashboard's utility, we have recently included the Managers' Insights report which provide tailored insights for managers across various service areas. Additional reports added include the PSI reports and iWantGreatCare reports
- The dashboard's ability to display trends and patterns has enabled us to conduct in-depth reviews (Absconscions and Sleeping on duty, etc.), leading to informed recommendations for service improvements. This proactive approach allows us to address issues more effectively and supports our commitment to maintaining the highest standards of patient safety and service quality

Development of ward-level quality assurance framework that provides oversight and evidence on safety of care

- Developed new Quality Assurance Framework aligned to the development of the Quality of Care strategy
- Tactical development group oversaw development of quality planning priorities, review of audit tools (e.g. Tendable) and data to support controls
- Developed new assurance visit methodology

Data-informed strategy - highlights



- Patient Safety Dashboard enables clinical staff to use data to make more informed decisions
- Dashboard uses established software which supports intelligent use of data
- Data is shown in real time and enables staff to interrogate data and identify trends at service level to inform service improvements

PARTNERSHIPS AND SAFETY

Building system partnerships and working ever more closely with colleagues to provide the safest possible care.

Priority initiatives

- Build on the work of our Patient Safety Partners to co-design and co-produce services
- Using Quality Together to improve collaboration with ICBs and other system partners
- Essex Police Mental Health Team
- Mental Health Urgent Care Department
- Deepening our partnership with primary care
- Increasing the presence and visibility of Independent Mental Health Advocates

Highlights

- **Patient Safety Partners have co-designed and co-produced new services and guidance** and the Trust's first co-production conference
- **Built on strong relationships with Essex Police and primary care teams to deliver holistic care for people in mental health crisis**, with EPUT nominated for Essex Police's Public and Partnership award
- **Opened the Mental Health Urgent Care Department at Basildon Hospital**, part of a new and successful urgent care pathway to support people experiencing a mental health crisis and support the Mid and South Essex emergency and urgent care pathway. The Department was shortlisted for three national awards
- **Independent Mental Health Advocates are provided by independent charities** and the service is promoted to inpatients

Partnerships and safety - highlights

Building on the work of our Patient Safety Partners (PSPs) to co-design and co-produce services

Patient Safety Partner members co-designed and co-produced key service priorities, including:

- Time to Care programme
- Staff buddy scheme
- Mental Health Urgent Care Department
- Updated guidance for therapeutic engagement and supportive observations
- Adult Eating Disorders Service service users' network
- Inaugural Co-Production Conference to showcase the valuable contribution made to services by people with lived experience
- Development of Quality of Care Strategy
- Development of bespoke EPUT patient safety partner handbook, including guidelines and regulations, PSP rights and responsibilities and PSP code of practice

Working with the Essex Police Mental Health Team

- Continued to build on **strong relationship with Essex Police to ensure collective response puts a person in crisis at the heart of all decisions** through ongoing development of the Essex Crisis Care Concordat
- Focus on **ensuring a smooth transition to the nationally approved Right Care Right Person model**
- Memoranda of Understanding developed specifying agreed outcome measures
- Essex Police take part in twice daily sit rep calls to ensure smooth and proactive care of patients held on a section 136 requiring transfer to a health based place of safety – reducing handover times as a result
- Trust nominated by Essex Police for its Public and Partnership award

Working with local authorities

- Closer integration of local authority, physical and mental health services to reduce handoffs and avoid patients being dropped between services

Supporting people experiencing a mental health crisis

- **Developed our Mental health Urgent Care Department** which has cared for over 3,400 patients since opening in March 2023
- Most patients leave the Department within 5 hours with a care plan in place and/or a plan for admission to an inpatient ward
- Far fewer are admitted to an inpatient facility as a result
- Seamless transition to mental health crisis and liaison teams; close links to housing and social care
- Helping to resolve issues which can lead to repeat A&E attendance
- Supports entire MSE system by improving flow within the urgent care pathway, reducing ambulance handover times and helping reduce mental health A&E 12hour trolley wait breaches by over 90%
- I Want Great Care scores show 91% of patients rated their experience of the centre as positive
- **Introduced joint ambulance response cars** to care for people in the community
- Over 2,000 people seen by the car teams, over 80% of whom could remain at home or in the community for support

EMBEDDING LEARNING

We will continue to embed what we have learned since the launch of this strategy to ensure consistent good practice across our Trust.

Methods of Cascading Lessons

- **Sharing investigation reports with patients and families/carers**
- **Two way communications**
- **Five Key Messages – making it easier for staff to see and understand key actions to take**
- **Lessons Identified Newsletter**
- **Live Learning Sessions – Learning Matters**
- **Safety Alert Learning Call (SALC)**
- **Learning Collaborative Partnership**

The work on the **Newsletter and the Five Key Messages** is valued across the organisation and it was great to be a part of these discussions. Good to hear the trust is making ongoing efforts to improve communication with patients and family members. I'm looking forward to attending future meetings and to share knowledge from my PSP role.'' **Dave Cawston** - Patient Safety Partner

KEY PERFORMANCE INDICATORS

COMMUNICATING A CULTURE OF LEARNING IN EPUT

RESOURCES

5 Key Messages - 12 posters
3185 views

Lessons Identified Newsletter & 5 Key Messages SWAY version
5 editions
5680 views

Lessons Identified Newsletter printed version - 12 editions
2508 views

Lessons Briefing - 5 posters
642 views

TRAINING SESSIONS

Human Factors
From April 2023 until March 2024
11 sessions
92 attendees

SEIPS
From April 2023 until March 2024
27 sessions
108 attendees

GROUP SESSIONS

LCP meeting - 12 sessions
From April 2023 until March 2024
315 attendees

MaPSaF - 3 sessions
From April 2023 until March 2024
68 attendees

Learning Matters - 10 sessions
From April 2023 until March 2024
783 attendees

Lessons Briefing LIVE - 1 session
From April 2023 until March 2024
115 attendees

SITE VISITS

ECOL Landing Page
From April 2023 until March 2024
12,754 visits

ECOL YouTube video
From April 2023 until March 2024
362 views

ECOL Digital Folder
From April 2023 until March 2024
189 visits

Feedback from Patient Safety Partner (PSP)

''I attended my first Learning Collaborative Partnership meeting in March 24, it was good to see a broad representation of staff working together to improve services and safety. The presentations were informative and educational. I enjoyed the presentation on the **SEIPS Framework**, and the importance of this to improving our incident response.

NHS
Essex Partnership University
NHS Foundation Trust

Looking to the future

Embedding learnings and taking continuing improvement forward with our patients, families, carers, staff and partners

EPUT

The Future Direction – Quality of Care Strategy and Programme of Delivery

Our Quality of Care Strategy takes this work forward:

- Co-designed with people who use our services, alongside families, carers and our own teams, and gives us a holistic focus on safety, effectiveness and experience of care
- It reflects the things that people using our services have told us matter to them, along with the NHS's national quality of care standards
- Our new Time to Care clinical model includes a much broader range of staff roles and skills and will bring more therapeutic benefit to every mental health inpatient admission; and it will help us to virtually eliminate the need for temporary staffing to keep wards safe
- More involvement for our community mental health teams in inpatient admissions and discharge planning from the outset

The Future Direction – our overall ambition

Our overall ambition is to eradicate avoidable patient harm within our services by the end of 2026/27, focusing on key priorities including:

- Completing our ongoing thematic review of PFD themes and learning and improving from these
- Continuing to work with partner organisations to reduce the risk of suicide among particular groups of patients
- Continuing to develop and improve support for children and young people transferring to adult services
- Working with our partners to develop and implement our new single shared electronic patient record
- Developing a centralised Safety and Lessons Management System to collect and analyse data from a range of sources to address issues quickly, improve the quality of investigations and responses to incidents and embed learning across the Trust
- Using evidence and best practice, such as digital solutions - MAST and Oxevision - to ensure our care is reliable, consistent and meets the needs of our patients
- Introducing a new Quality Senate, a panel of staff from across professional disciplines and people with lived experience of using our services, who will meet regularly to discuss priority topics related to care

11. OTHER

11.1 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING.

Information Item SS 1

Verbal

11.2 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

Decision Item | ALL | 1

Verbal

11.3 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

Information Item ALL 5

Verbal

11.4 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (S.O REQUIREMENT)

Information Item | ALL | 1

12. ANY OTHER BUSINESS

Information Item | ALL | 5

Verbal

13. QUESTION THE DIRECTORS SESSION

10

14. DATE AND TIME OF NEXT MEETING

1

Wednesday 2 October 2024 at 10am, The Lodge, Training Room 1