NHS
Essex Partnership University
NHS Foundation Trust

Safety First. Safety Always.

Our strategy for ensuring inpatient safety

12 Month Progress Report

Contents

Executive Summary

- The *Safety First, Safety Always* strategy was agreed by Trust Board in February 2021, following widespread engagement with staff, NEDs, Governors and partners (including commissioners and NHSE/I).

- The strategy introduced **seven themes for improvement**, as an overarching framework for improvement in safety across the Trust. We shaped our strategy around cross-cutting themes to make it relevant to all staff, whatever their role, and to emphasise the importance of driving safety in a collaborative, systematic way that cuts across organisational boundaries.

- We said we would measure the success of the strategy using **five key outcomes.** Not all of these outcomes are easy to measure or exclusively within our control. They might rely, for example, on patient co-operation or engagement from partners. To reflect this complexity, we developed a set of **key measures** (which are quantitative) and **proxy measures** (which include qualitative information and evidence from supporting actions that have been taken).

- The five key outcomes are supported by a set of **supporting outcomes and measures**, which are more detailed, make use of the Trust's existing datasets and directly reflect the core safety and quality activities in clinical practice.

- **Patient safety is improving.** We have seen improvement in safety indicators in the majority of areas. Even in those areas where we have maintained the previous position, this has been done against a backdrop of unprecedented demand, huge pressures on staff and both a very challenging external environment and a cohort of patients with some very complex needs.

- We have made **good progress on the six urgent actions** that were set out as part of the strategy. Four of six are complete and two are substantially underway.

- We have made **good progress towards the five key outcomes**, with zero preventable deaths in the reporting period and a reduction in instances of self-harm. National guidance around patient safety planning has changed, so we need to update our metrics and data capture mechanisms for some indicators.

- We have made **good progress towards improved outcomes in physical health**, with a reduction in falls, pressure ulcers and early signs of deterioration. We have maintained levels of physical intervention and seclusion, despite very challenging circumstances and have **dramatically reduced use of prone restraint even in these circumstances**.

Recap: Safety First, Safety Always

Recap

- The *Safety First, Safety Always* strategy was agreed by Trust Board in February 2021, following widespread engagement with staff, NEDs, Governors (including service user and carer representation) and partners, including safeguarding partners, commissioners, local authorities and NHSE/I.

- The strategy introduced **seven themes for improvement**, as an overarching framework for improvement in safety across the Trust. We shaped our strategy around cross-cutting themes to make it relevant to all staff, whatever their role, and to emphasise the importance of driving safety in a collaborative, systematic way that cuts across organisational boundaries.

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Recap: 7 Strategic Themes

Leadership

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

Culture

Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility

Continuous Learning

Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff

Wellbeing

Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care

Innovation

Facilitating and inspiring patient safety initiatives through new ways of working

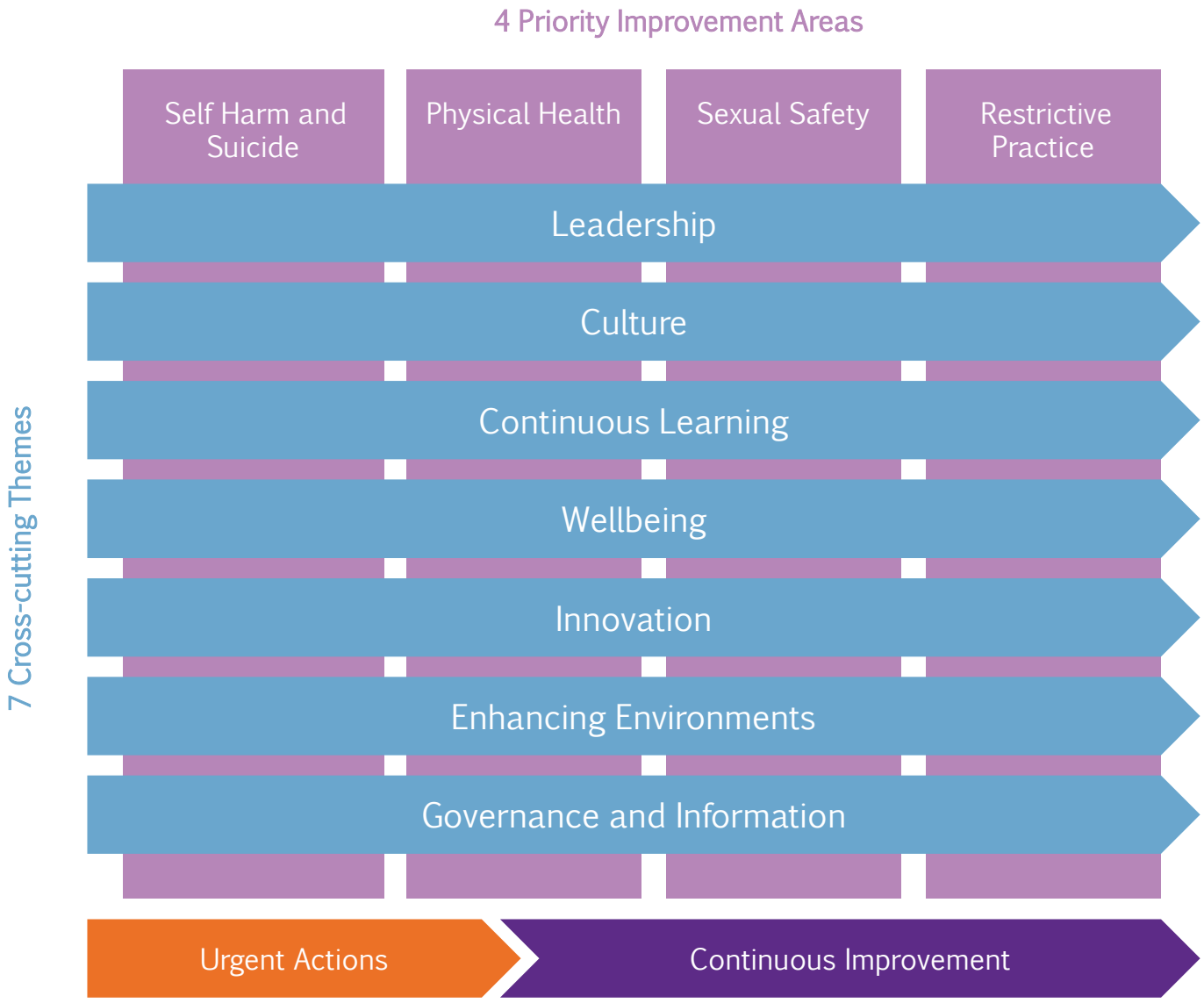
Enhancing Environments

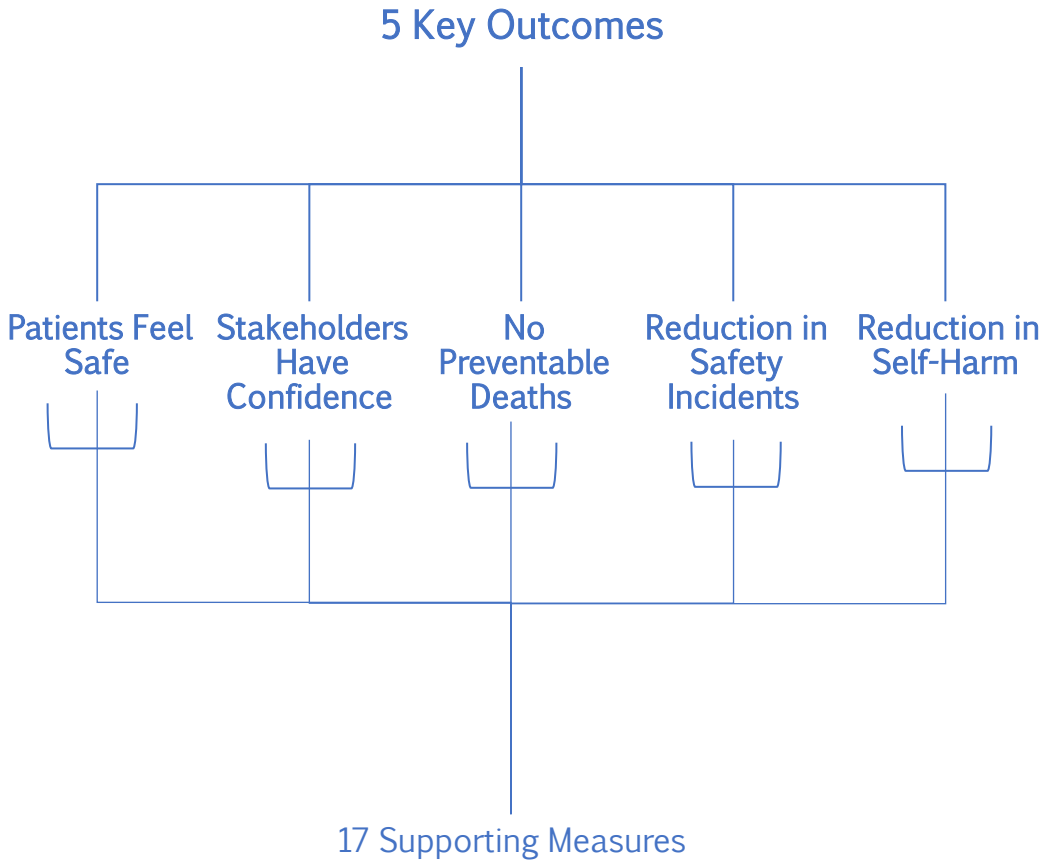
Ensuring our buildings and estates support the *Safety First, Safety Always* agenda

Governance and Information

Building the foundations for safety through governance, processes and availability of information that put safety first

Recap: The Anatomy of our Strategy



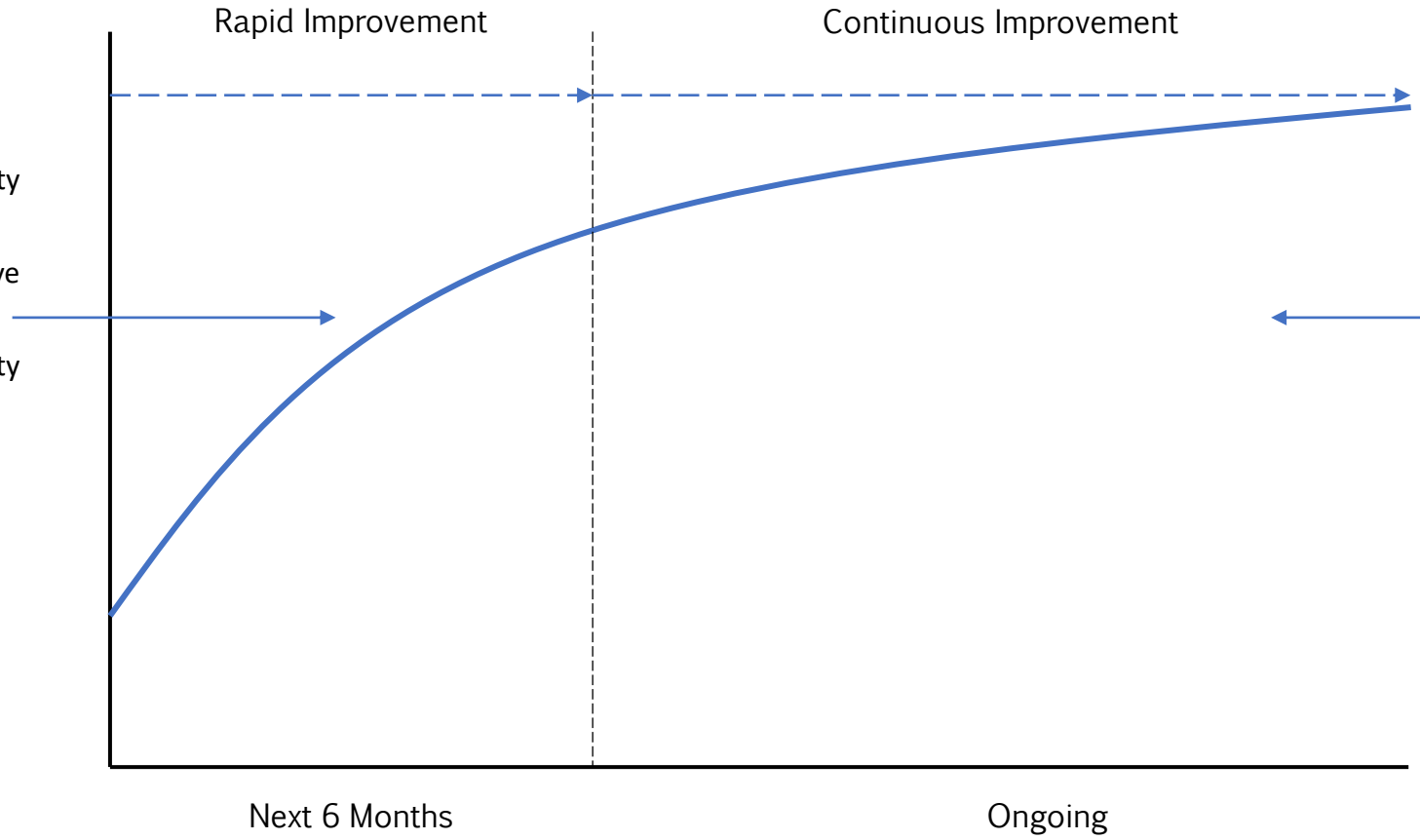


Recap: Improvement Journey

We recognised that there would be a journey of improvement. Some actions needed to be taken urgently, some would take longer to embed in the organisation and others would continue beyond the duration of the strategy, because safety never stops.

Urgent Actions

- Appointment of Senior Safety Specialist
- Establish Safety Executive Committee
- Selection of external quality improvement partner
- Implementation of PSIRF
- Improvements in record keeping
- Communications with other agencies
- Urgent estate and security issues



Continuous Improvement

- Embedding and sustaining a just culture
- Culture of continuous learning
- Modern estate
- Improving safety through technology
- Innovation
- Co-production
- Partnership working

Actions Since Approval

- We set out a roadmap for improvement as part of the strategy, which had 55 actions organised by theme. Some of these actions have since come under the governance of the Trust PMO and others are being implemented locally by teams, with support from a small team working to the Executive Nurse.

- 6 actions were identified as urgent. Good progress has been made against these, with further detail on page 11 of this report.

- Following approval of the strategy, four areas of priority were identified for **quality improvement** activities, using the 7 themes of the strategy for consistency. These areas are:

    1. Self Harm and Suicide Prevention
    2. Restrictive Practice
    3. Sexual Safety
    4. Physical Health

- Sub-Committees and working groups have been established for these activities to ensure clinical leadership of improvement. Quality Committee oversees all activity related to safety across the Trust.

- Each priority area has a Quality Framework and supporting action plan, either complete or in development. These documents reflect the themes of the Trust's overarching *Safety First, Safety Always* strategy and aspects of quality improvement that are specific to each specialist area, including alignment to national priorities and indicators.

Progress Against Measures

Local and National Context

- Across the NHS, **demand for services is rising**. The Government has announced an additional £500m as part of its Mental Health Recovery Action Plan, but this falls far short of the historic and projected increase in demand. The additional funding represents 4% of national spend on mental health services, whereas there has been a 21% increase in demand since 2016.

- **COVID-19** has presented significant operational challenges and unknown consequences for future demand on services. The pandemic required us to redirect staff and resources, both directly to administer the vaccination programme across a population of 1.8 million, and to respond to the increased demand on mental health services from the initial outbreak to present.

- Research shows that a 1% increase in long-term unemployment increases the suicide rate of a population by 0.83%. While the **long-term effects of COVID on population mental health** are not yet quantified, the evidence points to an increase in demand on services that could last up to 18 years.

- Alongside the pandemic, we have experienced **challenges in CAMHS**, with a recent cohort of patients with particularly complex needs. Some patients have been deemed suitable for intensive clinical intervention and secure services. This has presented challenges to good progress that had been made towards reducing the use of restrictive practice, which had otherwise been on a downward trajectory since May 2020.

- Staff at EPUT and across the NHS have made extraordinary efforts throughout the pandemic and have given more than could have been asked of them. But putting more pressure on staff is not a sustainable solution and there are **systemic workforce issues to be addressed in the NHS**. There is a national nursing shortage, with the most significant shortages in mental health, learning disabilities and community nursing. The Interim NHS People Plan identifies this as a national challenge to be addressed, but there is not yet a clear action plan and there is unlikely to be a 'silver bullet' solution. Locally, we are taking action through initiatives such as the Safe Staffing project, a refreshed pipeline of graduate talent and creating new Clinical Assistant Psychologist roles.

- This report has been made against the backdrop of this context, which has presented significant challenges to providing consistent, good quality, safe care. But the outlook is optimistic – despite these challenges, good progress has been made in a number of areas of patient safety.

Celebrating Successes

- **Patient safety is improving.** We have seen improvement in safety indicators in the majority of areas. Even in those areas where we have maintained a position, this has been done against a backdrop of unprecedented demand, huge pressures on staff and both a very challenging external environment and a cohort of patients with some very complex needs.

- **We've moved in the dial even in the most challenging circumstances**. We have seen improvements across the majority of areas, despite the ongoing impact of COVID and the operational impact of running one of the largest vaccination schemes in the country. Some of our indicators, such as physical intervention, have moved in the right direction despite the direct pressure of COVID driving against them.

- **The message is getting clearer.** We have seen an increase in reporting of incidents, even where these resulted in little or no harm. This reflects the commitment of staff to the *safety first, safety always* ethos – no matter how small a risk, patient safety comes first and there is always an opportunity to incorporate learning into practice improvement. Our absolute focus on safety means that we may be over-reporting in some areas (such as physical intervention) and this is causing our progress indicators to look cautious – but it is the right thing to do to ensure we place patient safety at the heart of everything we do.

- **Patients are having more of a say.** We have launched a new Engagement and Involvement strategy and programme and are making sure that patients, their carers and families are involved in planning their care. Having begun research into family involvement in suicide and incident prevention in 2021, we are now ready to conduct focus groups with patients and families. We are also leveraging the lived experience of our service users, for example by co-producing advice on how to stay safe online with our CAMHS patients.

- **Lessons are being learned.** We are capturing more learning and disseminating this more widely in the organisation and across the system. The implementation of PSIRF is changing our focus to learning from incidents and applying that learning to future prevention. Data on incident reporting indicates that staff are reporting more no-harm and low-harm incidents than before, so that we can learn from near-misses and prevent more serious incidents occurring.

- **Things are more joined up.** We are seeing greater levels of collaboration than ever before, both internally and with partners. This is taking the form of QI Hubs, collaboratives of learning and improved communications between agencies.

Safety Never Stops…

- **We are one year in to our three-year strategy.** While good progress has been made in circumstances that continue to be very challenging for our patients and staff, we want to go even further to make care at EPUT the safest available and the safest it can be. We are headed into a period of transformational change, including the launch of our Accountability Framework and the development of a new Target Operating Model.

- **We're becoming more agile and responsive.** Our organisational focus is shifting from observation and engagement to flow and capacity, embedding the best of what we have learned from our response to COVID-19. Public sector organisations have responded to the pandemic with a new pace and agility and we intend to capitalise on this. We have formed an Executive Safety Oversight Group (ESOG) which meets weekly, giving us real-time oversight and the ability to make decisions quickly to ensure that patients receive the right care at the right time from the right people in the right environment.

- **We're planning for the future** while managing the present. We're developing our workforce of the future, drawing on national best practice to meet local needs. We have new workforce strategies that blend growing our own talent with innovative international recruitment and training plans. Our new Nursing and AHPs Workforce Strategy is one of the first integrated strategies in the country, putting us ahead of expected best practice in the new NHS People Plan.

- **We want to see even greater clinical leadership.** The Accountability Framework will devolve maximum autonomy and decision making to those on the frontline who are responsible for patient safety and care. We are also considering how best to organise our services in the future to provide a leadership structure which is clinically-led, delivering patient-centric care in inpatients, specialist and locality settings.

- **We're focusing even more on people, place and pathways**. System-wide working throughout Essex and across the public sector has seen a step-change during COVID. We want to capitalise on this change and embed the best of our pandemic working practices with partners going forward. We are finalising our strategy for safety in community settings, which complements this strategy, joins up pathways and seeks to improve outcomes for people through greater prevention and early intervention.

- **We're continually improving** both our working practices and our ability to measure and evidence what works. In year 2 of the strategy, we are focused on continually increasing the sophistication of our data collection and measurement techniques so that we can evidence some of the 'hard to measure' improvements in the strategy and ensure that decision making is based on data, evidence and insight.

Progress Against Urgent Actions (1/2)

Urgent Action	RAG Rating	Notes
1. Appointment of Senior Safety Specialist	Complete	• Director of Patient Safety post has been created and appointed • Priority improvement plan in place based on national indicators
2. Establish Safety Executive Committee	Complete	• ESOG has been established and providing specific governance in relation to safety since November 2020 • This oversight is now supplemented by BSOG, which meets monthly
3. Selection of external quality improvement partner	Complete	• We are working with UCL Partners on a Mental Health Safety Improvement programme, the CAMHS National Team and the provider collaborative led by local commissioners to drive forward quality improvement initiatives • We are identifying QI opportunities jointly with the local ICSs • Culture of learning being introduced in association with Military of Defence • Newton Europe's diagnostic report has identified further improvements

Progress Against Urgent Actions (2/2)

Urgent Action	RAG Rating	Notes
4A. Implementation of PSIRF 4B. Improvements in record keeping	**Complete**	• PSIRF has been implemented and signed off by commissioners; new practices are being embedded and PSII reporting is taking place, including the incorporation of lessons learned into practice • Improvements in record keeping have been made and progress is reflected in audits, with actions incorporated in QI programmes • High level of investment with families and coroners • Improvement trajectories being development in line with learning
5. Communications with other agencies	**In Progress**	• We have improved communications with partners across the local system, including commissioners, system partners and provider collaboratives, including a number of joint appointments with local government partners • Strategic objectives have been developed with partner agencies and agreed at September Trust Board • Mid & South Essex Community Collaborative in place, driving system wide improvements • Conferences and learning events delivered in relation to safeguarding and patient safety
6. Urgent estate and security issues	**In Progress**	• Risk stratification has been undertaken to identify priorities • Additional funding of £10m allocated for estates modernisation • Estates have appointed Patient Safety Co-ordinators

Progress Against Key Outcomes

Outcome	Key Measure	RAG Rating	Notes
Patients and families feel safe in EPUT's care	An upward trend in the number of patients and families that say they feel safe in EPUT's care	Metrics Under Development	• The Trust received 275 complaints and 1,000 compliments • We have documented positive feedback from patients • We have developed a new Involvement and Engagement Roadmap as part of our Patient Experience Strategy
Stakeholders have confidence that EPUT is a safe organisation	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	Metrics Under Development	• We have documented positive feedback from commissioners and partners • There was an increase in MP enquiries in 2020/21 compared with 2019/20, although most of these related to COVID-19 vaccinations
No preventable deaths	Zero instances of preventable deaths	Zero	• As of March 2021, 0% of patient deaths for Q1-Q3 have been judged more likely than not to have occurred due to problems with the care patients received • 72 reviews are still awaiting judgement.
A reduction in patient safety incidents for investigation	A downward trend in the number of serious incidents	Trend = Variable	• It is difficult to compare SI information directly against incident information from PSIRF because of the change in focus to learning and future risk mitigation • There was a rise in instances of death or catastrophic harm to May 2021, but this has since dramatically reduced
A reduction in self-harm	A downward trend in instances of self-harm	Trend = Down	• There was a sharp rise in instances of self-harm between April and June 2021. This has since reduced to below the average, but is higher than when the strategy was approved in January. • This is due to specific incidents in CAMHS and is related to the increase in use of physical intervention. Trend is representative of the national picture due to the affect of the pandemic.

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Progress Against Supporting Indicators (1/2)

Outcome	Key Measures	RAG Rating	Notes
Reduction in instances of physical intervention	• Reduction the number of all episodes of physical intervention • Maintain reduction in prone restraints	Trend = Same	• Instances of physical interventions increased significantly between January and July 2021, but has decreased slightly over the last 24 months. • The number of prone restraint incidents has also increased since January 2021, but is significantly lower than 18 months ago. • The increase is attributable to the admission of a complex CAMHS cohort during the reporting period. There has been a sharp decline since August 2021.
Reduction in episodes of seclusion	• Reduction in all episodes of seclusion • Reduction in episodes of long-term segregation	Trend = Up	• Instances of seclusion have fluctuated significantly in 2021, with sharp dips and increases, followed by a steady increase since May. • August 2021 figures are above the mean average for the last 24 months and higher than in January 2021. • Instances of long-term segregation have gradually increased since January 2021.
Reduction in inpatient falls	• Continued reduction in the overall rate of inpatient falls • % Reduction in people who fall more than once • % Reduction in falls resulting in moderate and severe harm	Trend = Down	• The number of inpatient falls has fluctuated in 2021, with dips and increases. • Figures have stayed below the mean average for the last 24 months and August 2021 figures are below January 2021 figures.

Progress Against Supporting Indicators (2/2)

Outcome	Key Measures	RAG Rating	Notes
An improved experience of care at the end of life	• Patients and families experience an improvement in care at the end of life • % Increase in number of Do Not Attempt CPR for people at end of life • % Increase in preferred places of death	Trend = Up	• 100% of DNACPRs were in place at time of death for in-patients services. • There is documented evidence that next of kin had been involved in discussions 80% of the time • Patients offered PPD has decreased from 61.8% to 57.7% over the last 12 months.
Reduction in pressure ulcers	• A reduction in instances of pressure ulcers acquired in care • % Reduction in all ulcers • % Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings • Zero category 3, 4 and unstageable ulcers on mental health wards	Trend = Down	• Trust-wide pressure ulcers have declined steadily since January 2021 and are at the lowest in at least 24 months. • There is variation between inpatients and community figures but both show a downward trend overall. • There have been zero category 3, 4 and unstageable pressure ulcers reported in inpatients settings.
Improvement in clinical response to signs of deterioration	• An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards • Improvement in rate of raised early warning scores being escalated appropriately	Trend = Up	• On average across all services, 88% of patients had MEWS charts in place as of January 2020. This average is made up of 5 services with 93% or more of MEWS charts in place and 1 service (LD Services) with 40%. • 82% of cases with raised MEWS were escalated in Q3 2019/20, compared to 43% in 2018/19. There was also an increase in appropriate action being taken, from 43% in Q3 2018/19 to 68% in 2019/20. • The 2020/21 audit is pending.

Progress Against Priority Areas

1. Suicide and Self-Harm
2. Sexual Safety
3. Physical Health
4. Physical Intervention

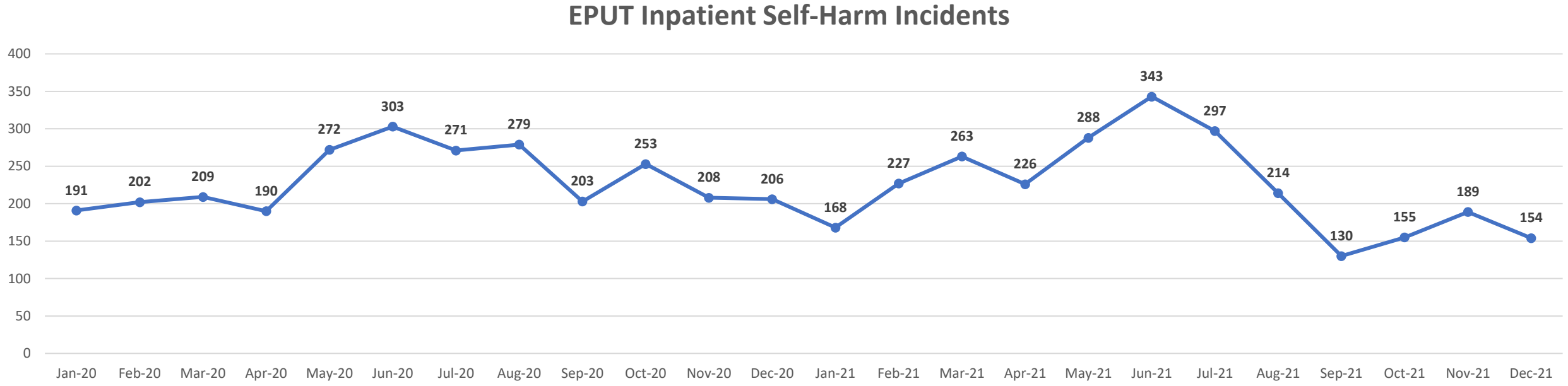
Self-Harm and Suicide Prevention

Self-Harm and Suicide Prevention: Overview

Outcome	Indicator	Result
A reduction in suicide, self-harm and serious incidents	Zero instances of preventable deaths	Zero
	A downward trend in the number of serious incidents	Variable
	A downward trend in instances of self-harm	19.3% down

0% of patient deaths in 2020/21 have been judged more likely than not to have occurred due to problems with the care patients received (72 are awaiting judgement). This data is based on our mandated mortality review process which we report on as part of the Trust's annual Quality Accounts in line with NHS England requirements.

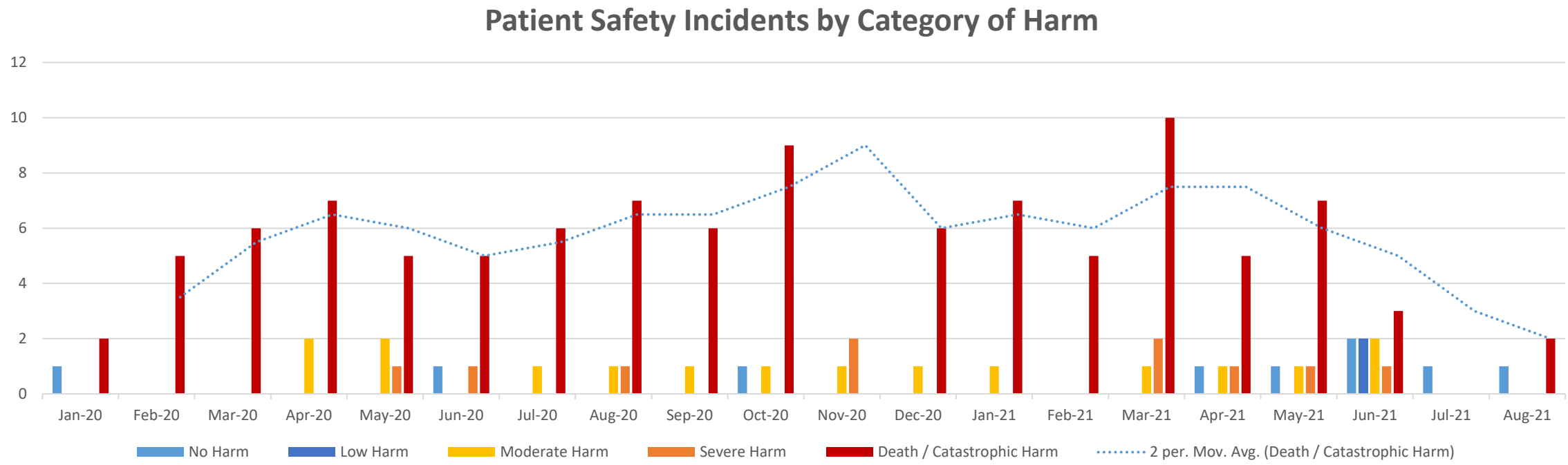
Self Harm and Suicide Prevention: Key Trends and Insights



High levels of reporting were recorded during May, June and July 2021. The rest of the year saw a reduction, with September, October and December incidents falling below the level set in January 2021 when the strategy was approved and the most recent month's data representing a 19.3% reduction since January 2020.

The CAMHS Inpatient Units admission restrictions had a direct impact on the number of reported incidents and accounts for the reduction.

Self Harm and Suicide Prevention: Key Trends and Insights



The number of patient safety incidents has fluctuated over the reporting period but we have started to see a downward trend since March 2021, with the number of incidents resulting in death or catastrophic harm reaching a two-year low in August 2021.

There has also been a reduction in incidents causing moderate and severe harm.

There has been an increase in the number of incidents recorded that resulted in no harm or low harm, which is positive as it indicates there is a good culture of reporting and learning from near-miss incidents can be captured and applied to prevent incidents of greater harm taking place.

Self Harm and Suicide Prevention: Initiatives and Interventions

- We have rolled out STORM training and an accompanying train-the-trainer programme. STORM is the first fully evaluated suicide prevention and self-harm mitigation training for frontline workers, supported by over 20 years of academic and clinical research.
- We have rolled out *Breaking the Silence* Trust-wide, patient groups which explore suicidality, coping and management.
- We are establishing a patient group to explore the role social media plays in suicide attempts on the wards.
- We have rolled out safety plans across the Trust, which have now been added to the patient electronic record.
- We are using reflective practice sessions to discuss recent case studies in small groups, allowing staff to reflect on their experience of managing suicidality in patients and sharing learning with and from others.
- We are undertaking more regular safety huddles, prioritised by level of risk and used to agree the level of observation required for patients presenting warning signals
- We are researching family involvement in suicide and incident prevention. Having conducted the literature review in 2021, we are now ready to conduct focus groups with patients, carers and families.

- We have rolled out 10 Ways to Improve Safety from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Our suicide prevention workstream monitors delivery and an annual assessment is undertaken against the NCISH toolkit.
- We have introduced new regular risk review calls for patients waiting for intervention.

Sexual Safety

Sexual Safety: Overview

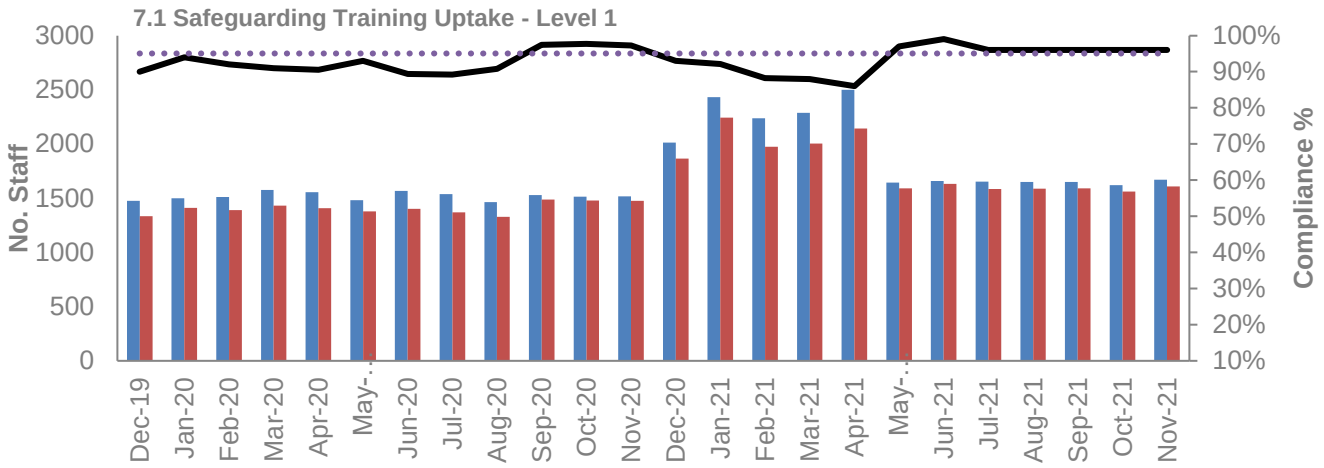
Outcome	Indicator	Result
Our wards are free from sexual harm	Number of enquiries raised to ensure safeguarding of patients across the Trust	**37% increase**
	A downward trend in the number of substantiated enquiries	**40% decrease**
	Level of uptake of level 1 safeguarding training compliance	**95%**

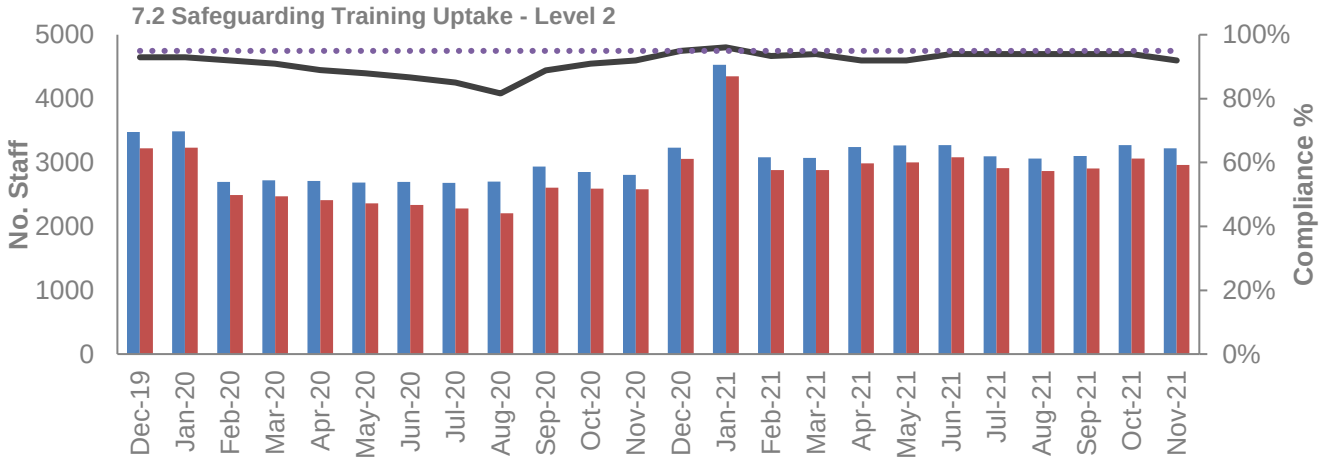
There has been an increase the number of safeguarding referrals, rising by 37% from 2020/21 to 2021/22. This includes all cases, including allegations against staff and allegations against other patients. Our ambition was to see an increase in the number of enquiries that support the protection and safeguarding of our patient population – an increased level of activity indicates heightened awareness of safeguarding issues and an increased willingness for people to speak out.

There has been a decline in enquiries from acute inpatient settings, indicating that our interventions to maintain and improve patient safety are having a positive effect. The move to more single-sex accommodation is expected to further influence these figures.

Substantiated cases from enquiries have decreased by 40% over the 24 month reporting period.

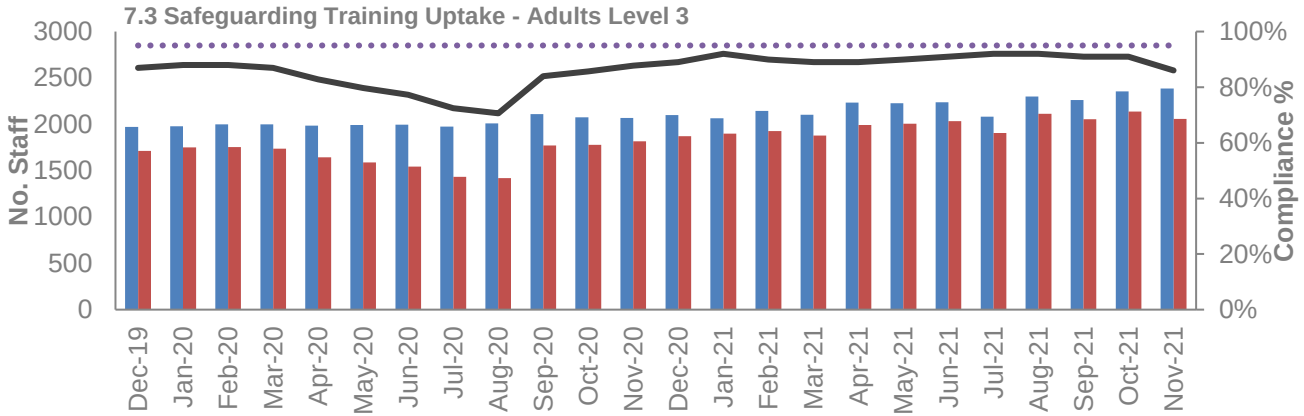
Safeguarding Training Compliance

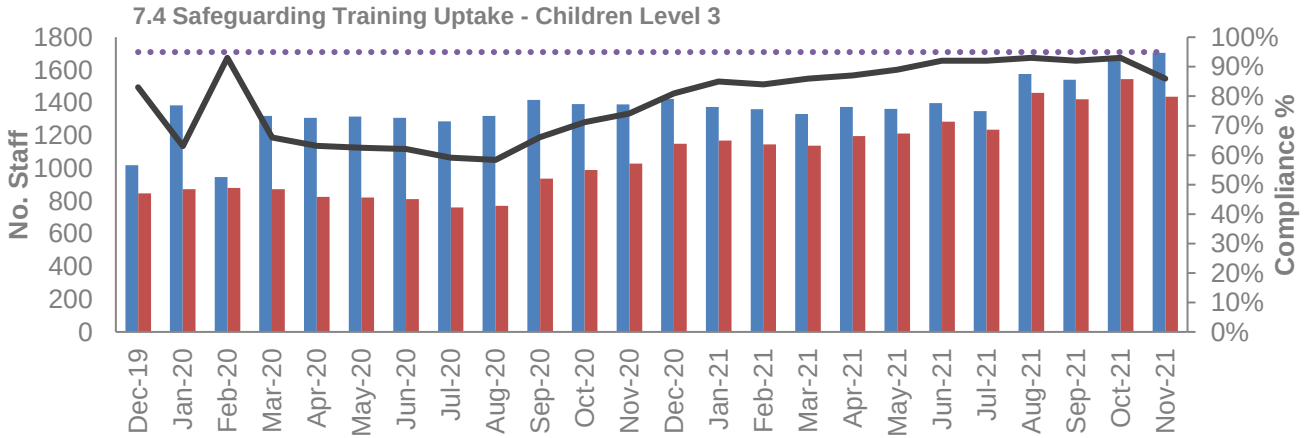




Safeguarding is one component of our work on sexual safety. Our latest training uptake figures show 95% compliance with level 1 safeguarding training and 92% compliance with level 2 training.

Safeguarding Training Compliance





Our latest training uptake figures show 86% compliance with safeguarding training specific to Adults and 86% compliance with training specific to Children.

These figures fall slightly below target but are still very good, against the backdrop of operational pressures from the pandemic and vaccination programme. We stood down all training during the peak of COVID in March and August 2020 and our targets have increased as a result of needing to train huge additional numbers of staff and volunteers to work at vaccination sites.

Sexual Safety: Initiatives and Interventions

- Sexual safety is becoming embedded in the fabric of the organisation – it is discussed in all team meetings and safeguarding practitioners attend to provide expert advice and communicate the importance of raising all concerns, no matter how small.

- Sexual safety forms a major component of our safeguarding training, including the risks of sexual abuse for both adults and children. The training deals both prevention and intervention.

- We have co-produced information for young people on sexual safety and staying safe online with patients in our CAMHS wards.

- We have opened more single-sex wards, which has been shown to dramatically reduce the risk of sexual harm. In line with NHS England guidance on eliminating mixed-sex accommodation, we have opened single-sex accommodation at Cedar, Willow, Cherrydown and Kelvedon Wards.

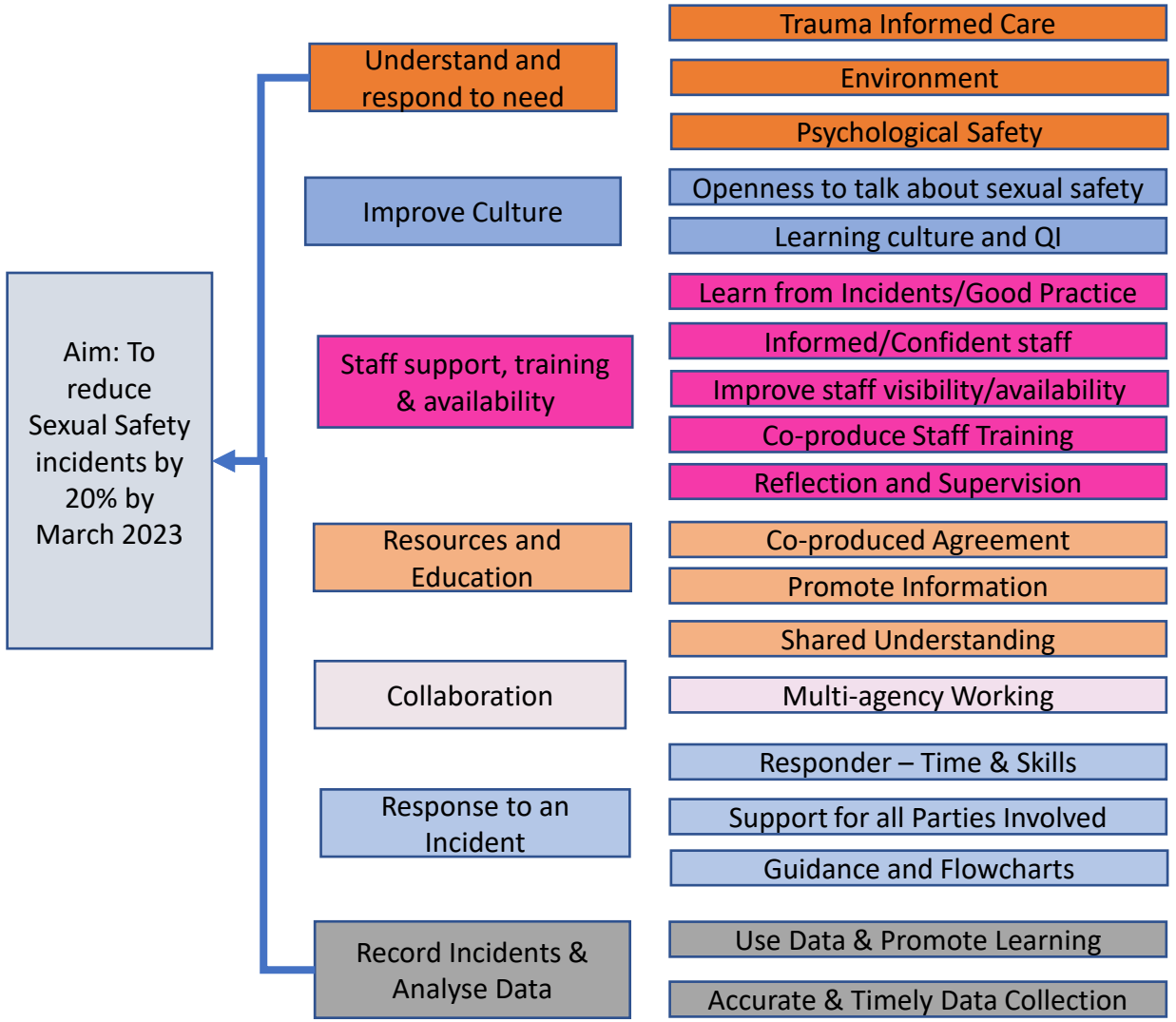
- We are participating in multi-disciplinary Quality Improvement hubs with NHS England & Improvement and the Royal College of Psychiatrists.

- We are improving information and communication for patients on how to keep themselves safe and when and how to speak up if they have any concerns. We have communicated the same messages to staff as part of our *Speak Out Safely* campaign.

- We are working closely with partner agencies on initiatives such as the Sexual Violence Scrutiny Panel and tackling street prostitution in Southend.

- We have a new sexual safety framework under development with a new set of outcomes, indicators and measures that will help us track how well initiatives are being embedded, what impact they are having and how safe people feel on the wards.

Sexual Safety: Key Workstreams Underway



Physical Health

Physical Health: Overview (1/2)

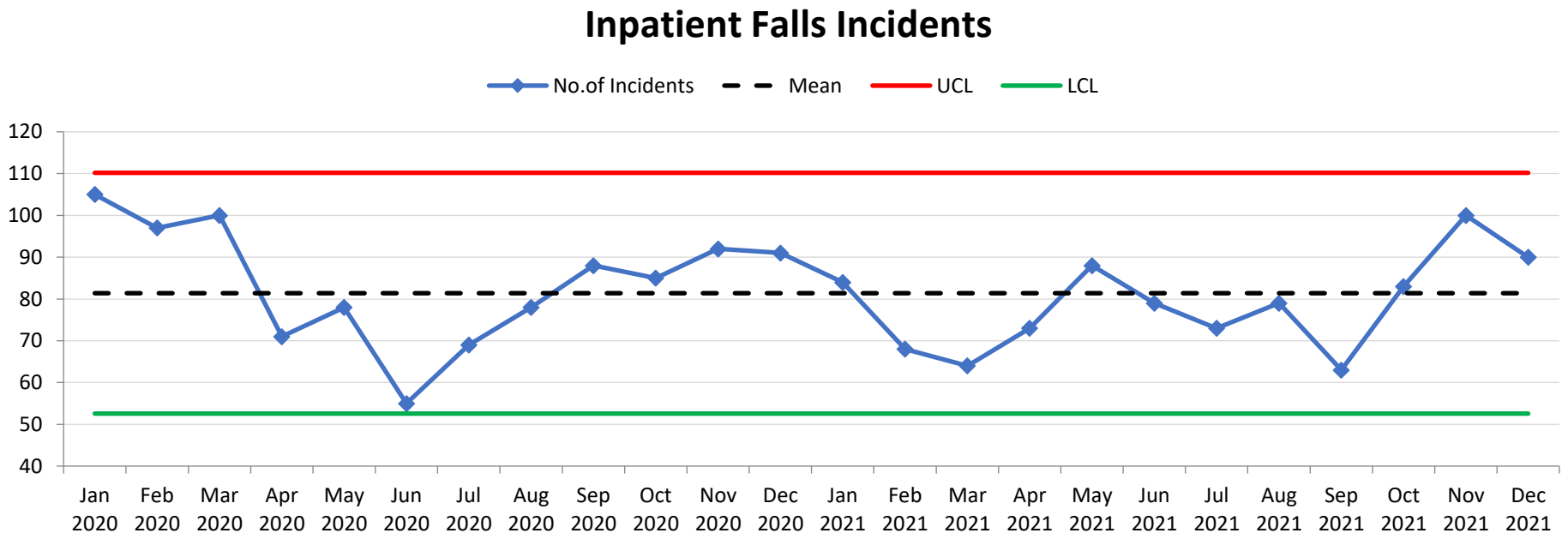
Outcome	Indicator	Result
Reduction in falls in inpatient settings	Continued reduction in the overall rate of inpatient falls	**14.3% down**
	% Reduction in people who fall more than once	**9.6% down**
	% Reduction in falls resulting in moderate and severe harm	**16% down**
Reduction in pressure ulcers in all settings	A reduction in instances of pressure ulcers acquired in care	**32.7% down**
	% Reduction in all ulcers	**21.8% down**
	% Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings	**Zero**
	Zero category 3, 4 and unstageable ulcers on mental health wards	**Zero**

Physical Health: Overview (2/2)

Outcome	Indicator	Result
An improved experience of care at end of life	Patients and families experience an improvement in care at the end of life	Up
	% Increase in number of Do Not Attempt CPR for people at end of life	100%
	% Increase in preferred places of death	4 % points down
Improvement in clinical response to signs of deterioration	An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards	25 % points up
	Improvement in rate of raised early warning scores being escalated appropriately	39 % points up

Physical health indicators are green across the board with the exception of preferred place of death, which has seen a minor decrease. This is attributable to the demands of COVID and the complexities of controlling infection rates in healthcare settings.

Inpatient Falls: Key Activities and Trends

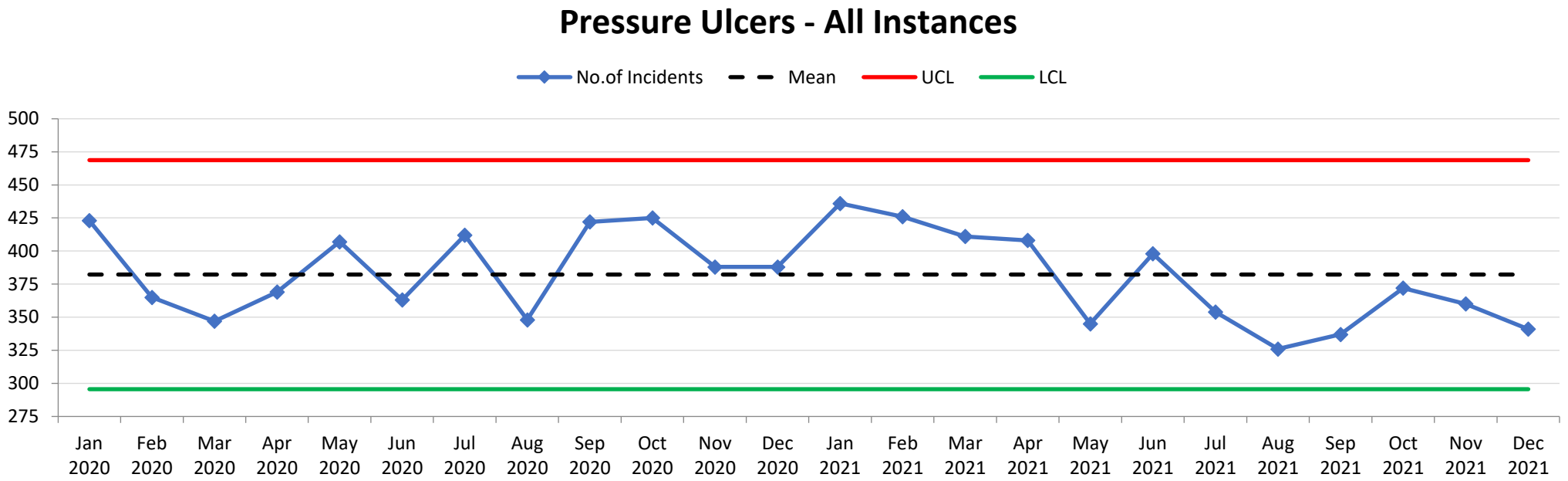


Falls in inpatient settings have had peaks and troughs over the last 24 months, but have seen an overall decline.

A sharp increase was observed in November and December 2021, with Meadowview Ward reporting 29 incidents across the period involving 12 separate patients, 10 of which were involved in 2 or more falls.

The number of falls resulting in moderate, severe or catastrophic harm has reduced from 50 to 42 between 2020 and 2021.
The number of repeat falls has also reduced by 9.6% over the same period.

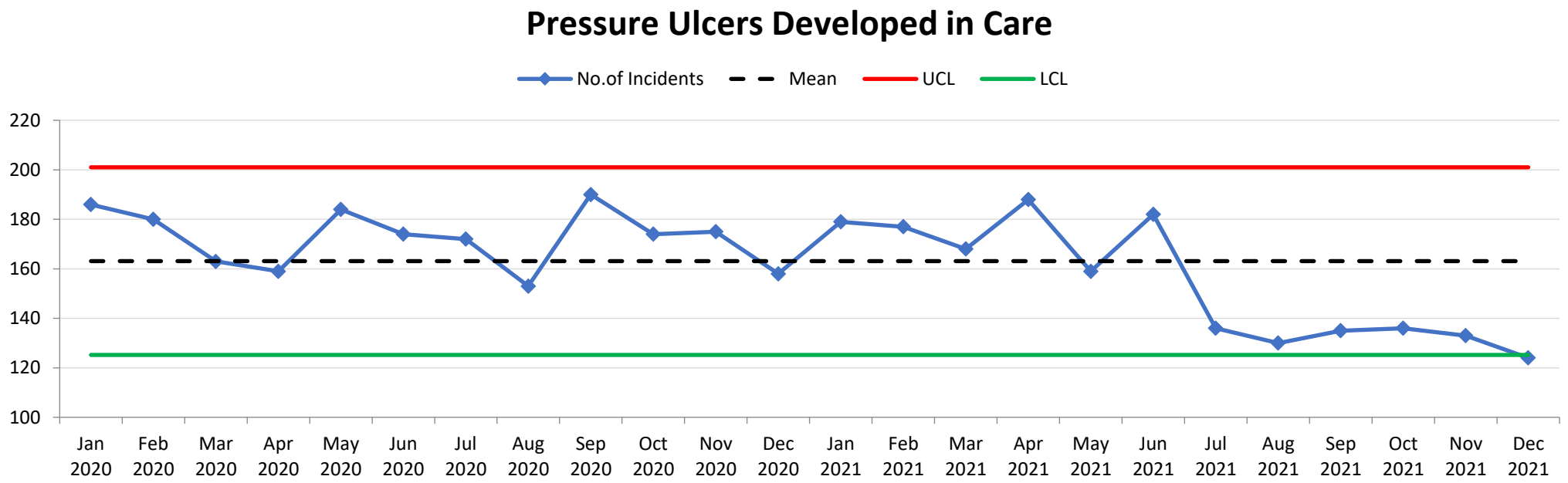
Inpatient Falls: Key Activities and Trends



Instances of pressure ulcers have fluctuated over the last 24 months, but have seen an overall decrease of 19%.

This data represents pressure ulcers in all settings, including community settings, where prevention is more challenging.

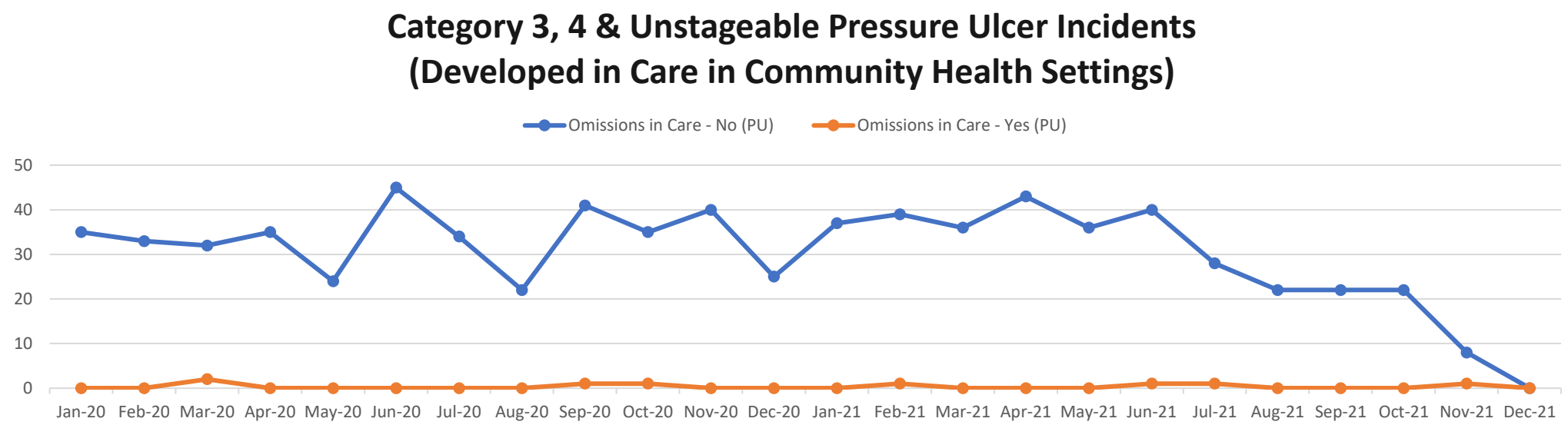
Pressure Ulcers: Key Activities and Trends



The total number of pressure ulcers developed in care has reduced by 32.7%, with December 2021 being at the lowest level for 24 months.

There have been **zero instances of Category 3, 4 & Unstageable pressure ulcers** developed in our care reported by Mental Health inpatient units since April 2020.

Pressure Ulcers: Key Activities and Trends



The majority of pressure ulcer incidents recorded have occurred in community health settings (as opposed to inpatients settings, where there have been zero category 3, 4 or unstageable ulcers).

Ulcers developed in community settings are harder to identify early and prevent than in inpatients settings, but the number of ulcers that have developed as a result of omissions in care has remained low and is currently at zero.

Physical Health: Initiatives and Interventions

- We have rolled out Oxehealth to digitally monitor patients' vital signs, which improves safety across a broad range of measures including self harm and attempted suicide, falls and early signs of deterioration in a patient's physical health.
- We are increasing use of hydration jellies across the wards to prevent dehydration – these have been successfully piloted on Ruby Ward for patients with physical frailty and have now been introduced at Clifton Lodge dementia care home.
- Alongside essential safety improvements, the estate is being brought up to date to reflect modern healthcare needs. This includes transforming wards in line with National Building Standards and ensuring accessibility for patients and visitors with disabilities and bariatric patients.
- Training compliance is at 94% across all essential courses, including falls prevention and pressure care. We are working to train more staff on specialist processes like transfusion.
- We have rolled out FloJac inflatable lifting devices to assist patients who have fallen while minimizing risk of further injury from moving them.
- We are implementing a new wound care app, which allows nurses to share information with other staff involved in a patient's care and produces a visual timeline of development and healing.

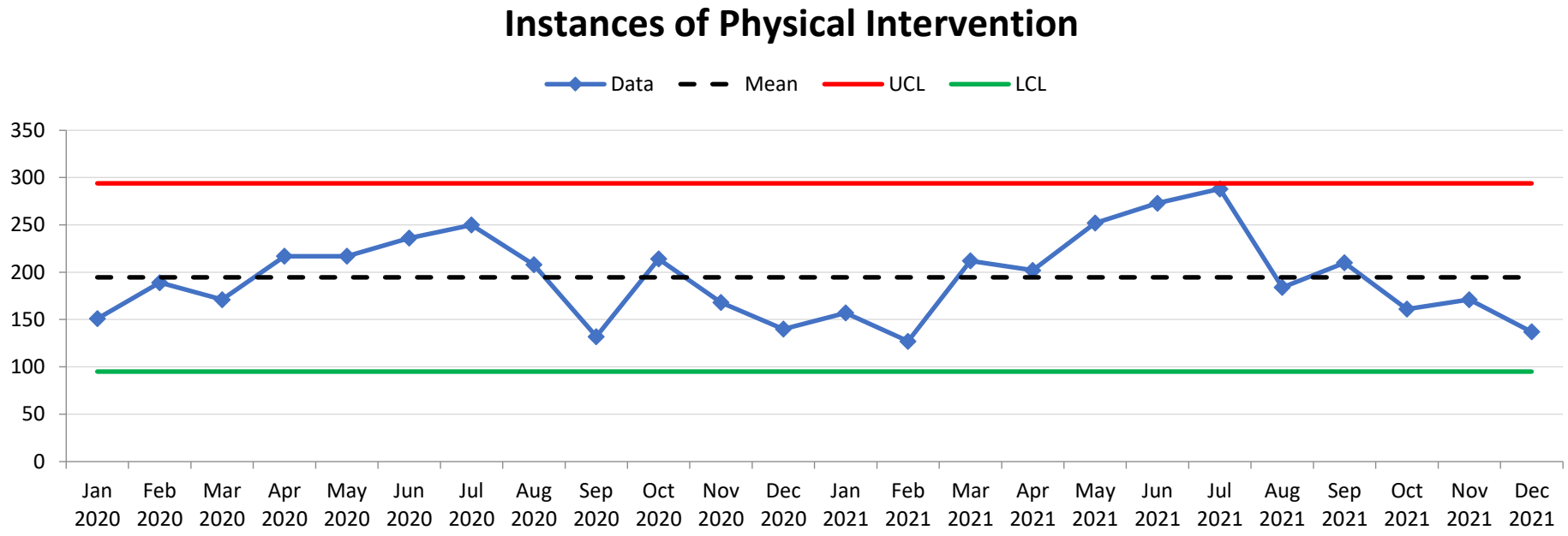
- We have developed a new framework for physical health with five priority areas. Progress is being measured and monitored by a refreshed Physical Health Sub-Committee, with representation from across the Trust.
- We are working to join up our data to promote whole-patient care, looking to create a single view of all data from physical health checks, no matter which system it sits in.

Physical Intervention and Seclusion

Physical Intervention and Seclusion: Overview

Outcome	Indicator	Result
Reduction in physical intervention	Reduction in the number of episodes of physical intervention	**9.2% down**
	Maintain the reduction in prone restraints	**88% down**
Reduction in seclusion	Reduction in all episodes of seclusion	**Same**
	Reduction in episodes of long-term segregation	**+2 incidents**

Physical Intervention: Key Activities and Trends



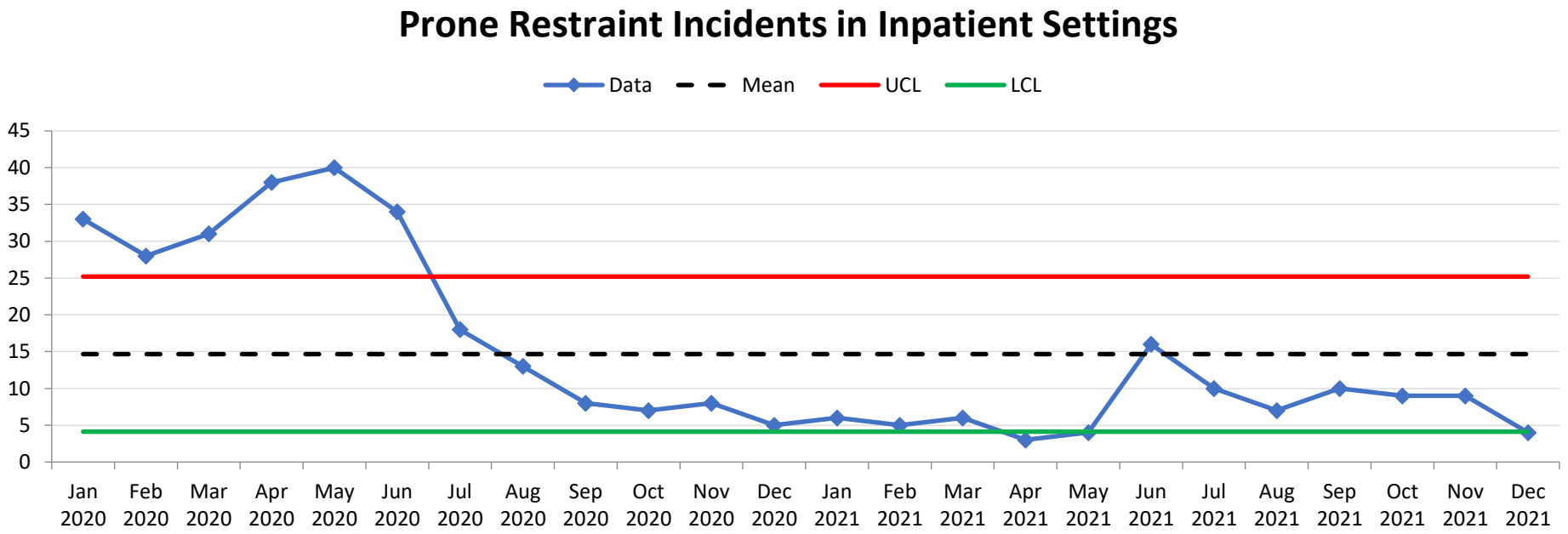
Instances of physical intervention in inpatient settings have fluctuated considerably over the last 24 months, due to a wide range of factors including both the complex needs of some of our patients and the need to move patients to maintain their safety during COVID.

Staff have erred on the side of caution and have been recorded each instance of physically assisting a patient between locations as a 'physical intervention', but the majority of these are not restraints in the usual sense. This is reflected in the significant decline in the number of prone restraints (see next page).

The admission of a CAMHS cohort with particularly complex needs accounts for the sharp rise in physical interventions between May and July 2021. The closure of inpatient admissions to CAMHS units resulted in a significant decrease in August, which has continued to fall.

Physical interventions recorded on the Christopher Unit for psychiatric intensive care increased from 147 in 2020 to 370 in 2021, where one patient with particularly complex needs accounted for 62% of all restraints.

Seclusion: Key Activities and Trends

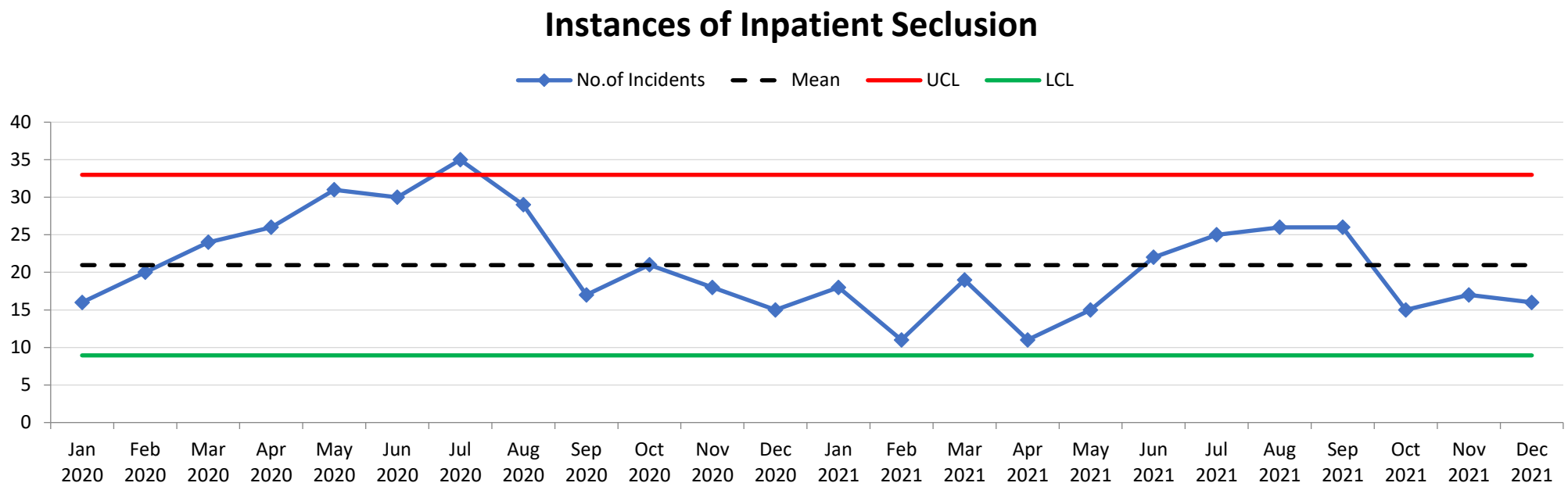


Use of the prone restraint has declined dramatically over time, since a peak in May 2020.

We saw an increase earlier in 2021, attributable to a single patient on Christopher Unit for psychiatric intensive care, who was restrained in the prone position on 26 occasions between June and November. 24 of these incidents involved the patient being placed into seclusion or long-term segregation to ensure their safety and the safety of others; the prone position was used to allow staff to safely exit the area.

Despite this increase due to complex patient needs, use of the prone restraint has continued to decline over time and is well below both the upper control limit (tolerance) and average for the 24 month reporting period.

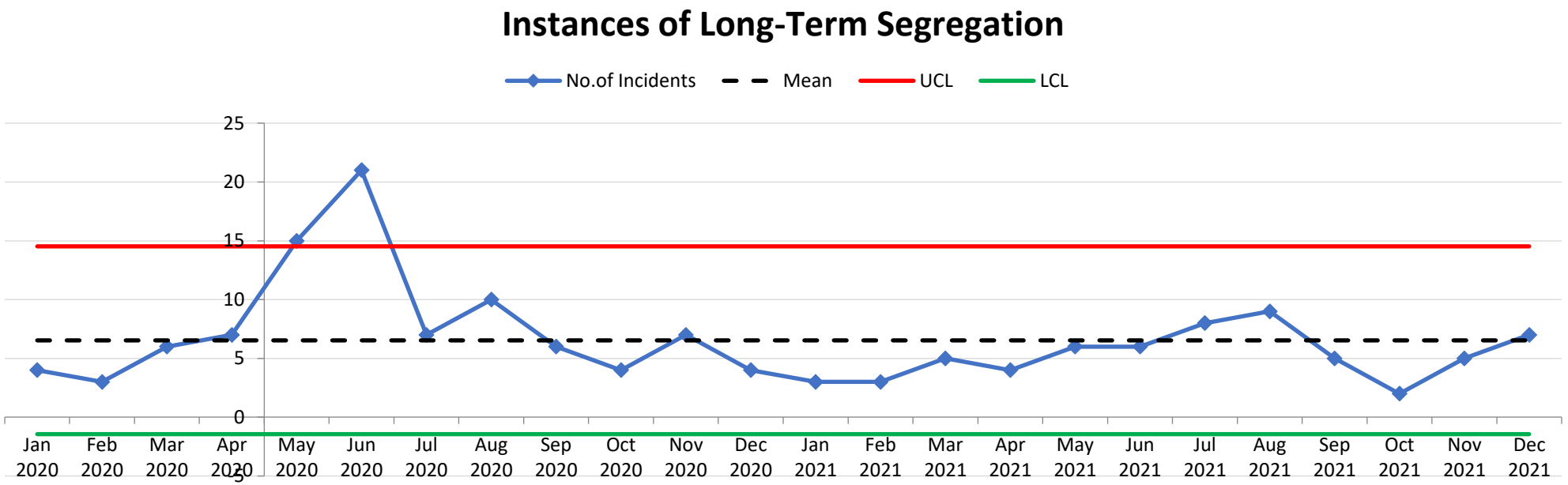
Seclusion: Key Activities and Trends



Instances of patients being placed into seclusion remain within control limits across the 24 month period, following a peak in July 2020 that has since been managed down.

The period between June and September 2021 saw increases in the use of seclusion to ensure safety, specifically at Christopher Unit, Longview Ward and Larkwood Ward. This corresponds to the increase in use of prone restraint explained on the previous page.

Seclusion: Key Activities and Trends



Instances of patients being placed into long-term segregation remain within control limits across the 24 month period, following a peak in June 2020 that has since been managed down.

Physical Intervention and Seclusion: Initiatives and Interventions

- We have adopted a *No Force* First policy, the effects of which are being seen in practice – we have consistently reduced use of the prone restraint, virtually eliminating its use except in circumstances where it is necessary to prevent a patient from harming themselves, other patients or staff.

- We are undertaking an audit of use of physical interventions and a programme of training and communications that reflects changes to the national guidance around reducing restrictive practice.

- We are undertaking a project to look at alternative techniques for existing seclusion environments that could reduce the use of prone restraint, including use of safety pods.

- We have produced accessible guidance, including *Why Am I Being Held?* Information in child-friendly formats for use on CAMHS wards.

- We have agreed a new policy for Therapeutic and Safe Interventions and De-escalations, which was approved by Quality Committee in April 2021. This refreshes our previous policy to reflect national guidance and best practice. The policy has been communicated to staff through Teams Live events and our *5 Key Messages* bulletins.

- We have incorporated national learning and development objectives on restrictive practice into the preceptorship programme, which welcomes, inducts and integrates newly registered professionals to the organisation.

Transforming the Trust's Approach to Safety

7 Themes for Improvement

Alongside our 4 key areas for quality improvement, we developed 7 pan-organisational themes as part of our strategy which will transform the Trust's operating model, way of working and culture. These are helping us to achieve a transformational and sustainable cultural shift in attitudes and approaches to patient safety.

Leadership

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

Culture

Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility

Continuous Learning

Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff

Wellbeing

Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care

Innovation

Facilitating and inspiring patient safety initiatives through new ways of working

Enhancing Environments

Ensuring our buildings and estates support the *Safety First, Safety Always* agenda

Governance and Information

Building the foundations for safety through governance, processes and availability of information that put safety first

Leadership

Building Effective Communication	PS Embedded in Leadership Programmes
	Weekly Communications and Briefings
	Governance arrangements agreed
	Lunchtime Learning Events
Quality Improvement Partnerships	Mental Health Safety Programme
	CAMHS Collaboratives
	Provider Board Joint Working
	Staff/Service User involvement in QI Hubs
Patient Safety Specialists	Director of Patient Safety in Post
	Multi Professional Patient Safety Specialists
	Work Programme in place
	PMO in place
Patient Safety Incident Response Framework (PSIRF)	Achievement of Early Adopter Status
	New Working Practices Introduced
	Structure in Place for Learning Lessons

Summary

All Executive Directors are firmly engaged in leading improvements in patient safety across the Trust. Patient Safety is recognised by the Executive Committee as the key priority across the EPUT. To this end, the Executive Oversight Committee is now in place and supported by our new Programme Management Office to help prioritise and drive improvements across the trust.

The PMO has established a Patient Safety Specialist Programme and through this we have embedded a culture of learning, which offers our staff training programmes, events, communication briefings, webinars and podcasts.

Our leadership and management programmes have been reviewed and developed to enhance a culture of learning and focus on patient safety. Team away days have also been reviewed to embrace the wellbeing of staff and embed a 'Just Culture', promoting multi-disciplinary working to drive improvements in the provision of safe, effective and person-centered care.

EPUT is an early adopter of PSIRF and have commenced our transformation journey by engaging with the wider system's partners including CCGs and local coroners. We now have a system in place to expedite the learning from incidents, ensuring we build programmes of change.

We have formed Quality Improvement Hubs across EPUT Directorates to identify and drive safety improvements locally.

Culture

Alignment of Culture	Just Culture Framework
	Values and Behaviours development
	Cultural barometer at team level
	Review of leadership and management programmes
Ensure Culture of Co-Production	Strategy under review – update due autumn
	Service users and carers QI induction
	NHSE/I Co-production projects
Instil Culture of Reflective Practice	Staff completing Professional Nurse Advocate training
	Review of supervision policy underway
	Data incident reviews taking place
	Facilitators trained for 360 appraisal process
Embed a Just Culture	Just Culture embedded in MDP
	Steering Group to be established
	Culture project commissioned
	HR policies and procedures aligned

Summary

Culture change is underway at all levels in the organisation, from ward to board. This shows on the ground in initiatives such as our efforts to minimize restrictive practice, the introduction of safety huddles and an increase in reporting low-harm and no-harm incidents. Learning is being taken from data, patient safety incidents and best practice and are being shared through a wide range of communications and engagement structures.

At a strategic level, the new Accountability Framework is flipping the organisation's culture on its head – devolving maximum autonomy, responsibility and accountability to those on the frontline who understand patients' needs best. A revised Involvement and Engagement Strategy was approved by the Executive Team in Sept 2021 that has now moved into implementation with a 6-month plan being led by the Director of Patient Experience. As part of this, a series of Co-Production projects will take place with the support of NHSE/I to define the EPUT CoPro way.

Across services a number of our nurses have undertaken the Patient Nurse Advocate programme to take steps to preserve human dignity and promote equality. Learning from the programme will be embedded within practice and drive through supervision arrangements.

Continuous Learning

EPUT Culture of Learning	Arrangements in place to learn from incidents
	Working groups responding to learning
	Lunchtime learning events in place
Collaboratives of Learning	QI Hubs in place
	Collaborative Priorities Agreed
	Involvement of national and CAMHS
	Lunchtime learning events
Schwartz Rounds	Steering group in place
	Facilitator team trained
	Schedule of rounds in place
Structured feedback programme	Lunchtime learning events in place
	Individual and team level programmes

Summary

EPUT is dedicated to creating a culture of individual and organisational learning that will drive quality improvement and innovation throughout the whole system. We want to incorporate accountability and lessons learned without creating a culture of blame. To this end, a 'Just Culture' is being embedded and is shown in the response to incidents and the HR processes applied. The fundamentals are being embedded into systems, processes and actions taken.

Empowerment and engagement is at the heart of the Patient Safety strategy. Directorates have formed QI Hubs that are open to all staff welcoming their ideas and their involvement in making improvements across all services.

Schwartz rounds have been introduced with a range of staff being trained as facilitators. We want to engage our workforce in conversations about the emotional impact of their work. This promotes learning and is giving insight to further steps that could be taken to support to support the wellbeing of our workforce.

Structured feedback programmes have been put in place at a range of levels. Feedback and support programmes are provided at an individual level but also at a team and organisational level to share learning and develop new ways of working.

Wellbeing

Workforce	Safer staffing steering group in place
	Team building / wellness packages
	Group coaching
	Wobble rooms and rest nest
	Equality networks
	Engagement / 'Freedom to Speak' Champions
	'Here for you' Psychological Service
Delivery of Whole Person Care	Whole Person Framework and steering group
	QI Collaborative
	Directorate QI Hubs leading delivery
	Equally Well Programme
Staff Support	Occupational Health, screening and health services
	Menopause support group
	Long covid awareness group
	Chaplaincy service
	Online support for mental wellbeing

Summary

The Executive Team is driving delivery of a workforce strategy that aims to build and retain a strategy in line with organisational need. Bank workers have been offered substantive posts and students have been successfully appointed.

A range of networks and engagement forums have been established with staff positively engaging to drive improvement in relation to wellbeing. This includes staff support networks and engagement champions in teams.

A series of live events on wellbeing has taken place.

Here for You confidential staff support scheme has been rolled out by EPUT and HPFT.

The wellbeing of those that use services is fundamental and to drive improvements in physical and mental health. To enhance delivery of the whole person agenda QI Hubs are supporting the Physical Health sub-committee deliver against agreed priorities.

The last 22 months have been particularly challenging for staff and a range of support systems have been put in place. The engagement and wellbeing team are actively working across the Trust to identify and put in place support systems requested by staff.

Innovation

EPUT LAB	Strong Clinical Engagement
	Provision of digital innovations
	Digital Dementia Neighbourhood
	Oxehealth rollout to all MH wards
	Smart Dashboards
Quality Academy	Life QI Procured to support learning
	Engaged as part of national collaboratives
	Ongoing training of Quality Champions
	QI Hubs across all Directorates
	Collaboratives supporting patient safety priorities
Partnerships and Learning from Others	Electronic observation recording
	Mindfulness therapy
	Hydration jellies
	Collaboratives and Networks

Summary

- Oxehealth continues to be installed on all Mental Health wards, monitoring patients at risk of self harm or suicide in addition to the engagement and supportive observations.
- Wound care app has been procured there is a working group to ensure staff have the latest devices to be able to use the app.
- Digital Dementia Neighbourhood in North-East Essex (Cognitive Stimulation Therapy for people with Dementia helps to slow down progression) is reducing isolation and building a social network for people with Dementia.
- We are making more use of dashboards and whiteboards, ward status and patient information. This gives us vital information when managing the risks on the wards based on what is recorded for patients.
- We are part of national collaboratives for Reducing Restrictive Practices, Sexual Safety and Suicide Prevention.
- The number of Quality Champions is steadily increasing, supported by the Quality Hubs and led by Quality Leads locally.
- Electronic Observation recording, developed by Oxehealth to support the recording of information on the wards with engagement and supportive observations. This is about to be piloted on CAMHS and other wards.
- Mindfulness Therapy in Southend, supporting patients with mild to moderate depression as suggested in NICE guidance, run by the Occupational Therapists groups.

Enhancing Environments

Compliance with National Standards	Appointment of Patient Safety Coordinators
	Allocation of Patient Safety resources
	Risk Stratification processes
	Governance structures in place
	Triage and prioritisation schedules
	National Building Standards
Learning from People with Lived Experience	Learning from incidents/events
	Co-production approach
	Frontline engagement in improvements
	Governor/champion roles
	Recompense
Relational Security	Transformation programmes
	Development of therapy/sensory areas
	Improvements to physical environments
	Governance processes

Summary

£10m capital investment has been committed to modernizing the estate and ensuring it is fit for purpose for modern healthcare needs. This includes addressing the basics of making secure that facilities are safe and secure, and transforming them into places that promote wellness and support patients with both their physical and mental health.

A Ligature Risk Reduction Group is in place which has oversight of the inspection process, standard setting and incident monitoring. There were 13 secured ligature incidents to the end of August 21/22, against a year-end total of 34 for 20/21. This indicates a possible downward trend, although it is likely to be too early to make an accurate projection to year-end for 21/22. No incidents this year have resulted in death or catastrophic harm.

Alongside essential safety improvements, the estate is being brought up to date to reflect modern healthcare needs. This includes transforming wards in line with National Building Standards and ensuring accessibility for patients and visitors with disabilities and bariatric patients.

Governance and Information

Governance Structures	Reset of Organisational Values and Strategic Objectives
	Accountability Framework
	Corporate PMO
	ESOG established
	Sub-Committees for Quality priorities
Dashboards	Dashboards in development for Quality Priorities
	PMO safety projects dashboard
	Complaints and Compliments dashboard
External Oversight and Involvement	MerseyCare
	Provider Collaboratives in East London
	Collaboration with NHSE/I
	Newton Europe diagnostic

Summary

A refresh of the trust's organisational values and strategic objectives is underway. These will place safety at the heart of the everything the organisation does and be supported by the trust's new Accountability Framework. The Accountability Framework will deliver a change in the way the organisation operates, devolving maximum autonomy and empowerment to staff on the frontline who are responsible for delivering safe, good quality care to our patients.

PSIRF has now been implemented and is changing the approach the trust takes to safety incidents, focusing on learning as well as reporting.

The Trust PMO is managing delivery of the organisation's top strategic projects in a more coordinated way than before. This includes projects vital to patient safety such as the Safe Staffing project and estates programme.

A consolidated programme plan and dashboard for the quality areas in this report is under development, which will give central visibility of progress against key outcome and measures across our four priority areas of quality improvement.

Appendix:

Explanation of Outcomes and Measures

Five Key Outcomes

Outcome	Key Measure	Risks/Challenges	Proxy Measures
Patients and families feel safe in EPUT's care	An upward trend in the number of patients and families that say they feel safe in EPUT's care	• Facts do not always change perceptions • Each experience will be individual and personal	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans • Compliments and complaints • Anecdotal feedback
Stakeholders have confidence that EPUT is a safe organisation	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	• Facts do not always change perceptions • Baseline to be established	• Anecdotal feedback • Increase in contracts awarded or extended • Nature of media coverage
No preventable deaths	Zero instances of preventable deaths	• Lack of patient co-operation • No standard definition of a preventable death	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans • Suicide awareness training targets achieved
A reduction in patient safety incidents for investigation	A downward trend in the number of serious incidents	• We must not achieve this outcome as a consequence of under-reporting	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans
A reduction in self-harm	A downward trend in instances of self-harm	• Lack of patient co-operation • We must not achieve this outcome as a consequence of under-reporting	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans

Explanation of Supporting Indicators (1/2)

Outcome	Key Measures	Risks/Challenges	Proxy Measures
Reduction in restrictive practice	• Reduction the number of all episodes of restrictive practice • Reduction in restraint incidents • Maintain reduction in prone restraints	• Restrictive practice may be necessary to prevent harm • We must not achieve this outcome as a consequence of under-reporting	• Mental Health Data Services benchmarking • Compliance with learning disability improvement standards • Increased awareness of blanket rules and global restrictions • Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in episodes of seclusion	• Reduction in all episodes of seclusion • Reduction in episodes of long-term segregation	• Seclusion may be necessary to prevent harm and as an alternative to restrictive practice	• Mental Health Data Services benchmarking • Compliance with learning disability improvement standards • Increased awareness of blanket rules and global restrictions • Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in inpatient falls	• Continued reduction in the overall rate of inpatient falls • % Reduction in people who fall more than once • % Reduction in falls resulting in moderate and severe harm	• Up to 60% of falls are unwitnessed • We must not achieve this outcome as a consequence of under-reporting	• Weekly reviews take place • Audit of recurrent fallers • Analysis of unwitnessed falls • Lessons learned are disseminated

Explanation of Supporting Indicators (2/2)

Outcome	Key Measures	Risks/Challenges	Proxy Measures
An improved experience of care at the end of life	• Patients and families experience an improvement in care at the end of life • % Increase in number of Do Not Attempt CPR for people at end of life • % Increase in preferred places of death	• Dependency on other agencies • The experience of each patient and family will be individual and personal	• Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in pressure ulcers	• A reduction in instances of pressure ulcers acquired in care • % Reduction in all ulcers • % Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings • Zero category 3, 4 and unstageable ulcers on mental health wards	• Identification of ulcers in community health settings • Prevention of ulcers in community health settings	• Roll-out of training against targets and schedule • Lessons learned are disseminated
Improvement in clinical response to signs of deterioration	• An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards • Improvement in rate of raised early warning scores being escalated appropriately	• Completeness and accuracy of information	• Roll-out of training against targets and schedule • Improvement in completeness, accuracy and quality of information • Lessons learned are disseminated