Meeting of the Board of Directors held in Public  
Wednesday 29 January 2020 at 10:30am  
Training Room 1, The Lodge, Lodge Approach, Wickford, SS11 7XX

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC

AGENDA

| 1 | APOLOGIES FOR ABSENCE | SS | Verbal | Noting |
| 2 | DECLARATIONS OF INTEREST | SS | Verbal | Noting |

**PRESENTATION:**
Perinatal Mental Health Services by Caroline Bogle & Emma Strivens

| 3 | MINUTES OF THE PREVIOUS MEETING HELD ON: 27 November 2019 | SS | Attached | Approval |
| 4 | ACTION LOG AND MATTERS ARISING | SS | Attached | Noting |
| 5 | Chairs Report including Governance Update | SS | Attached | Noting |

**QUALITY AND OPERATIONAL PERFORMANCE**

(a) Board of Directors Quality & Performance Scorecard | SM | Attached | Noting
(b) Ligature Risk Management Report | SM | Attached | Noting
(c) Establishment Review Report | NH | Attached | Approval
(d) Learning from Deaths – Mortality Review Quarterly Report | NH | Attached | Noting

**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**

(a) Board Assurance Framework | SM | Attached | Approval

Standing Committees:

(i) Audit Committee | JW | Attached | Noting
(ii) Finance & Performance Committee | ML | Attached | Noting
(iii) Quality Committee | AS | Attached | Noting
(iv) Strategy & Planning Committee | ARQ | Attached | Noting

**STRATEGIC INITIATIVES**

(a) Mental Health & Community Health Services Transformation | NL | Attached | Noting
(b) Draft Mid and South Essex Health and Care Partnership – 5 Year Strategy and Delivery Plan | SM | Attached | Approval
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<tr>
<th>9</th>
<th>REGULATION AND COMPLIANCE</th>
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<tr>
<td>(a)</td>
<td>CQC Update</td>
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<td>PHSO &amp; HSE Steering Group Assurance Report</td>
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<td>Safe Working of Junior Doctors Report (Oct-Dec 2019)</td>
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<th>OTHER REPORTS</th>
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<td>Use of Corporate Seal</td>
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<td>- 30 September 2020 with lunch at 12:30pm, Part One starts at 1pm</td>
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<td>- 25 November 2020 with lunch at 12:30pm, Part One starts at 1pm</td>
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Professor Sheila Salmon, Chair
Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 27 November 2019
At The Lodge, Lodge Approach, Wickford, SS11 7XX

Attendees:
Prof Sheila Salmon (SS) Chair
Sally Morris (SM) Chief Executive
Andy Brogan (AB) Deputy Chief Executive/Chief Operating Officer Executive
Mark Madden (MM) Chief Finance Officer
Dr Milind Karale (MK) Executive Medical Director
Nigel Leonard (NL) Executive Director of Strategy and Transformation
Prof Natalie Hammond (NH) Executive Nurse
Sean Leahy (SL) Executive Director of People and Culture
Alison Davis (AD) Non-Executive Director
Rufus Helm (RH) Non-Executive Director
Manny Lewis (ML) Non-Executive Director
Alison Rose-Quirie (ARQ) Non-Executive Director
Amanda Sherlock (AS) Non-Executive Director
Nigel Turner (NT) Non-Executive Director
Janet Wood (JW) Non-Executive Director

In Attendance:
Faye Swanson (FS) Director of Compliance and Assurance/Trust Secretary
Tina Bixby (TB) Assistant Trust Secretary (minutes)
Keith Bobbin (KB) Public Governor
Dianne Collins (DC) Public Governor
Pippa Ecclestone (PE) Public Governor
Mark Dale (MD) Public Governor
Paula Grayson (PG) Public Governor
Clive White (CW) Public Governor
Andy Wood (AW) Appointed Governor, Essex County Council
Judith Woolley (JW) Public Governor
Alex Zihute (AZ) Public Governor
Charlie Bosher (CB) Senior Consultant, Quality Health (presenter)
Sharon Constancon (SC) Genius Boards (observing as part of Board evaluation)
Alistair Frost (AF) Member of the Public
Yogeeta Mohur (YM) Freedom to Speak Up Guardian
Astrid Pollard (AP) Clinical Psychologist

SS welcomed Governors, staff and members of the public to the meeting. The meeting commenced at 10:30.

220/19 APOLOGIES FOR ABSENCE

No apologies were received.

221/19 DECLARATIONS OF INTEREST

There were no declarations of interest.
SS welcomed Charlie Bosher (CB) from Quality Health. Quality Health carried out the national community mental health service user survey (on behalf of the CQC and NHSE/I) for EPUT.

CB advised that the survey is a mandatory annual national survey. The survey is major source of data for the CQC. He advised that the CQC had just released the national data but he was only presenting the data produced by Quality Health but advised it would be similar to the CQC published data as Quality Health had carried out the survey for approximately 95% of providers who were required to participate in it. The survey was undertaken between February and June 2019.

CB highlighted the following key points:

- The Trust overall response rate was 27% which was above average. (227 respondents from a final sample of 830)

- A new question ‘Did the person or people you saw appear to be aware of your treatment history; EPUT response rate was 74%, higher than the sector response rate of 71%.

- In the Organising Care category – the question ‘Have you been told who is in charge of organising your care and services – EPUT score was 78%, an increase from 2018 and above the national average of 73%.

- The involvement of patients score dropped slightly from 71% to 69%, although this was still an average score.

- The “Reviewing your care” score had increased from 74% to 76%. CB reiterated the importance of adding to our appointment letters that this is your ‘formal review’ meeting, as patients are not always aware of this.

- Crisis Care revealed a mixed picture. “Do you know who to contact out of office hours in a crisis” increased from 74% to 80%, however, “Did you get the help you needed from that person” the response rate dropped from 68% to 63%.

- The Trust scored well in the two new questions in relation to medicines and was in line with or above average.

- The overall rating of our service had improved from 68% to 71%, 3 points above the national average.

CB summarised by adding:

- The scores are on or around the average mark and the Trust appears to be performing well.
- Seven questions are in the top 20% category and three fall into the bottom 20% range.
- The score for dignity and respect has declined but remains in the intermediate range.
- The overall rating for care has improved and is now at the upper end of the intermediate range.

CB suggested that the Trust take action as follows:

- Ensure that (staff) are aware of the service users’ treatment history. The score is in the intermediate range.
• Embed and consolidate positive action taken around organisation of care. This score has improved and is in the top performing range.
• Examine why many service users do not report feeling involved in agreeing what care they will receive. This score is in the bottom range.
• Continue excellent work on formal review meetings: this score is in the top range.
• However, seek to ensure decisions are jointly made at this meeting. This score is in the bottom range.
• Continue excellent work on ensuring service users know who to contact when in crisis. This score is in the top 20%.
• However, review the range and level of support provided by the out of hours service. This score is in the intermediate range.
• Continue excellent work in the NHS Therapies area, both scores are in the top performing category.
• Scores in the support and wellbeing section are generally positive and in the intermediate range.
• Focus on involving family members in the service users’ care, this score is close to the bottom range.
• Continue excellent work on access to peer support and seek to continue this positive trend. This score is in the top range.

AS thanked CB for an interesting presentation and commented as a Board it was important to know how patients feel about our services, our achievements, as well as where improvements are needed.

NL advised that the Crisis 111 service scheduled to start in April will give more options to patients in crisis and hopefully improve the scores.

ARQ was encouraged by the results and congratulated the teams providing community mental health services. She suggested that more clarity around the average is required, because if the average Trust is underperforming in general, benchmarking against them loses some of the value. AB agreed with ARQ.

NT reflected on a good set of results, referring specifically to the annual patient review he suggested a list of actions that must be carried out each year. SM clarified that patients are reviewed and that we will add the additional line to our letters to ensure that patients are aware that they are having their annual review. She confirmed that action will be taken to re-enforce the message to staff. AB stated that he was reluctant to introduce a checklist as it would potentially create another performance tool.

SM stated that she was very pleased that actions that have been taken in response to previous survey results appear to be leading to improvement. She acknowledged that “being average” in most areas is not where she would want the Trust to be but the improvement is very much welcomed.

SS was encouraged by the results. She stated that the findings should spark off a range of ideas of how services can be improved that would lead to scores in the top quartile.

The Board received and noted the contents of the presentation.

223/19 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 30 October 2019 were agreed as an accurate record of discussions.
**224/19 ACTION LOGS AND MATTERS ARISING**

The action log was reviewed and noted all items were completed.

SS noted the one remaining action outstanding regarding an update on progress with implementing the Quality Improvement Framework is due in March 2020.

**The Board discussed and noted the Action Log.**

**225/19 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE**

The Chair presented a report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust.

SS noted that the Programme Directors/Leaders from each of the STP’s that engage with EPUT; Mid and South Essex, Herts and West Essex and Suffolk and North East Essex joined the November Board Development Session to present their 5 year plan. It was an extremely useful session which gave the board the opportunity to crystallise its thinking.

**The Board received and noted the Chair’s Report.**

**226/19 BOARD OF DIRECTORS QUALITY AND PERFORMANCE SCORECARD MONTH 7**

SM presented the Board of Directors Quality and Performance Scorecard which provided a summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirmed quality / performance “hotspots” agreed by the Finance and Performance Committee.

SM advised that work had been undertaken over the past 2 months to improve the Board Scorecards and performance reporting to create an improved overall report that utilises different analytical methods. The Month 7 reporting utilises more trend analysis identifying when an indicator should be considered as a hot spot, utilises SPC charts and has been re-formatted into an integrated report including analysis guidelines and a new performance summary page.

Six hotspots were identified as at the end of October 2019. Five hotspots identified as at the end of September 2019, have remained as hotspots. One new hotspot was identified and one hotspot was downgraded in October. SM advised the Board that there is national challenge in respect of the ambition of reducing out of area placements and EPUT are well placed compared to some peers.

SM advised that there are eight quality account priorities identified for 2019/20. Four individual actions had past the timescale for completion.

SM confirmed that the CIP hotspot identified by the Finance and Performance committee was discussed in great detail at the committee. MM added that the amber risk rating previously given to the CIP had moved to red as assurance was required that the efficiency schemes in the pipeline would be delivered. MM assured the Board that the Finance and Performance Committee had requested more detailed analysis which would be provided.

ML asked that the Board is given assurance that the CIP is given a priority by the Executive Directors. MM confirmed that he had written to each Executive to seek assurance on delivery plans and assurance will be provided to the next Finance and Performance Committee. SM reminded all that the delivery of CIPs is a challenge for all Trusts, not just EPUT.
RH congratulated Jan Leonard and her team on the new format of the report which he felt gave improved clarity on the performance measures. He sought assurance on how the report will be used to drive change and improvement throughout the Trust. AB confirmed that the report is discussed at all Senior Management Team meetings. The detailed report is not circulated to ward level but each ward has a local performance station.

AS questioned how the CIP target would be delivered if cost pressures continue. AS sought further assurance on out of area placement beds, requesting that the Trust continues to keep the numbers low. AB confirmed that the base number is very low as the performance was above average for last year. He confirmed that there is a focus on managing bed capacity and many different activities taking place but the demand for beds is not reducing and the risk remains that patients will be placed out of area as winter approaches.

AS also requested additional information on safer staffing, NH advised this could be provided outside of the meeting.

ARQ reiterated the thank you given by RH, although added the report was still quite generic. ARQ added that a lengthy discussion was held last month over the delay with blood tests associated with the CMA target; however it had not been mentioned in this month’s report. AB confirmed there still remains issues with delayed blood tests and plans have been implemented to improve the timescales but they will not be evident quickly. ARQ commented that this is a significant issue and the underlying issues need to be addressed. SS acknowledged with improved system working, changes will be easier to implement.

AD noted that some actions associated with Quality Priorities had not been updated. NH confirmed that all the action plans are being reviewed and the new format will be presented to the next Quality Committee.

SM confirmed that revising the report format remained a work in progress. SS noted the change in style brought about as a result of participating in the NHSI Leadership for Quality programme. She stated that the report will give the Board and staff the opportunity to access relevant information that enables greater understanding of performance and how improvements can be made.

The Board received and noted the report.

227/19 BOARD ASSURANCE FRAMEWORK (BAF)

SM presented an overview of the Board Assurance Framework as at November 2019, advising that there are currently 14 potential risks identified. SM continued that it is recommended that one risk is transferred to the CRR (EU EXIT BAF23). SM advised that 11 action plans are in place to mitigate the potential risks.

Two new potential risks were recommended for escalation to the CRR:
- IMT infrastructure to support the urgent care transformation programme and
- capacity to support the HSE investigation.

In October 2019 the Board of Directors agreed to de-escalate BAF Risk 22 in respect of contractual performance, as there had been no contract performance notices issued. A Contract Performance Notice has since been issued by Mid & South Essex CCG’s in respect of performance relating to one KPI. The EOSC considered this issue on 19 November 2019 and agreed to monitor the situation within the wider context of relationships with CCG colleagues before escalating the risk to the BAF again.
ARQ noted the reason behind the escalation of the HSE risk and was reassured that staff would be allocated if possible. NL advised the staffing issue had been discussed by the Executive team and agreed to supplement the team with temporary staff appointments.

The Board of Directors:

1. Reviewed the potential risks identified in the Board Assurance Framework 2019/20 in Table 1 and approved the risk scores
2. Approved transfer of risk BAF23 EU EXIT to the CRR until January 2020
3. Noted the mapping of BAF risks in Table 2
4. Noted the movement of the BAF risks in Table 3
5. Approved escalation of potential risks identified in section 3 to the CRR
6. Did not identify any further risks for escalation to the BAF or risk registers.

### 228/19 STANDING COMMITTEES

(i) **Audit Committee**

JW presented the Audit Committee Assurance Report. She advised that the Cyber Essentials Plus Certification due in 2021 was on target. There were no new risks identified by the Audit committee.

The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) **Finance and Performance Committee**

NT presented the Finance and Performance Committee Assurance Report. Noting the non-delivery of the CIP programme as a hot spot and the potential issues going forward. Agency spend was above plan. CAPEX forecast has reduced to £8m, the Estate and IT department were asked to review any future priorities for consideration to bring forward.

The Board received and noted the report, and confirmed acceptance of assurance provided.

(iii) **Quality Committee**

AS presented the Quality Committee Assurance report, noting the update on the implementation of the perfect ward app and progress being made to implement the national standards for learning disability.

AD asked for clarification on the hotspot identified in respect of workplace risk assessment and requested assurance that this is being addressed. AB advised that he had not been aware of the problem before it was brought to the Quality Committees attention but he was able to confirm that the backlog is being addressed and/or assessments already completed are being forwarded to the Risk Team for recording.

The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) **Strategy and Planning Committee**

ARQ presented the Strategy and Planning Committee Assurance Report, noting:

- an update on Enable East and the potential areas for future growth was presented;

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In the Chair
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• recruitment issues associated with the Transformation Programme and action being taken;
• the committee had reviewed its TOR and agreed to meet bi-monthly going forward following discussion at the recent Board Seminar.

The Board:
• received and noted the report and confirmed acceptance of assurance provided.
• approved revised Terms of Reference for the Committee.

229/19 STANDING ORDERS FOR THE PRACTICE AND PROCEDURES OF THE BOARD OF DIRECTORS

SS presented revisions to the Standing Orders for the Practice and Procedures of the Board of Directors which had been made to reflect revised provisions in respect of the Vice Chair and Acting Chair role and appointment process. She advised that the changes had been made following the recommendations made by the Senior Independent Director.

AD confirmed that the revisions were in line with her recommendations.

The Board of Directors approved the amendments to the Standing Orders for the Practice and Procedures of the Board of Directors.

230/19 FINAL CHARITABLE FUND ACCOUNTS 2018/2019

MM presented the final charitable funds accounts to the Board of Directors. He confirmed that the auditors had reviewed the accounts and no issues had been identified.

The Board:
• approved final Charity Annual Reports and Accounts for 2018/19
• approved the signing of the Letter of Representation and related certificates on behalf of the Trust.

231/19 EPUT TRANSFORMATIONAL PROGRAMMES

NL presented the Transformation Programme update. The report focused on staffing requirements across the mental health programme. NL referred to the earlier discussion in respect of BAF risk 34 and how the Trust plan to recruit to the number of posts required. He confirmed that this risk had also been discussed by the Strategy and Planning Committee. NL advised that there are 140 posts to recruit. This number does not include the additional posts required to meet the increased need in Primary Care. The appointments are required by 1 April 2020.

NL advised that the Executive Director of People and Culture is preparing a revised approach to recruitment by rebranding and reframing existing processes. There was also recognition that international recruitment will be required and a small project team is in place to examine this option. Earlier in the year, the recruitment team successfully secured 40 sponsorship places to aid future international recruitment if required. The recruitment team has developed a number of recruitment approaches to help deliver the start dates for the key schemes during 2020. To date the Trust has placed adverts on NHS Jobs, carried out local advertising and in professional journals and has held recruitment open days. As a result of these, the Trust has confirmed appointments for 12 of the vacancies. A number of posts are still to be advertised. The Trust is planning more strategic advertising on buses, national rail and at airports, which is hoped will attract new candidates. Preparations for radio campaigns and increasing social media coverage is underway.
SS noted that workforce is a huge issue nationally as well as for the Trust.

AB advised that work had been undertaken with the apprenticeship scheme to enable the Trust to ‘grow our own’ but accepted that this is not a short term fix.

MK advised that the Executive Team discussed the GMC sponsorship to enable applications for International recruitment for Consultants.

NL clarified for ML that all the 140 posts were required in EPUT. ML raised concern about the risk if the vacancies cannot be filled and the service still requires opening. NL confirmed that the Trust is in discussion with CCG’s. AB added that using Bank and Agency staff would be a short term solution.

JW noted the thorough content of the report. She requested that future reports consider the potential risk of draining staff from existing services.

SM suggested that workforce is a subject for a future Board seminar discussion. FS confirmed that this is being planned with SL.

NT thanked NL for the great amount of work being undertaken.

**The Board received and noted the report.**

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### 233/19 DEVELOPING A NEW CARE MODEL COLLABORATIVE

SM presented a report to update the Board on this initiative. She advised that in 2018, the National Clinical Director for Mental Health set out a national requirement to introduce new commissioning arrangements for specialist mental health across the country. This is an expansion of the ‘New Care Models’ scheme. NHS England has given approval to proceed with the development of a collaborative between six providers, including EPUT, within the East of England. Key milestones include submitting a full business case during April 2020, entering into shadow commissioning in April 2020 and assuming commissioning responsibility from October 2020.

In July 2019 a case was submitted to NHS England by the collaborative to develop 3 pathways of care across the region:

- Child and Adolescent Mental Health Services
- Adult Secure Services (low and medium secure)
- Adult Eating Disorder Services

SM stated that this is a really positive development that has good clinician buy in and will have a positive impact on patient care.

SS welcomed the development.

AD stated that good governance will be important and particularly making sure that potential conflicts of interest are managed appropriately. SM stated that a different mind-set will be required of all providers within the collaborative.

MM sought clarification as to whether the CAMHs collaborative included community services. SM confirmed that it was just inpatient provision.

SS thanked SM for her leadership of this initiative.
The Board of Directors received and noted the contents of the report.

### 234/19 CQC UPDATE

SM presented the CQC update which provided the Board with the final report received following the Well Led inspection completed in July / August 2019. The action plan approved by the Chair on behalf of the Board was submitted to the CQC on the 19th November. The CQC identified 18 Must Do and 29 Should Do action.

SM confirmed that robust monitoring of all current and past CQC actions is in place. 2 actions remain open (past agreed timescales) from previous inspections but they continue to be taken forward. She confirmed that all actions from previous inspections have now been transferred into the action plan presented.

ARQ sought clarification on how the cleanliness of wards remains an open action. MM advised that regular checks are now in place, mystery shoppers have been introduced along with cleaning boards to advise when cleaning has been undertaken. Further updates will be provided to Board.

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

### 235/19 PHSO & HSE STEERING GROUP ASSURANCE REPORT

AD presented the report, confirming that the action points were being undertaken without delays.

The Board received and noted the contents of the report.

### 236/19 FREEDOM TO SPEAK UP

Astrid Pollard presented a report covering quarters 1 and 2 of 2019/20.

She confirmed that in the summer of 2019 the process to elect a new Principal Guardian took place. This included the review of the current job description and the request for nominations from staff. The election period ran from 1 to 21 October 2019 with two candidates nominating themselves for election - Jennifer Sayer and Yogeeta Mohur. Yogeeta was elected and she commenced the role on 4 November 2019 and is currently receiving a full handover. Yogeeta is a registered nurse working for the Trust’s Access and Assessment Team. Yogeeta is passionate about the Freedom to Speak Up agenda and is keen to drive the raising of awareness so all staff know how to raise a concern and are then listened to.

EPUT’s vision for Freedom to Speak Up is ‘Supporting compassion, openness and empowerment’. The number of Local Guardians continues to grow, since the last report in May 2019, 5 have been recruited, and there are 24 local guardians in place. Staff are encouraged to consider becoming a Local Guardian.

The Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust Raising Concerns (Whistleblowing) Policy and Procedure. The 'I'm Worried About’ process changed in August 2019 and consequently concerns have been received by the Guardian Service which has included general questions regarding facilities. This process is being revised to ensure that staff receive the correct response/signposting for the concern they raise.
AP thanked NL and AD for their support during her time as the Guardian. Yogeeta thanked the Board for welcoming her today and explained how she intends to ensure that the good work that AP has undertaken continues.

RH commented on the number of bullying and harassment numbers being surprisingly low. AD added that one of the most important factors for staff to use the F2SPU process, is trust and a culture where speaking up is encouraged. AP advised that staff are still wary of using the process and this is an important area of focus for the Trust.

SM referred to the process for 'I'm worried about' changing and advised that SL would be looking at engagement across the Trust in general terms and further/improved communication channels for staff will be introduced.

SM concluded by adding that Alison Davis would be stepping down as the Non-Executive Champion for F2SPU and was being replaced by Alison Rose-Quire. SM thanks AD for her support with the role.

The Board received and noted the contents of the report.

37/19 PUBLIC ADMINISTRATION AND CONSTITUTIONAL AFFAIRS COMMITTEE REPORT (PACAC)

NL presented a copy of the full report of the PACAC report produced as a follow up to the PHSO report: missed opportunities: what lessons can be learned from failings at the North Essex Partnership NHS Foundation Trust. The report was published on 4 November 2019, and details in full the discussions of the PACAC on 15 October 2019. NL confirmed that the PHSO and HSE (Health and Safety Executive) Steering Group will be capturing any actions arising from the PACAC report to be taken forward by the Trust.

The Board received and noted the contents of the report.

238/19 BOARD OF DIRECTORS GOVERNANCE ARRANGEMENTS

SS presented the Board of Directors Governance Arrangements report. She confirmed that the Trust usually carries out an annual review of the efficacy of its governance arrangements during Q3. During 2019/20 the governance arrangements of the Trust have been subject to independent external review by Deloitte and by the CQC. As a result, the usual structured internal review of the arrangements was not required this year. The focus of action is therefore on taking forward the recommendations made by Deloitte.

Meetings of the Board of Directors in public
Following detailed consideration it was proposed that the number of meetings of the Board of Directors will reduce from ten to six per year. Meetings will take place bi-monthly.

Action will be taken to incorporate more focus and oversight on strategic activities and a greater focus on quality related reporting. Action will also be taken to enhance the assurance reporting by standing committees includes a greater focus on key strategic risks.

Board Seminars
In order to create more time for strategic discussion, the number of Board Seminar Sessions will increase from six to nine per year. A forward plan of Seminar Session business will be developed.
Board Development
There will be two x two day dedicated board development sessions in each year (in June and December) that will take place in months where there will not be a public Board meeting. This will ensure that there is no dilution of assessing and meeting the development needs of the unitary Board and its individual members by combining seminar discussion and development sessions going forward.

Standing Committees of The Board of Directors
The Strategy and Planning Committee is reviewing its role and responsibilities in light of the potential increase in the number of Seminar Sessions held. The Committee has agreed to reduce the frequency of meetings from monthly to bi-monthly as an interim measure to create capacity and reduce duplication whilst the review is undertaken. The Committee is considering whether there is potential to include oversight of workforce transformation activities within its remit which currently is reporting to both Finance& Performance and Quality Committees.

To make best use of the time that NEDs and Governors spend in the Trust, the introduction of “business days” has also been agreed in principle. This will mean that wherever possible and workable, more than one activity will be planned to take place on the same day e.g. a Board of Directors meeting and a Council of Governors meeting or a Board Seminar and a NED/ Governor informal meeting. Following approval of the proposals, detailed in the report a calendar of events for 2020 will be developed. Opportunities for engagement with Governors and the public have been reviewed and plans to enhance these are identified.

SM gave her general support to the proposed plans.

The Board approved the proposed changes to the governance arrangements and agreed implementation from 1 January 2020.

239/19 USE OF CORPORATE SEAL
The seal had not been used since the last report.

240/19 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING
There was no correspondence circulated to Board members since the last meeting.

241/19 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING
There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.

242/19 ANY OTHER BUSINESS
SS closed the meeting by asking AS to summarise how the Board had demonstrated the Trust’s vision and values through its deliberations and reports.

AS explained that today’s Board has had very open conversations. All colleagues had been reflective in their discussion, demonstrating compassion and empowerment. However, she felt that reports had been focussed on business and process driven. She felt that the response and conversations about under-achievement were potentially too defensive.
SS thanked AS. She advised that David Taylor (author; the Naked Leader) has spent some time with the Senior Leadership Team and will be joining the Board Development session in December. The focus of his sessions is on effective communication.

243/19 DATE AND TIME OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 29 January 2020, 10:30am, at the Lodge, Lodge Approach, Wickford, Essex, SS11 7XX

244/19 QUESTION THE DIRECTORS SESSION

Questions from attendees, members, public and staff are detailed in Appendix 1.

The meeting closed at 12:40
**Appendix 1: Governors / Public / Members Query Tracker (Item 219/19)**

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<th>Governor / Member / Public</th>
<th>Query</th>
<th>Response provided by the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alistair Frost</td>
<td>Alistair Frost (AF) a member of the audience asked to raise his concern to the Board over the treatment he had received from our Trust and 2 other that's he feels failed him. AF was referring to a period of care in 2016. AF advised he was attending all the Board meetings at Trusts involved in his care to highlight his case.</td>
<td>SS thank AF for attending and asked that as his question related to a personal matter it would be more suitable if he discussed it with Andy Brogan and Dr Karale once the meeting had finished. AF agreed to speak with them directly.</td>
</tr>
<tr>
<td>Clive White</td>
<td>Re the CQC report, CW asked how we can be assured that actions aren't missed and that appropriate action is being taken.</td>
<td>AS advised at the Quality committee review the action plans and rigorously review. SM added that she Chairs the CQC steering group. She recognises that for the Trust to achieve its aspiration of becoming outstanding the Trust needs a good level of safety. JW confirmed that we use an internal audit programme to capture what and how we respond to the CQC.</td>
</tr>
<tr>
<td>Mark Dale</td>
<td>MD was encouraged to hear about the plans for improved Crisis care across the Trust. MD also reminded Board of the excellent employment service that we run which would not have been included in the survey; we need to be mindful that we are capturing the right service users.</td>
<td>SS thanked MD.</td>
</tr>
<tr>
<td>Paula Grayson</td>
<td>With Board meetings reducing from 10 to 6, she is concerned that there will be less opportunity for the Governors to hold NEDs to account.</td>
<td>SS advised that she is looking at how Governors can be invited to some of the Seminar sessions being held by the Board. She reminded all that the Deloitte Well Led Review had looked at other outstanding Trust's and they hold less than 10 meetings a year, so the plans outlined will bring the Trust in line.</td>
</tr>
</tbody>
</table>
**Board of Directors Meeting**

**Action Log (following Part 1 meeting held on 27 November 2019)**

<table>
<thead>
<tr>
<th>Lead</th>
<th>Initials</th>
<th>Lead</th>
<th>Initials</th>
<th>Lead</th>
<th>Initials</th>
<th>Status</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andy Brogan</td>
<td>AB</td>
<td>Nigel Leonard</td>
<td>NL</td>
<td>Amanda Sherlock</td>
<td>AS</td>
<td>Completed</td>
<td>Green</td>
</tr>
<tr>
<td>Alison Davis</td>
<td>AD</td>
<td>Manny Lewis</td>
<td>ML</td>
<td>Nigel Turner</td>
<td>NT</td>
<td>Action Completed</td>
<td>Yellow</td>
</tr>
<tr>
<td>Natalie Hammond</td>
<td>NH</td>
<td>Mark Madden</td>
<td>MM</td>
<td>Janet Wood</td>
<td>JW</td>
<td>Action Completed</td>
<td>Yellow</td>
</tr>
<tr>
<td>Rufus Helm</td>
<td>RH</td>
<td>Sally Morris</td>
<td>SM</td>
<td>Trust Secretary</td>
<td>TS</td>
<td>Action Completed</td>
<td>Yellow</td>
</tr>
<tr>
<td>Milind Karale</td>
<td>MK</td>
<td>Alison Rose-Quirie</td>
<td>ARQ</td>
<td></td>
<td></td>
<td>Future Actions/ Not due</td>
<td>Grey</td>
</tr>
<tr>
<td>Sean Leahy</td>
<td>SL</td>
<td>Sheila Salmon</td>
<td>SS</td>
<td></td>
<td></td>
<td>Future Actions/ Not due</td>
<td>Grey</td>
</tr>
</tbody>
</table>

### Minutes Ref

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Dead-line</th>
<th>Outcome</th>
<th>Status</th>
<th>RAG rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share CQC guidance regarding long term segregation with PE and dementia</td>
<td>NH</td>
<td>November 2019</td>
<td>CQC guidance sent to PE 20 November. NH and PE discussed issue at the COG meeting 13 November</td>
<td>Completed</td>
<td>Green</td>
</tr>
<tr>
<td>The timescale for developing the suicide prevention and QI dashboards to be confirmed.</td>
<td>NH/MM</td>
<td>November 2019</td>
<td>Quality Account content reviewed in respect of suicide prevention dashboard as misleading. By August 2019 a suicide prevention dashboard will be in place to track and monitor progress on the ten key parameters for safer mental health services. Revised wording now: By August 2019 a suicide prevention action plan will be in place to track and monitor progress on the ten key parameters for safer mental health services. Action plan in place supported by work streams to ensure delivery. New separate action (with Mar 20 timescale ) is: Dashboard to be developed against action plan to monitor delivery at service level. QI dashboard: Quality Account action is - By September 2019 to have in place a dashboard against all quality priorities. Update: Dashboard is in place against a number of priorities with further work scheduled for roll out against all areas.</td>
<td>Completed</td>
<td>Green</td>
</tr>
<tr>
<td>Minutes Ref</td>
<td>Action</td>
<td>Owner</td>
<td>Dead-line</td>
<td>Outcome</td>
<td>Status</td>
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</tr>
<tr>
<td>October 207/19</td>
<td>Future transformation progress reports to explore workforce risks</td>
<td>NL/SL</td>
<td>November 2019</td>
<td>Transformation report presented November has focus on workforce issues</td>
<td>Completed</td>
</tr>
<tr>
<td>September 174/19</td>
<td>Quality Committee Terms of Reference to be revised to reflect</td>
<td>AS/NH</td>
<td>November 2019</td>
<td>TOR revised and approved by Quality Committee 14 November 2019</td>
<td>Completed</td>
</tr>
<tr>
<td>July 149/19</td>
<td>Quality Committee to be provided with an update on implementation of AS/NH</td>
<td>AS/NH</td>
<td>November 2019</td>
<td>Quality Committee 14 November received update</td>
<td>Completed</td>
</tr>
<tr>
<td>September 174/19</td>
<td>Update on progress with implementing the QI framework to be</td>
<td>NH</td>
<td>March 2020</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>July 150/19</td>
<td>Ensure that any target dates missed within Quality Priorities include</td>
<td>NH</td>
<td>September 2019</td>
<td>Update 25/9: Addressed in report presented to September Board of Directors.</td>
<td>Completed</td>
</tr>
<tr>
<td>June 131/19 (iii)</td>
<td>Chair of Quality Committee to continue to monitor capacity of the Quality Committee and incorporate this into the annual efficacy review of the committee.</td>
<td>AS / NH</td>
<td>September 2019</td>
<td>25/9 Update: Quality Committee considered position 12 September 2019. Format of meetings has been amended to hold alternate developmental and assurance meetings. This has resulted in a better management of the agenda. Sub-committees are considering merger potential which will also support a reduction in assurance reports required to be considered. Chair of the Committee (and members) were satisfied that this is not a significant risk at this time.</td>
<td>Completed</td>
</tr>
<tr>
<td>Minutes Ref</td>
<td>Action</td>
<td>Owner</td>
<td>Dead-line</td>
<td>Outcome</td>
<td>Status Comp/ Open</td>
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</tr>
<tr>
<td>May 104/19</td>
<td>Strategy and Planning Committee to discuss strategy for mitigating potential risk regarding loss of income/ activity in CAMHS and Learning</td>
<td>ARQ/ NL</td>
<td>September 2019</td>
<td>25/9 Update: New Care Models were presented and discussed at the Strategy &amp; Planning Committee. EPUT is a key partner in each system and will work with partners to reduce risk and plan for future changes</td>
<td>Completed</td>
</tr>
<tr>
<td>May 105/19</td>
<td>Ensure NED reviews are carried out on a cross section of complaints across all services (e.g. evidence)</td>
<td>SS</td>
<td>September 2019</td>
<td>Update 25/9: NEDs have reviewed the complaints review process, considering coverage, impact and percentages. A revised process has been drafted, focusing on quality of response, investigation, lessons learnt and themes (both content and location). This will be discussed with the Executive lead for complaints on 24th September and then presented to the appropriate committee for approval. Current review process will continue until the revised process is approved.</td>
<td>Completed</td>
</tr>
<tr>
<td>May 105/19</td>
<td>NED Reflective Discussion Group to review process to consider including impact</td>
<td>SS</td>
<td>September 2019</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>May 105/19</td>
<td>NED Reflective Discussion Group to consider what percentage of complaints should be</td>
<td>SS</td>
<td>September 2019</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>May 109iii/19</td>
<td>SS has received confirmation from partners that they would want to deliver presentations to committees (like that delivered by Enable East), NL to lead on</td>
<td>NL</td>
<td>September 2019</td>
<td>Update 25/9: Presentations have been received at the Strategy and Planning from Enable East and the lead for the North East Essex and Suffolk STP. A presentation from the Mid and South STP lead is scheduled for October 2019, and from the West Essex and Hertfordshire STP leads in November 2019.</td>
<td>Completed</td>
</tr>
<tr>
<td>February 031/19</td>
<td>NL to review the Kark review and provide a brief to Board.</td>
<td>NL</td>
<td>May 2019 Revised to September 2019</td>
<td>Update 25/9: Briefing provided by Hempsons included in Chair’s report to BOD September 2019.</td>
<td>Completed</td>
</tr>
<tr>
<td>Minutes Ref</td>
<td>Action</td>
<td>Owner</td>
<td>Dead-line</td>
<td>Outcome</td>
<td>Status Comp/ Open</td>
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</tr>
<tr>
<td>May 108/19 (1)</td>
<td>Risk BAF18 – review wording of risk to provide clarity on risk to be mitigated and review risk score, as risk should reduce but not consequence.</td>
<td>NL / MMC</td>
<td>June 2019</td>
<td>Update 26/6: Risk description revised with Exec Lead; however Finance &amp; Performance Committee 20 June 2019 has requested that description is reviewed again and simplified. This will be carried out over the next month. Update 31/7: risk description reworded and reflected in BAF presented to BOD.</td>
<td>Completed</td>
</tr>
<tr>
<td>May 105/19 (2)</td>
<td>Provide assurance in future complaints reports that staff named in complaints more than once is followed up</td>
<td>NL</td>
<td>September 2019</td>
<td>Update 31/7 The Complaints Team will be recording these details and following up with the relevant Service Director. Details of services where this has been noted will be provided in future quarterly reports submitted to the Patient and Carer Experience Sub Committee.</td>
<td>Completed</td>
</tr>
<tr>
<td>May 108/19 (2)</td>
<td>Risk BAF32 – review risk to be mitigated, is it in relation to cyber or innovations.</td>
<td>NL / MM</td>
<td>June 2019</td>
<td>Update 26/6: The Finance &amp; Performance Committee 20 June 2019 considered the risk description and agreed that it should focus on innovation not technology (technology will be part of mitigation strategy). Risk description to be revised and updated in July 2019 Update 31/7: Risk description reworded and reflected in BAF presented to BOD</td>
<td>Completed</td>
</tr>
<tr>
<td>April 085/19</td>
<td>NH to arrange for the format of future Quality Impact Assessment Overview and Assurance Update reports to be revised to provide more clarity.</td>
<td>NH</td>
<td>July 2019</td>
<td>Update 26/6: NH to take forward via the Executive Operational Sub Committee and the Finance &amp; Performance Committee Update 31/7: Considered by Finance and Performance Committee 25/7/19</td>
<td>Completed</td>
</tr>
<tr>
<td>Minutes Ref</td>
<td>Action</td>
<td>Owner</td>
<td>Deadline</td>
<td>Outcome</td>
<td>Status</td>
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</tr>
<tr>
<td>June 131/19 (ii)</td>
<td>Concerns raised in respect of overspends on delegated budgets and the CIP to be remitted to the Executive Team and Finance and Performance Committee to monitor and report.</td>
<td>Executive Team / Finance and Performance Committee</td>
<td>July 2019</td>
<td>Update 31/7: update provided via Finance &amp; Performance Committee assurance report to BOD</td>
<td>Completed</td>
</tr>
<tr>
<td>April 06/19 / May 110/19</td>
<td>MMC to provide an update on communication with service users about Mental Health Update</td>
<td>MMC</td>
<td>June 2019</td>
<td>MMC confirmed this will be included within the Transformation Update provided to the Board in June</td>
<td>Completed</td>
</tr>
<tr>
<td>May 105/19 (1)</td>
<td>Complaints Annual Report subject to final data accuracy check for publication and subsequent reporting</td>
<td>NL</td>
<td>June 2019</td>
<td>Complaints Annual Report was revised and finalised.</td>
<td>Completed</td>
</tr>
<tr>
<td>May 107/19</td>
<td>Summary of Operational Plan 2019/20 – NL to incorporate final changes (financial data and outcomes)</td>
<td>NL</td>
<td>June 2019</td>
<td>Revised Summary of Operational Plan is presented to the Board of Directors June 2019</td>
<td>Completed</td>
</tr>
<tr>
<td>April 080/19</td>
<td>MK to provide updates to Board on the Cardio Metabolic emerging risk via Finance &amp; Performance Committee</td>
<td>MK</td>
<td>May 2019</td>
<td>Delegated to the Finance &amp; Performance Committee, and added to the work plan.</td>
<td>Completed</td>
</tr>
<tr>
<td>April 080/19</td>
<td>AS to provide updates to Board on the signoff backlog via Quality Committee</td>
<td>AS</td>
<td>June 2019</td>
<td>Delegated to the Quality Committee.</td>
<td>Completed</td>
</tr>
<tr>
<td>April 081/19</td>
<td>AB to add information about Clinical Programmes to the Executive Summary</td>
<td>AB</td>
<td>May 2019</td>
<td></td>
<td>Completed</td>
</tr>
<tr>
<td>April 081/19</td>
<td>NL to include Training Service Business Opportunities on the strategy Statement</td>
<td>NL</td>
<td>May 2019</td>
<td>Delegated and placed on workplan for Strategy &amp; Planning Committee.</td>
<td>Completed</td>
</tr>
<tr>
<td>Minutes Ref</td>
<td>Action</td>
<td>Owner</td>
<td>Dead- line</td>
<td>Outcome</td>
<td>Status Comp/ Open</td>
</tr>
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</tr>
<tr>
<td>April 082/19</td>
<td>NL to arrange for MH capacity in Kelvedon Ward to be added to the Risk Register</td>
<td>NL</td>
<td>May 2019</td>
<td>Mental Health Capacity added to Directorate Risk Register.</td>
<td>Completed</td>
</tr>
<tr>
<td>November 167/18</td>
<td>F2SU - Further updates to be provided at a later date</td>
<td>NL</td>
<td>May 2019</td>
<td>Item on Agenda.</td>
<td>Completed</td>
</tr>
</tbody>
</table>
### Purpose of the Report

This report provides a summary of key activities and information to be shared with the Board and stakeholders and an update on governance developments within the Trust.

<table>
<thead>
<tr>
<th>Approval</th>
<th>Discussion</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✓</td>
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</tbody>
</table>

### Recommendations/Action Required

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

### Summary of Key Issues

The report attached provides information in respect of:
- Chair and NED Service Visits
- STP/ICS involvement
- CEO Recruitment
- Flu Vaccinations
- Quality Awards
- Finance Christmas Choir
- 2019 NHS Staff Survey
- Legal and policy matters of interest

### Relationship to Trust Strategic Priorities

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Delivery Status</th>
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</thead>
<tbody>
<tr>
<td>SO 1</td>
<td>✓</td>
</tr>
<tr>
<td>SO 2</td>
<td>✓</td>
</tr>
<tr>
<td>SO 3</td>
<td>✓</td>
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</table>

### Which of the Trust Values are Being Delivered

<table>
<thead>
<tr>
<th>Value</th>
<th>Delivery Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open</td>
<td>✓</td>
</tr>
<tr>
<td>Compassionate</td>
<td>✓</td>
</tr>
<tr>
<td>Empowering</td>
<td>✓</td>
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</table>

### Relationship to the Board Assurance Framework (BAF)

<table>
<thead>
<tr>
<th>Risk Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Are any existing risks in the BAF affected?</td>
</tr>
<tr>
<td>No</td>
<td>If yes, insert relevant risk</td>
</tr>
<tr>
<td>No</td>
<td>Do you recommend a new entry to the BAF is made as a result of this report?</td>
</tr>
</tbody>
</table>
## Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

<table>
<thead>
<tr>
<th>Assurance(s) against:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</td>
<td>✓</td>
</tr>
<tr>
<td>Data quality issues</td>
<td></td>
</tr>
<tr>
<td>Involvement of Service Users/Healthwatch</td>
<td>✓</td>
</tr>
<tr>
<td>Communication and consultation with stakeholders required</td>
<td></td>
</tr>
<tr>
<td>Service impact/health improvement gains</td>
<td>✓</td>
</tr>
</tbody>
</table>

### 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

- Lead

### Supporting Documents and/or Further Reading

- Professor Sheila Salmon
- Chair
CHAIR’S REPORT

1.0 PURPOSE OF REPORT

This report provides a summary of key activities and information to be shared with the Board and stakeholders.

2.0 CHAIR’S REPORT

2.1 Chair and NED Service Visits
The NEDs and I continue to visit services across the Trust; these visits allow us to see our fantastic staff in action and provide an opportunity for staff to share any concerns or positive practice with us. Recent visits have included Finance at Thurrock; Eating Disorders at Colchester; the Derwent Centre; West Essex Community Services and Community Inpatient Wards; Beech Ward (Rochford); South Essex Community Services, Complaints Department at the Lodge and Brockfield House.

2.2 ICS/STP Collaboration and Engagement
All Executive and Non-Executive Directors are becoming increasingly active with our key stakeholders and partners, currently focussed within 3 STP/ICS footprints across Essex and reaching into Hertfordshire and Suffolk. Our outward looking approach reflects our strategic aim to be consistently recognised as valued, trusted and proactive partner. Working together collaboratively across systems and networks has the power to unlock and unleash transformation potential that would not necessarily be in the sole gift of EPUT, but would directly benefit the population that we serve.

2.3 CEO Recruitment
Following the announcement of our CEO Sally Morris’ intention to retire, the recruitment process for her successor has begun. The advert for the position ‘went live’ on 06 January and an Executive Search Agency is actively engaged. The indicative date for selection and stakeholder panels is 23/24 March (to be confirmed). Further detail will follow in due course.

2.4 Flu Vaccinations
The Trust Flu Vaccination campaign continues which encourages our staff to receive their flu vaccination this year. The current staff uptake figure is heading in the right direction, but there is still some way to go.

2.5 Annual Quality Awards
The Trust will be holding the annual Quality Awards to recognise individuals, teams and projects for their contribution to delivering the Trust’s values and quality improvement ambitions. The nomination period closed on 13 January and I was pleased to hear that we have received so many worthy nominations in the twelve award categories. I particularly look forward to reviewing the nominations for the Chair’s Award; this is an award that recognises both clinical and non-clinical members of staff who have gone above and beyond the expectations of their role.

2.6 Finance Christmas Choir
Members of our Finance Team, including Executive Chief Finance Officer Mark Madden, spread some festive cheer to Gloucester Ward and Meadowview Ward at
Thurrock Community Hospital prior to Christmas. The team formed a choir to sing Christmas carols to our patients and staff which was enjoyed by all.

2.7 2019 NHS Staff Survey
48% of staff responded to the 2019 NHS Staff Survey; this was an improvement to the previous year’s response rate. The answers provided are incredibly important and they give us a snapshot of staff views on the Trust which help shape our plans to improve the experience of working at EPUT.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Mental Health Network Responds to Conservative Party Manifesto: Responding to the Conservative Party’s manifesto for the 2019 General Election, Sean Duggan, chief executive of the Mental Health Network, which is a part of the NHS Confederation, said: “A considerable majority of health leaders agree improving mental health care should be a priority for whoever forms the next Government and the renewed focus on mental health services from all political parties during this election campaign has been very welcome. Providers of NHS mental health services face incredible challenges, with extreme workforce pressure and the urgent need for investment in modern, appropriate settings. Financial support for trainee nurses would be extremely beneficial, as workforce shortages are especially pronounced among mental health nursing staff. Likewise, the focus on improving care for people with learning disabilities is encouraging. If we are to make the improvements we know are necessary, the next government’s infrastructure plan must recognise the needs of the mental health sector and they must investigate ways of making it a more attractive place to work. This includes looking more creatively at how we staff services. Modernising the Mental Health Act will also make a big difference to ensuring that those who have reached the point of crisis receive the care they need.”

3.2 Let’s Do Our Duty: Top Nurse Leads NHS Staff Flu Jab Drive: England’s most senior nurse has called on the NHS’ million plus frontline workers to protect themselves and their patients this year by taking up their free flu jab. Ruth May, the Chief Nursing Officer for England, is spearheading this year’s drive to ensure that as many NHS staff as possible get vaccinated against seasonal flu – meaning they are both less likely to need time off over the busy winter period, and less likely to pass on the virus to vulnerable patients. Since September, hospitals and other healthcare settings across the country have been laying on special activities designed to highlight the importance of the flu vaccine, and celebrate those staff who choose to protect themselves and their patients. A record 70% of doctors, nurses, midwives and other NHS staff who have direct contact with patients took up the vaccine through their employer last year, with most local NHS employers achieving 75% or higher.

3.3 Latest Vacancy Figures More Evidence NHS Teams Under Intolerable Strain: Responding to the latest NHS vacancy statistics published by NHS Digital, Nick Ville, director of membership and policy at the NHS Confederation, said: “This is yet more evidence that teams across the NHS are under intolerable strain, with 105,518 full time equivalent vacancies in England for the second quarter of 2019/20, including 43,593 vacant nursing posts. Workforce is the number one concern among health leaders, and it’s not hard to see why. There has been commendable commitment from them to recruit and retain staff, but the NHS will need support from the incoming government to prove what is rapidly becoming a dire situation.”
3.4 NHS Digital Publishes Detailed Picture of Mental Health in England: Annual figures on mental health, learning disability and autism services have been published by NHS Digital. The Mental Health Bulletin 2018-19 covers NHS funded secondary care and provides a picture of people referred for treatment or assessment to mental health services in England. Included in the report is a count of people who have an open referral at some point during 2018-19, regardless of them accessing treatment during that period. The data is broken down into age, gender, ethnicity and deprivation demographics.

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by:

Angela Horley
PA to Chief Executive, Chair and NEDs

On behalf of

Professor Sheila Salmon
Chair
SUMMARY REPORT

BOARD OF DIRECTORS

PART 1

29th January 2020

Report Title: Quality and Performance Scorecards
Executive/Non-Executive Lead: Sally Morris
Chief Executive Officer
Report Author(s): Jan Leonard
Director of ITT
Report discussed previously at: Executive Operational Steering Committee
Finance and Performance Committee
Level of Assurance: Level 1
Level 2 ✔
Level 3

Purpose of the Report
The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance “hotspots” agreed by the Finance and Performance Committee.

The scorecards are provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board. The content has been considered by those committees and it is not the intention that further in depth scrutiny is required at the Board meeting.

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

Summary of Key Issues
Reporting Changes
Over recent months work has been underway to redevelop the Trust Board Scorecards and performance reporting for different Trust Board Sub-committees to create a more integrated report and to utilise different analytical methods including Statistical Process Control Charts (SPCs) to aid better trend analysis. This work has been taking place through Trust Board Development Sessions. Following the last session at the beginning of November a number of changes have been made to the score cards starting the journey of transforming into a more integrated report.

Work remains ongoing with the Trust Board to further enhance reporting.

Performance Reporting
The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have considered the full Trust integrated quality and performance report, from which the content of this report is summarised, in respect of performance against targets in the month of December 2019.

Nine hotspots (variance against target/ambition) have been identified at the end of December 2019 and are summarised in the Quality and Performance Reporting Hotspots Scorecard.

Six hotspots from last month have remained as hotspots at the end of December:
- Timeliness of Data Entries (MH Services)
- Cardio Metabolic Assessment
- Referral to Treatment, MH Crisis and Routine
- Psychiatric Readmissions (Older Adults)
- Continued Reduction in Out of Area Placements
- Agency breaches

Three new Hotspots have been identified in December:
- CPA 12 month reviews
- Inpatient Capacity (Mental Health Adults)
- CQC Action Plan Slippage
Summary of Key Issues

One Hotspot from last month remains in the Oversight Framework for December 19:
- Continued Reduction in Out of Area Placements

There are no hotspots in the EPUT Safer Staffing Dashboard for December 2019.

There are eight Quality Accounts priorities identified for 2019/20. Four individual actions are past timescale in December:
- Development of dashboard for all quality priorities incorporating data from the new Patient Safety Incident Management System.
- Implementation of procedure guideline for Delirium.
- Review of Self Harm Policy
- To have in place a dashboard against all quality priorities.

In December Cost Improvement Programmes has been identified as a hotspot in the Finance summary. At the end of December £6,418K of CIP schemes were agreed against a 19/10 target of £11,661. Agency Costs has also been brought forward as an emerging risk in December, our current expenditure exceeds the NHSI plan.

The CQC summary has been updated to reflect the recent changes to EPUT’s action plan. The information now represents Overarching, Must Do and Should Do actions.

The CQC summary identifies that there are eight Overarching, two Must Do and two Should Do actions past timescales.

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

Relationship to Trust Strategic Objectives

| SO 1: Continuously improve service user experiences and outcomes | ✓ |
| SO 2: Achieve top 25% performance | |
| SO 3: Valued system leader focused on integrated solutions | |

Which of the Trust Values are Being Delivered

1: Open ✓
2: Compassionate |
3: Empowering ✓

Relationship to the Board Assurance Framework (BAF)

| Are any existing risks in the BAF affected? | Yes |
| If yes, insert relevant risk | BAF9, BAF10, BAF20, BAF21, BAF30, BAF31, BAF32 |

Do you recommend a new entry to the BAF is made as a result of this report? No

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

<table>
<thead>
<tr>
<th>Impact on equality and diversity</th>
<th>YES/NO</th>
<th>If YES, EIA Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Impact Assessment (EIA) Completed?</td>
<td>YES/NO</td>
<td>If YES, EIA Score</td>
</tr>
</tbody>
</table>

### Acronyms/Terms Used in the Report

<table>
<thead>
<tr>
<th>Acronym/Phrase</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td>Average Length Of Stay</td>
</tr>
<tr>
<td>AWoL</td>
<td>Absent without Leave</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CHS</td>
<td>Community Health Services</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CRHT</td>
<td>Crisis Resolution Home Treatment Team</td>
</tr>
<tr>
<td>CWP</td>
<td>Connecting with People</td>
</tr>
<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
</tr>
<tr>
<td>FEP</td>
<td>First Episode of Psychosis</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>RWB</td>
<td>Recovery &amp; Well-Being Team</td>
</tr>
<tr>
<td>FRT</td>
<td>First Response Team</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS improvement</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed days</td>
</tr>
<tr>
<td>OT</td>
<td>Outturn</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
<tr>
<td>PHSO</td>
<td>Public Health Service Ombudsman</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>RAG</td>
<td>Red-Amber-Green</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment</td>
</tr>
</tbody>
</table>

### Supporting Documents and/or Further Reading

Board Integrated Quality & Performance report

### Lead

Name: Sally Morris  
Job Title: Chief Executive
**Use of Hyperlinks**
Hyperlinks have been added to this report to enable electronic navigation. Hyperlinks are highlighted with an underscore (usually blue or purple colour text), when a hyperlink is clicked on, the report moves to the detailed section. The back button can also be used to return to the previous place in the document.

**How is data presented?**
Data is presented in a range of different charts and graphs which can tell you a lot about how our Trust is performing over time. The main chart used for data analysis is a Statistical Process Chart (SPC) which helps to identify trends in performance a highlight areas for potential improvement. Each chart uses symbols to highlight findings and following analysis of each indicator an assurance RAG (Red, Amber, Green) rating is applied, please see key below:

<table>
<thead>
<tr>
<th>Statistical Process Control (Trend Identification)</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Cause – no significant change</td>
<td>Variation indicates consistently falling short of the target</td>
</tr>
<tr>
<td>Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ower values</td>
<td>Variation indicators consistently (P)assing the target</td>
</tr>
<tr>
<td>Special Cause of improving nature of lower pressure due to (H)igher or (L)ower values</td>
<td>Variation indicates inconsistently hitting and passing and falling short of the target</td>
</tr>
<tr>
<td>Variation indicates inconsistently hitting and passing and falling short of the target</td>
<td>Variation indicates consistently (F)alling short of the target</td>
</tr>
<tr>
<td>ASSURANCE (HOW ARE WE DOING?)</td>
<td></td>
</tr>
<tr>
<td>Meeting Target</td>
<td></td>
</tr>
<tr>
<td>EPUT is achieving the standard set and performing above target/benchmark</td>
<td></td>
</tr>
<tr>
<td>Emerging Risk</td>
<td></td>
</tr>
<tr>
<td>EPUT is performing under target in current month/ Emerging Trend</td>
<td></td>
</tr>
<tr>
<td>Hot Spot</td>
<td></td>
</tr>
<tr>
<td>EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL</td>
<td></td>
</tr>
<tr>
<td>Variance</td>
<td></td>
</tr>
<tr>
<td>Trust local indicators which are at variance as a whole or have single areas at variance at variance against national position</td>
<td></td>
</tr>
<tr>
<td>For Note</td>
<td></td>
</tr>
<tr>
<td>These indicate data not currently available, a new indicator or no target/benchmark is set</td>
<td></td>
</tr>
<tr>
<td>Trend</td>
<td></td>
</tr>
<tr>
<td>Depicts current trend and colour coded accordingly</td>
<td></td>
</tr>
</tbody>
</table>
## Summary of Quality and Performance Indicators (Pg 6)

### December Hotspots
- Timeliness of Data Entry - MH Mobius (Pg 6)
- CPA 12 Month Reviews (Pg 7)
- Cardio Metabolic Assessment (Pg 8)
- MH RTT (Pg 9)
- Inpatient Capacity (Adults) (Pg 10)
- Readmissions (Pg 11)
- Out of Area Placements (Pg 11)
- CQC Actions (Pg 12)
- Agency Cap (Pg 12)

## Summary of Oversight Framework Indicators (Pg 13)

### December Hotspots
- Out of Area Placements (Pg 23)

## Summary of CQC Indicators (Pg 27)

### December Hotspots
- Overarching Actions - 8 CQC Must Do and Should do actions are past timescale at the end of December 2019
- 2 CQC Must Do actions are past timescale at the end of December 2019
- 2 CQC Should Do actions are past timescale at the end of December

## Summary of Safer Staffing Indicators (Pg 28)

### December Hotspots
- No hots identified. Please note two new emerging risks identified in Safer Staffing.

## Summary of Quality Account Indicators (Pg 34)

### December Hotspots
- Four actions are past timescale:
  - Development of dashboard for all quality priorities (Patient Safety Incident Management System).
  - Implementation of procedure guideline for Delirium.
  - Review of Self Harm Policy
  - Dashboard against all quality priorities.

## Finance Summary (Pg 43)

### December Hotspots
- Slippage against cost improvement programmes
## SECTION 2 - EPUT Quality and Performance Reporting Hot Spots Scorecard

For Note:
- **1.2.1 Serious Incidents** – MH EPUT set an ambition to have a reduction in SIs in 2019/20 compared to 2018/19. As at month 9 the forecast year end position is 20% below 18/19 OT. In December 2019 there were 10 SI’s reported by MH and Specialist services, 2 Serious / Self Harm (Recovery Wellbeing CPR and Cedar Ward) and 8 Unexpected deaths and there have been 65 SIs year to date.
- **1.2.2 SIs – CHS EPUT** set an ambition to have a reduction in SIs in 2019/20 compared to 2018/19. There were 4 SIs in CHS in 18/19 and have been 5 SIs in CHS in 19/20 (all SIs were in West Essex CHS services and were patient accident (Fall/Fracture) x4 and unexpected death x1). In December 2019 there were no SIs in CHS.

*RD = Anticipated Recovery Date*

<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
</tr>
<tr>
<td>2.2.2 Timeliness of Data Entry</td>
<td>95% of patient activity will be captured on local systems within 1 day (Mental Health Mobius EPR)</td>
<td>87.8%</td>
<td>●</td>
<td>Inconsistently achieving Target</td>
<td>No Change</td>
</tr>
</tbody>
</table>

**Lead Committee**: Finance & Performance

---

**Click here to return to Summary**
### Hot Spot

#### Ambition / Indicator

<table>
<thead>
<tr>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
</table>
| Perf     | RAG   |         | CPA review has been highlighted as a hot spot as there is a declining trend and compliance is below 95% target at 90.6% for December 2019. There were 5 Teams in the South, 2 Teams in Mid, 7 Teams in NE and 3 Teams in West below target. Latest nationally published figures are showing EPUT below target at 87%.
| Inconsistently meeting target | Deteriorating Trend |       | The Operational Productivity Team is working with teams to increase performance. |

#### Hot Spot

| 2.4 CPA Review within 12 months |

>95% of patients on CPA will have a review CPA review within 12 months

**Lead Committee:** Quality

---

**Click here to return to Summary**
People with psychosis receive an annual Cardio Metabolic Assessment
90% of Inpatients
90% People with First Episode Psychosis
65% of people seen in the community (in our care less than 1 year)

It should be noted that the indicator construct has been re-developed to meet national technical guidance. Currently there are 6 parts which make up a full cardio metabolic assessment. The technical guidance is clear that undertaking of cardio metabolic assessments is the responsible of primary care services except for inpatients and people within the first 12 months of secondary MH care.

Technical guideline does not give a target for secondary MH providers but sets an overall target of 60% of people on the GP SMI register. Local targets have been set using those previously issued in the NHSI Oversight Framework (although this has now been removed.

Chart Key
- Red line = local set target
- Grey line = % with a physical health check
- Orange line = % with full parts 1-6 assessment completed

*Please note figure in brackets shows % of people with some part of a cardio metabolic assessment completed but not all 1-6 parts or a physical health assessment completed in a format which the system cannot identify the 1-6 parts have been completed.
<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
</tr>
<tr>
<td>2.11</td>
<td>Referral to Treatment</td>
<td>80.8%</td>
<td><img src="image" alt="Inconsistently meeting target icon" /></td>
<td><img src="image" alt="Deteriorating Trend icon" /></td>
<td></td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral to Treatment - MH Crisis South Essex starting 01/04/18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>Crises RTT</td>
<td>Process limits - 3σ</td>
<td>Special cause - concern</td>
</tr>
<tr>
<td>Crisis MH Referrals seen within 24 hours (South Essex MH Services) is seeing a declining trend and performance for month 9 is below the 95% target at 80.8%.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90.9%</td>
<td><img src="image" alt="Consistently failing target icon" /></td>
<td><img src="image" alt="No change icon" /></td>
<td></td>
</tr>
<tr>
<td>Routine MH Referrals seen within 28 days (Mid, West and NE Essex) remains consistently failing target. This is due to receiving cluster 1-3/IAPT referrals which is affecting the waiting lists and discussions are underway with commissioners as to how this cohort of patients is addressed.</td>
<td></td>
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<td></td>
<td>Jan 19</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Click here to return to Summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.13 Inpatient Capacity MH Adults

**Ambition / Indicator:**
- Adult ALOS and DTOC Rates will be in line with NHS benchmarking
- ALOS 31.2 days DTOC 5%

<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf RAG</td>
<td>Assurance Variation</td>
<td>ALOS Adults is showing a Special Cause of concerning nature with sustained increase in ALOS since October 2019.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>56.6</td>
<td>Consistently failing target Increasing Trend</td>
<td>It should be noted that some variation is expected against national benchmark as EPUT has assessment units which are excluded in monthly figures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ALOS - Adult MH on Discharge-Mental Health Services starting 01/12/17</td>
<td>Latest national data from MH Benchmarking 2018 reported EPUT having ALOS of 38.6 (Inc Assessment Unit) which was above national average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jan 20</td>
</tr>
</tbody>
</table>

|          |                      | 9.51% | Consistently failing target Increasing Trend | DTOC Adults is showing a special Cause of concerning nature with sustained increase |
|          |                      |     | ALOS - Adult MH on Discharge-Mental Health Services starting 01/12/17 | Latest national data from MH Benchmarking 2018 reported EPUT having 3.5% DTOC rate which was below national average |
|          |                      |     |     |      |

**Lead Committee:** Quality

[Click here to return to Summary]
### 2.16 Readmission Rates

**Lead Committee:** Quality

**EPUT readmission rate for Older adults will be in line with national benchmark of 3.1%**

<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>Assurance</td>
<td>Variation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.5%</td>
<td>Inconsistently meeting target</td>
<td>SCV - Increasing Trend</td>
<td></td>
</tr>
</tbody>
</table>

### 4.4 Out of Area Placements

**Lead Committee:** Quality

**Continued reduction in Out of Area Bed days to 0 by 2020/21**

<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>Assurance</td>
<td>Variation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>447 OBDs</td>
<td>Inconsistently meeting target</td>
<td>SCV - Increasing Trend</td>
<td></td>
</tr>
</tbody>
</table>
### Hot Spot

<table>
<thead>
<tr>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = Good)</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1 CQC Action Plans</strong></td>
<td>276</td>
<td>Consistently failing target</td>
<td>N/A</td>
<td>Lead Committee: Finance and Performance</td>
</tr>
<tr>
<td>All CQC Action Plans will be completed within timescales set</td>
<td></td>
<td>SCV - Improving Trend</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5.7 Use of Agency</strong></td>
<td>25</td>
<td></td>
<td>N/A</td>
<td>Lead Committee: Finance and Performance</td>
</tr>
<tr>
<td>0 Agency Cap breaches</td>
<td></td>
<td>SCV - Improving Trend</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5.1 CQC Action Plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are currently 12 actions past timescale, please see separate CQC Dashboard for details (Pg 27)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**SECTION 3 – Oversight Framework**

**Summary**
Please note the national Oversight Framework was revised in August 2019. Not all indicators have been issued with a target. Where there is a national target or benchmark this has been used to assess if potentially an emerging risk (colour coded Amber) or risk (colour coded red). The Oversight Framework highlighted that an indicator will be a cause for concern only if below targets set for 2 months therefore indicators have only been indicated as a risk if below for 2 months.

<table>
<thead>
<tr>
<th>Hot Spot</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.4 Out of Area Placements</strong></td>
<td>Continued reduction in Out of Area Bed days to 0 by 2020/21</td>
<td>447 OBDs</td>
<td>Inconsistently meeting target</td>
<td>Increasing Trend</td>
<td>Out of Area Placements has been highlighted as a hot spot due to trend Special Cause of concerning nature with an increasing number of OOA placement Occupied Bed Days. In December EPUT placed 13 new clients out of Area and 10 remained OOA from previous months. The total Occupied bed days for all out of area placements was 447. Reduction in OOA Placements is part of the MHSI Oversight Framework and EPUT set a trajectory of less than 194 OBDs per month to achieve the required reduction Nationally EPUT is reporting an increase in OOA occupied bed days</td>
<td><a href="https://example.com">Chart</a></td>
</tr>
</tbody>
</table>
## OVERSIGHT FRAMEWORK (Quality of Care and Outcomes)

<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>CQC Rating</td>
<td>Good</td>
<td>●</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CQC rating of Good or above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achieved overall “Good” with Outstanding for Caring Oct 2019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>4.1</td>
<td>Written Complaint Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(no target set)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaint rates are currently not reportable due to National ESR reporting problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>5.6</td>
<td>Staff FFT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(no target set)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>The FFT survey is not reported in Q3 whilst the NHS Staff Survey is taking place</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>1.1</td>
<td>Occurrence of a Never Event in last 6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(no target set)</td>
<td>0</td>
<td>●</td>
<td>0 in last 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAG</td>
<td>Ambition / Indicator</td>
<td>Position</td>
<td>Trend</td>
<td>Nat RAG</td>
<td>Narrative</td>
<td>RD*</td>
</tr>
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<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>5.1 CQC Rating</td>
<td><strong>Patient Safety Alerts not completed by deadline</strong> (no target set)</td>
<td>0</td>
<td>● 0 in last 12 months</td>
<td></td>
<td>Monitoring is looking over 12-month rolling period</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient Survey MH</td>
<td><strong>CQC community mental health survey</strong> (no target set)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>3.3.2 Patient FFT CHS</td>
<td><strong>Community scores from Friends and Family Test – % positive</strong> (extremely likely or likely to recommend) (no target set)</td>
<td>94%</td>
<td><img src="image" alt="Inconsistently meeting target" /> <img src="image" alt="No Change" /></td>
<td></td>
<td>National average is 96%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Click here to return to Summary**
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
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<th>RD*</th>
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<td></td>
</tr>
<tr>
<td>3.3.1 Patient FFT MH</td>
<td>Mental health scores from Friends and Family Test – % positive (extremely likely or likely to recommend) (no target set)</td>
<td>89%</td>
<td>Inconsistently meeting target</td>
<td>Increasing Trend</td>
<td>National average 88.3%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3.3.1 Patient FFT MH</td>
<td>Admissions to adult facilities of patients under 16 years old (No target set)</td>
<td>1</td>
<td>1 YTD</td>
<td></td>
<td>1 under 16 placed on Fuji ward due to lack of ben availability for 1 night in December 2019</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.8 7 Day Follow Up</td>
<td>95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital</td>
<td>96.6%</td>
<td>Inconsistently meeting target</td>
<td>Increasing Trend</td>
<td>There was a change in construct to match national constructs in 18/19, this caused EPUT figures to fall below target. An Action Plan was put in place to recovery this for April 2019. Plan complete and recovery sustained for nine months. In December six patients were not followed up within 7 days. National reporting via MHSDS Q3 EPUT achieved 92.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>RAG</td>
<td>Ambition / Indicator</td>
<td>Position</td>
<td>Trend</td>
<td>Nat RAG</td>
<td>Narrative</td>
<td>RD*</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>2.9 Settled Accommodation</td>
<td>69.5%</td>
<td>Inconsistently meeting target</td>
<td>No Change</td>
<td>EPUT Local Authorities monitor this indicator and have set a 70% target. EPUT has remained just below the Local Authority target of 70% since August 2019. Performance remains inconsistent and no significant change has occurred. CQC Insight Report published in May 2019 reported EPUT at 31% against England Average of 59%. This variation in being investigated</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>% clients in settled accommodation</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>(no target set)</td>
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<tr>
<td></td>
<td>% clients in settled accommodation</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>(no target set)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% clients in employment</td>
<td>36.4%</td>
<td>Consistently above target</td>
<td>Deteriorating Trend</td>
<td>EPUT Local Authorities monitor this indicator and have set a 7% target. CQC Insight Report published in May 2019 reported EPUT at 24% against England Average of 9%.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>% clients in employment (no target set)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% clients in employment (no target set)</td>
<td></td>
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<tr>
<td>RAG</td>
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<td>Position</td>
<td>Trend</td>
<td>Nat RAG</td>
<td>Narrative</td>
<td>RD*</td>
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<td>---------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>Potential under-reporting of patient safety incidents</td>
<td>44.6</td>
<td>●</td>
<td>●</td>
<td>MH benchmark &gt;44.3</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>There are a number of reasons why Trust reporting rates can be at variance:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Delays in incident sign off by managers. As at 6th January 2020 there are 715 incidents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>awaiting manager approval/sign off, 445 of which are overdue.</td>
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<tr>
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<td></td>
<td></td>
<td>• Staff do not always correctly categorise incidents as patient safety incidents.</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>The Trust Risk Management team undertake 6 monthly auditing of incident reporting to ensure</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>all Patient Safety incidents have been recorded as such on the Datix system.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>CQC Insight Report April 2019: Reported EPUT rate of 27.8 (Dec 17 – Nov 18) against national</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>average of 34.8 and median time taken to report incidents for EPUT was 55 days (National</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average 22 days).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.14 U16 Admissions</td>
<td>1</td>
<td>●</td>
<td>1 Year to date</td>
<td>There was one admission of a person under 16 to Fuji Ward in December 2019 due to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admissions to adult facilities of patients under 16 years old</td>
<td></td>
<td></td>
<td></td>
<td>unavailability of appropriate bed.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Please note this indicator is using the MHSDS definition and therefore includes all</td>
<td></td>
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<tr>
<td></td>
<td>wards with the exception of Byron Court and CAMHS.</td>
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</tr>
</tbody>
</table>

Click here to return to Summary
## OVERSIGHT FRAMEWORK (Operational Metrics)

<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Performance</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SE CHS 97.7%</td>
<td>Consistently above target</td>
<td>No change</td>
<td>Consistently above target</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WE CHS 95.0%</td>
<td>Inconsistently meeting target</td>
<td>Increasing Trend</td>
<td>Recovery achieved with increasing trend and 7 months above target.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**SB CHS RTT**

Maximum time of 18 weeks from point of referral to treatment (CHS) Target 92%
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>F.E.P</td>
<td>Perf</td>
<td>88%</td>
<td>✔️</td>
<td>Consistently above target</td>
<td>No Trend</td>
</tr>
<tr>
<td></td>
<td>56% of people with a first episode of psychosis (FEP) begin treatment with a NICE-recommended care package within two weeks of referral</td>
<td>RAG</td>
<td></td>
<td></td>
<td>EPUT is meeting target for December 19. Three clients breached in December, one in Castlepoint &amp; Rochford, and two in Southend. Validation has been undertaken and identified one patient is incorrectly showing as a breach due to a recording error and this is being corrected. One patient was a transfer from another EIP service and work is underway to see how this can be reported in MHSDS as a transfer. National reported data via MHSDS July 2019 for Mid and South STP 100% achieved.</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assurance</td>
<td></td>
<td></td>
<td>Trend above Target = Good</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Variation</td>
<td></td>
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<td></td>
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<td>Nat</td>
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<tr>
<td></td>
<td></td>
<td>RAG</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2.3</td>
<td>DQMI</td>
<td>Perf</td>
<td>94.7%</td>
<td>✔️</td>
<td>Not enough data points to analyse trend</td>
<td>Reduction in compliance due to new requirements added for Q4 18/19. Action plan has been developed and is currently being implemented. Due to national data being published in arrears latest figures are for September 2019. Internal forecast shows continued improvement. Compliance with DQMI Q2,3 and 4 is also a CQUIN with payment starting at 90% and achieving full payment at 95%</td>
</tr>
<tr>
<td></td>
<td>Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95%</td>
<td>RAG</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>RAG</td>
<td>Ambition / Indicator</td>
<td>Position</td>
<td>Trend</td>
<td>Nat RAG</td>
<td>Narrative</td>
<td>RD*</td>
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<tr>
<td></td>
<td>Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery</td>
<td></td>
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<table>
<thead>
<tr>
<th>RAG</th>
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<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>54.6%</td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consistently meeting target</td>
<td>No change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trend above target = Good**

**IAPT - Recovery Rates - CPR starting 01/12/17**

- Mean
- % Moving to Recovery
- Process limits - 3σ
- Special cause - concern
- Special cause - improvement
- Target

- Peak seen in Feb 19 due to data upload when changing to IAPTUS system
- MHSDS September 19: CPR 53.3% / SOS 51.4%

<table>
<thead>
<tr>
<th>SOS</th>
<th>52.4%</th>
<th>Perf</th>
<th>RAG</th>
<th>Assurance</th>
<th>Variation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consistently meeting target</td>
<td>No change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trend above target = Good**

**IAPT - Recovery Rates - SOS starting 01/12/17**

- Mean
- % Moving to Recovery
- Process limits - 3σ
- Special cause - concern
- Special cause - improvement
- Target

- Peak seen in Feb 19 due to data upload when changing to IAPTUS system
- MHSDS September 19: CPR 53.3% / SOS 51.4%
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improving Access to Psychological Therapies (IAPT)/talking therapies</td>
<td></td>
<td></td>
<td></td>
<td>2.18 IAPT Waiting Times</td>
</tr>
<tr>
<td></td>
<td>b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks</td>
<td></td>
<td></td>
<td></td>
<td>Please note reporting on all IAPT indicators is via National figures until the most recent publication. Figures until September 2019 are National with those after this coming from our Trust internal system.</td>
</tr>
</tbody>
</table>

**2.18 IAPT Waiting Times**

**Improving Access to Psychological Therapies (IAPT)/talking therapies**

b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks

<table>
<thead>
<tr>
<th>Trend</th>
<th>Natural RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend above target = Good</td>
<td>99%</td>
</tr>
<tr>
<td>Consistently meeting target</td>
<td>No change</td>
</tr>
</tbody>
</table>

Waiting Times (seen within 6 weeks) - IAPT starting 01/12/17

**100%**

Consistently meeting target

Trend above target = Good

Waiting Times (seen within 18 weeks) - IAPT starting 01/12/17

Consistently meeting target

No change
### 4.4 Out of Area Placements

Continued reduction in Out of Area Bed days to 0 by 2020/21

**Lead Committee:** Quality

<table>
<thead>
<tr>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>447 OBDs</td>
<td></td>
<td>Inconsistently meeting target</td>
</tr>
</tbody>
</table>

Out of Area Placements has been highlighted as a hot spot due to trend Special Cause of concerning nature with an increasing number of OOA placement Occupied Bed Days.

In December EPUT placed 13 new clients out of Area and 10 remained OOA from previous months. The total Occupied bed days for all out of area placements was 447.

Reduction in OOA Placements is part of the MHSI Oversight Framework and EPUT set a trajectory of less than 194 OBDs per month to achieve the required reduction.

Nationally EPUT is reporting an increase in OOA occupied bed days.
### OVERSIGHT FRAMEWORK (Leadership and Workforce)

<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.1 Staff Sickness</td>
<td>Staff Sickness Rates (no target set)</td>
<td>Staff sickness - Trustwide starting 01/04/18</td>
<td><img src="image" alt="Trend below target = good" /></td>
<td><img src="image" alt="Inconsistently meeting target" /> <img src="image" alt="No change" /></td>
<td><img src="image" alt="Internal target set at 5% based on MH benchmark of 6%" /></td>
</tr>
<tr>
<td></td>
<td>3.2 Turnover</td>
<td>Staff turnover rates (no target set)</td>
<td><img src="image" alt="Inconsistently meeting target" /> <img src="image" alt="Decreasing Trend" /></td>
<td><img src="image" alt="Internal target set of 12% based on benchmark" /></td>
<td><img src="image" alt="SPC analysis shows recent special cause variation of improving nature noted with 16 points below mean from Sep 18 to Dec 19. Variation also indicates inconsistently hitting and missing target" /></td>
<td><img src="image" alt="There has been no significant change in turnover at 11.1% in December (12.1% in November) and due to the variance each month we cannot expect to consistently meet the target" /></td>
</tr>
<tr>
<td>RAG</td>
<td>Ambition / Indicator</td>
<td>Position</td>
<td>Trend (below target = good)</td>
<td>Nat RAG</td>
<td>Narrative</td>
<td>RD*</td>
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<tr>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
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<td></td>
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<tr>
<td>3.2%</td>
<td>-</td>
<td>Consistently failing target</td>
<td>Decreasing Trend</td>
<td></td>
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</tr>
</tbody>
</table>

**Proportion of temporary staff Agency staff costs (no target set)**

![Chart showing trend of temporary staff costs]

**Place to Work of Receive Treatment**

**Recommendation of the organisation as a place to work or receive treatment**

<table>
<thead>
<tr>
<th>Staff Survey 2018</th>
<th>EPUT</th>
<th>Average</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>C21a Care of patients / Service users is my organisations top priority</td>
<td>72.7%</td>
<td>73.6%</td>
<td>In line with average</td>
</tr>
<tr>
<td>C21c I would recommend my organisation as a place to work</td>
<td>59.2%</td>
<td>59%</td>
<td>In line with average</td>
</tr>
<tr>
<td>C21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation</td>
<td>60.1%</td>
<td>66.2%</td>
<td>Below average</td>
</tr>
</tbody>
</table>

**Support and compassion Average rating of:**

- % experiencing harassment, bullying or abuse from staff in the last 12 months
- % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
- % not experiencing harassment, bullying or abuse at work from managers in the last 12 months

<table>
<thead>
<tr>
<th>Staff Survey 2018</th>
<th>EPUT</th>
<th>Average</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Environment – Bullying &amp; Harassment (high is better)</td>
<td>7.9</td>
<td>8.2</td>
<td>Below Average</td>
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<td>Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)</td>
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<td>Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)</td>
<td>18.4%</td>
<td>16.3%</td>
<td>Above Average</td>
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</table>

Positive reduction can be seen from March 19.
<table>
<thead>
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<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Nat RAG</th>
<th>Narrative</th>
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<tbody>
<tr>
<td></td>
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<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
</tr>
<tr>
<td>5.5 Staff Survey</td>
<td>Team Work</td>
<td>Teamwork Average of:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>% agreeing that their team has a set of shared objectives</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>% agreeing that their team often meets to discuss the team’s effectiveness</td>
<td></td>
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<tr>
<td></td>
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<td><strong>Staff Survey 2018</strong></td>
<td><strong>EPUT</strong></td>
<td><strong>Average</strong></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Q4h The Team I work in has a set of shared objectives</td>
<td>74.2%</td>
<td>74.2%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Q4i The Team I work in often meets to discuss the team’s effectiveness</td>
<td>67.7%</td>
<td>69.3%</td>
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<tr>
<td></td>
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<td>Trusts in lowest third across the sector will represent a concern</td>
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<tr>
<td>5.5 Staff Survey</td>
<td>Inclusion</td>
<td>Inclusion (1) Average of</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>% staff believing the trust provides equal opportunities for career progression or promotion</td>
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<td></td>
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<td></td>
<td>% experiencing discrimination from their manager/team leader or other colleagues in the last 12 months</td>
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<tr>
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<td></td>
<td><strong>Staff Survey 2018</strong></td>
<td><strong>EPUT</strong></td>
<td><strong>Average</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td>
<td>83.1%</td>
<td>85.8%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months</td>
<td>9.5%</td>
<td>6.6%</td>
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<td>Trusts in lowest third across the sector will represent a concern</td>
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<td></td>
<td>Inclusion (2)</td>
<td>The BME leadership ambition (WRES) re executive appointments.</td>
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<tr>
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<td>Trusts in lowest third across the sector will represent a concern</td>
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<tr>
<td></td>
<td></td>
<td>New Indicator – under development</td>
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[Click here to return to summary page]
### SECTION 4: Care Quality Commission Inspection (2018)

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<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend (below target = good)</th>
<th>Narrative</th>
</tr>
</thead>
</table>
| **CQC Overarching Actions** |                      | There will be 0 CQC Overarching Must Do and Should Do actions past timescale | ![Overarching Achieved](chart) | 8 CQC Must Do and Should do actions are past timescale at the end of December 2019, which are identified below:  
  • M1. S1. S2. The trust must review their governance arrangements for ligature risk assessment and management - 2 Actions  
  • M6. S5. S6. The Trust must review their governance arrangements to ensure actions identified from incident investigations are applied consistently across wards.  
  • M7. The Trust must ensure that they eliminate mixed-sex accommodation on Henneage Ward to uphold patients’ privacy and dignity.  
  • M10. Staff must record when they spoke to informal patients about their rights.  
  • S8. The Trust should review the efficiency of its data systems. |
| **CQC Must do Actions**   |                      | There will be 0 CQC Must Do actions past timescale | ![Must Do Achieved](chart)  | 2 CQC Must Do actions are past timescale at the end of December 2019, which are identified below:  
  • M15. The provider must ensure patients have access to appropriate psychological therapies.  
  • M13. The Trust must review their staff recruitment and retention processes for acute mental health wards and psychiatric intensive care units. |
| **CQC Should do Actions** |                      | There will be 0 CQC Should Do actions past timescale | ![Should Do Achieved](chart) | 2 CQC Should Do actions are past timescale at the end of December 2019, which are identified below:  
  • S11. The Trust should improve the way they get feedback from patients and carers and involve them in the development of the ward.  
  • S12. The Trust should review their systems for ensuring staff complete regular checks of patients’ physical health. |
## SECTION 5 – Safer Staffing Summary

<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Perf</td>
<td>RAG</td>
<td>Assurance</td>
<td>Variation</td>
</tr>
</tbody>
</table>
| Day Qualified Staff | Day Qualified Staff | ≥90% of expected day time shifts filled. | 96.4% | Consistently meeting target | No change | The following wards were below target in December:  
Adult: Ardleigh, Basildon MHAU, Finchingfield, Hadleigh & Peter Bruff  
Specialist: Dune  
Older Adult: Beech (Rochford), Topaz & Tower  
Nursing Homes: Clifton Lodge & Rawreth Court  
Learning Disabilities: Heath Close |
|     |                       | Trend above target = good |     |          |           | |

Day Qualified Staff

Day Unqualified Staff

We will achieve ≥90% of expected day time shifts filled.

124%  
Consistently meeting target  
SCV – Increasing Trend  
Trend above target = good  
The following ward was below target in December:  
Adult: Peter Bruff  
Older Adult: Beech (Rochford)  
Rehabilitation: Ipswich Road
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Night Qualified Staff</td>
<td>Night Qualified Staff  We will achieve &gt;90% of expected night time shifts filled</td>
<td>95.6%</td>
<td>Consistently meeting target</td>
<td>No change</td>
<td></td>
<td>N/A</td>
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<tr>
<td>Night Unqualified Staff</td>
<td>Night Unqualified Staff  We will achieve &gt;90% of expected night time shifts filled</td>
<td>145%</td>
<td>Consistently meeting target</td>
<td>SCV – Increasing Trend</td>
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<td>N/A</td>
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</table>

The following wards were below target in December: Older Adult: Beech (Rochford), Henneage, Kitwood, Meadowview, Topaz and Tower Nursing Homes: Rawreth Court

The following ward was below target in December: Adult: Stort
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
<th>Nat RAG</th>
<th>Narrative</th>
<th>RD*</th>
</tr>
</thead>
<tbody>
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<td>Fill Rate</td>
<td>&lt;20 wards will have fill rates below 90%</td>
<td>17</td>
<td>Inconsistently meeting target</td>
<td>No change</td>
<td>This indicator is highlighted as an emerging risk as it is under review to consider the appropriateness of the target.</td>
<td>N/A</td>
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<tr>
<td>Shifts Unfilled</td>
<td>&lt;20 wards will have more than 10 days with shifts unfilled</td>
<td>12</td>
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<td>SCV - Decreasing Trend</td>
<td>This indicator is highlighted as an emerging risk as it is under review to consider the appropriateness of the target.</td>
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<td>Ward Name</td>
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<td>Staff in Post (WTE)</td>
<td>Occupancy Rate (Excluding Leave)</td>
<td>% Bank Use</td>
<td>% Agency Use</td>
</tr>
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<td>For</td>
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<td><strong>TARGET</strong></td>
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<td>Info</td>
<td>Info</td>
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<td><strong>EPUT Inpatient Total</strong></td>
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<td>-</td>
<td>-</td>
<td>87%</td>
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<td>-</td>
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<td>22.9%</td>
<td>15.4%</td>
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<td>Dune</td>
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<td>Forest</td>
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<td><strong>MH Mother &amp; Baby</strong></td>
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<td>16.2%</td>
<td>9.3%</td>
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</tbody>
</table>

Click here to return to Summary
## Inpatient Unit Quality and Safer Staffing Scorecard

**December 2019**

Please note due to National ESR problems we are currently unable to report Vacancy or Establishment, therefore overall scores cannot be calculated.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total Beds</th>
<th>Funded Establishment</th>
<th>Staff in Post (WTE)</th>
<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Day Fill Rate Care Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
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<tr>
<td>WEIGHTING</td>
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<td></td>
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</tr>
<tr>
<td>For</td>
<td>For</td>
<td>For</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
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<td></td>
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<td>TARGET</td>
<td>Info</td>
<td>Info</td>
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<td>Info</td>
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<td>≤5%</td>
<td>≥90%</td>
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<tr>
<td>EPUT Inpatient Total</td>
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<td>-</td>
<td>-</td>
<td>87%</td>
<td>32.7%</td>
<td>9.2%</td>
<td>96.4%</td>
<td>124.0%</td>
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<td>145.0%</td>
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### MH Adult Acute

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<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Day Fill Rate Care Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
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<td>Ardeleigh Ward</td>
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<td>-</td>
<td>-</td>
<td>96%</td>
<td>41.9%</td>
<td>6.1%</td>
<td>77.4%</td>
<td>175.6%</td>
<td>164.5%</td>
<td>140.3%</td>
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<td>26.0%</td>
<td>106.5%</td>
<td>191.9%</td>
<td>143.5%</td>
<td>258.1%</td>
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<td>-</td>
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<td>148.4%</td>
<td>100.0%</td>
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<td>93.5%</td>
<td>145.2%</td>
<td>93.5%</td>
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<td>16.0%</td>
<td>109.7%</td>
<td>165.6%</td>
<td>100.0%</td>
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<td>64.8%</td>
<td>14.6%</td>
<td>93.5%</td>
<td>156.5%</td>
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<td>22.1%</td>
<td>18.9%</td>
<td>108.1%</td>
<td>108.1%</td>
<td>203.2%</td>
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<td>53.8%</td>
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<td>93.5%</td>
<td>144.1%</td>
<td>98.4%</td>
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### MH Older Adult

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<th>Staff in Post (WTE)</th>
<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Day Fill Rate Care Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beech (Rochford)</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>90%</td>
<td>45.3%</td>
<td>0.7%</td>
<td>88.7%</td>
<td>87.9%</td>
<td>88.7%</td>
<td>114.5%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bernard Ward</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td>78%</td>
<td>20.8%</td>
<td>20.5%</td>
<td>90.3%</td>
<td>140.3%</td>
<td>132.3%</td>
<td>156.5%</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Gloucester</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>81%</td>
<td>34.4%</td>
<td>0.9%</td>
<td>98.8%</td>
<td>114.0%</td>
<td>96.8%</td>
<td>150.0%</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Henneage Ward</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>99%</td>
<td>18.9%</td>
<td>16.5%</td>
<td>91.9%</td>
<td>153.2%</td>
<td>53.2%</td>
<td>351.6%</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Kitwood Unit</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>104%</td>
<td>38.5%</td>
<td>0.0%</td>
<td>103.2%</td>
<td>141.9%</td>
<td>50.0%</td>
<td>300.0%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Meadowview</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>67%</td>
<td>40.6%</td>
<td>0.0%</td>
<td>90.3%</td>
<td>126.9%</td>
<td>85.5%</td>
<td>154.8%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Roding Ward</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td>103%</td>
<td>22.5%</td>
<td>1.9%</td>
<td>106.5%</td>
<td>111.3%</td>
<td>100.0%</td>
<td>111.3%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ruby Ward</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>100%</td>
<td>38.7%</td>
<td>13.3%</td>
<td>98.9%</td>
<td>158.1%</td>
<td>103.2%</td>
<td>162.9%</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Tepoz Ward</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>27%</td>
<td>45.2%</td>
<td>16.0%</td>
<td>50.0%</td>
<td>143.5%</td>
<td>50.0%</td>
<td>209.7%</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Tower Ward</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>62%</td>
<td>22.9%</td>
<td>2.4%</td>
<td>85.5%</td>
<td>124.2%</td>
<td>54.8%</td>
<td>193.5%</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### MH PICU

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total Beds</th>
<th>Funded Establishment</th>
<th>Staff in Post (WTE)</th>
<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Day Fill Rate Care Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Unit</td>
<td>10</td>
<td>-</td>
<td>-</td>
<td>79%</td>
<td>28.1%</td>
<td>22.6%</td>
<td>91.9%</td>
<td>146.2%</td>
<td>98.4%</td>
<td>135.5%</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hadleigh Unit</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>96%</td>
<td>52.2%</td>
<td>4.1%</td>
<td>87.1%</td>
<td>155.6%</td>
<td>98.4%</td>
<td>256.5%</td>
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<td>32</td>
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</table>

### MH Rehab

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total Beds</th>
<th>Funded Establishment</th>
<th>Staff in Post (WTE)</th>
<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Day Fill Rate Care Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich Road</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>82%</td>
<td>23.5%</td>
<td>0.6%</td>
<td>112.9%</td>
<td>82.3%</td>
<td>93.5%</td>
<td>196.8%</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

[Click here to return to Summary]
Inpatient Unit Quality and Safer Staffing Scorecard  
December 2019

Please note due to National ESR problems we are currently unable to report Vacancy or Establishment, therefore overall scores cannot be calculated.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total Beds</th>
<th>Funded Establishment</th>
<th>Staff in Post (WTE)</th>
<th>Occupancy Rate (Excluding Leave)</th>
<th>% Bank Use</th>
<th>% Agency Use</th>
<th>Day Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Registered Nursing Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Night Fill Rate Care Staff</th>
<th>Current Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHTING</td>
<td>For</td>
<td>For</td>
<td>For</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>For</td>
<td></td>
</tr>
<tr>
<td>TARGET</td>
<td>Info</td>
<td>Info</td>
<td>Info</td>
<td>&lt;=85%</td>
<td>&lt;=30%</td>
<td>&lt;=0%</td>
<td>&gt;=90%</td>
<td>&gt;=90%</td>
<td>&gt;=90%</td>
<td>&gt;=90%</td>
<td>Info</td>
<td></td>
</tr>
<tr>
<td>EPUT Inpatient Total</td>
<td>827</td>
<td>-</td>
<td>-</td>
<td>87%</td>
<td>32.7%</td>
<td>9.2%</td>
<td>96.4%</td>
<td>124.0%</td>
<td>95.6%</td>
<td>145.0%</td>
<td>15</td>
<td>223</td>
</tr>
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<td>817</td>
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<td>1813</td>
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<td>1957</td>
<td>1964</td>
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**CHS Older Adult**

<p>| | | | | | | | | | | | | |</p>
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<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Avocet</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>110%</td>
<td>12.1%</td>
<td>29.7%</td>
<td>101.6%</td>
<td>100.0%</td>
<td>96.8%</td>
<td>104.8%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plane</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>85%</td>
<td>17.7%</td>
<td>14.5%</td>
<td>100.0%</td>
<td>99.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Poplar</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>90%</td>
<td>18.6%</td>
<td>15.2%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Intermediate Care**

| Cumberlege IC Centre              | 22         | -                    | -                   | 75%                             | 33.9%      | 3.3%        | 100.0%                                 | 107.3%                                 | 100.0%                   | 100.0%                   | 0             | 1  |
| Mountnessing Ct                   | 22         | -                    | -                   | 53%                             | 19.5%      | 24.5%       | 96.8%                                  | 117.7%                                 | 98.4%                    | 148.4%                   | 0             | 1  |

**Stroke/Rehab Unit**

| Beech (St Margarets)              | 14         | -                    | -                   | 137%                            | 12.9%      | 23.3%       | 95.7%                                  | 99.5%                                  | 98.4%                    | 98.4%                    | 0             | 3  |
| Nursing Homes                     |            |                      |                     |                                 |            |             |                                         |                                        |                          |                          |               |     |
| Clifton Lodge                     | 35         | -                    | -                   | 86%                             | 29.6%      | 0.3%        | 75.8%                                  | 104.6%                                 | 91.9%                    | 129.0%                   | 0             | 1  |
| Rawreth Court                     | 35         | -                    | -                   | 85%                             | 42.8%      | 0.0%        | 79.0%                                  | 100.9%                                 | 50.0%                    | 196.8%                   | 0             | 11 |

Click here to return to summary page
## QUALITY PRIORITIES UPDATE (Month 9) December 2019

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>AIM(S)</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pressure Ulcers</strong>&lt;br&gt;1) Reduction in category 2 pressure ulcer development&lt;br&gt;2) Zero category 3 and 4 pressure ulcers acquired as a result of omissions in care with a 50% reduction in year against current performance (2018/19 outturn 6).</td>
<td>Develop a trajectory for a reduction in category 2 pressure ulcers (2018/19 outturn 669).&lt;br&gt;By April 2019 to develop and embed RCA Pressure Ulcer Guidelines across all clinical services.</td>
<td>Sept 19</td>
<td>Baseline complete Trajectory developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Avoidable Falls</strong>&lt;br&gt;1) Aim for a 15% reduction in all falls 2018/19 outturn 1620&lt;br&gt;2) Reduce the number of falls resulting in a serious incident by 10% 2018/19 outturn 13&lt;br&gt;3) Reduce the number of falls as a result of omissions in care by 50% against current performance 2018/19 outturn 6,</td>
<td>By April 2019 review Falls Guidance and provide clarification regarding the requirement to complete a Falls Risk Assessment in people under the age of 65.</td>
<td>April 2019</td>
<td>Complete</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By July 2019 to introduce Falls: Supportive &amp; Safe Observation Guidelines and measure outputs in relation to reduction in number of falls.</td>
<td>July 2019</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By September 2019 review all skin/pressure ulcer related data/information packs and ensure appropriate distribution.</td>
<td>Sept 19</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By September 2019 implement a procedural guideline for Delirium.</td>
<td>Sept 2019</td>
<td>Update December 19: Guidelines have been revised and following further comments are being presented to the Executive PH SC in January 2020</td>
</tr>
</tbody>
</table>

*Priority 1<br>Continued Reduction in Harm*
<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>AIMS</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Omission</td>
<td>1) To reduce the number of omitted does by 50% 2018/19 outturn 3762018/19 outturn 370</td>
<td>By September 2019 to have Falls Champions in all inpatient areas.</td>
<td>By September 2019 to have Falls Champions in all inpatient areas.</td>
<td>Sept 2019</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By October 2019 to review guidance in relation to the safe use of bedrails.</td>
<td>By October 2019 to review guidance in relation to the safe use of bedrails.</td>
<td>Oct 2019</td>
<td>Guideline reviewed and approved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By December 2019 hold a learning event for Falls Champions</td>
<td>By December 2019 hold a learning event for Falls Champions</td>
<td>Dec 2019</td>
<td>Complete – A further workshop is being held in November with plans in place to convene on a quarterly basis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To review the current data and develop an action plan to eliminate hotspots</td>
<td>To review the current data and develop an action plan to eliminate hotspots</td>
<td>Ongoing</td>
<td>Omissions will be a standing item on the agenda of the Medication Safety Group that they MSO is setting up as a sub group of the MMG**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To consider the use of ePMA and if appropriate develop a business case to support implementation</td>
<td>To consider the use of ePMA and if appropriate develop a business case to support implementation</td>
<td>March 20</td>
<td>A business case in place since 2014 for ePMA. We are currently awaiting the outcome of the bid for NHSE match funding Update: Funding had been approved and system currently being implemented.</td>
</tr>
<tr>
<td>Physical health of mental</td>
<td>1) To support nursing and support staff in the development of physical health competencies.</td>
<td>By June 2019 develop a Physical Health Training programme based on the competency framework and the management of diabetes and CVD.</td>
<td>By June 2019 develop a Physical Health Training programme based on the competency framework and the management of diabetes and CVD.</td>
<td>June 2019</td>
<td>Complete. Leads identified across all areas</td>
</tr>
<tr>
<td>health patients</td>
<td>2) To implement the competency framework</td>
<td>By June 2019 to review the physical health audit to incorporate qualitative outcome measures and develop a baseline.</td>
<td>By June 2019 to review the physical health audit to incorporate qualitative outcome measures and develop a baseline.</td>
<td>June 2019</td>
<td>Approved. Audit in progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By June 2019 the Physical Health Action Implementation Group will be reviewed to incorporate The Deteriorating Patient and Pressure Ulcers.</td>
<td>By June 2019 the Physical Health Action Implementation Group will be reviewed to incorporate The Deteriorating Patient and Pressure Ulcers.</td>
<td>June 2019</td>
<td>Update December 19: The Executive PH SC has requested that the Deteriorating Patient and PU Groups be re-convened as the Physical Health Action Implementation Group has now merged with the EPHSC.</td>
</tr>
<tr>
<td>PROJECT</td>
<td>AMBITION</td>
<td>AIMS</td>
<td>ACTIONS</td>
<td>Timescale</td>
<td>Progress</td>
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<td>----------</td>
</tr>
<tr>
<td>Priority 1</td>
<td>Continued Reduction in Harm</td>
<td>Early warning systems for deteriorating patients</td>
<td>For clinical staff working in community services to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required: Measures:</td>
<td>June 2019</td>
<td>Data collection for the physical health audit, incorporating Deteriorating Patient is complete. <strong>Update December 19:</strong> A paper on the Deteriorating Patient work stream is being presented to the Quality Committee in January 2020.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100% of community inpatient wards have implemented NWS 2</td>
<td>June 2019</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>To consider the use of NEWS2 in place of MEWS across mental health inpatient services.</td>
<td>March 2020</td>
<td>Review of processes has commenced. To agree ongoing processes by March 2020.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100% of inpatient wards have implemented the sepsis pathway</td>
<td>Dec 2019</td>
<td>Information relating to the detection of sepsis circulated to all wards. Guidance added to the EWS procedure. Head of Infection Prevention is updating guidance in line with national requirements.</td>
</tr>
<tr>
<td>PROJECT</td>
<td>AMBITION</td>
<td>ACTIONS</td>
<td>Timescale</td>
<td>Progress</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Priority 2 Restrictive Practices</td>
<td>The Trust has agreed to adopt No Force First as its restrictive practice reduction programme following significant success as a strategy in other mental health inpatient environments. The impact of No Force First on wards had shown to reduce conflict and restraint and associated work related sickness with significant benefits for service users and staff. In addition, two wards have been selected to take part in a two year collaborative working with Royal Colleague of Psychiatrists on restrictive practices. Through the Restrictive Practice Steering Group comprehensive and sustainable structures will be established to monitor, deliver and integrate the approach in clinical practice.</td>
<td>By April 2019 there will be a system in place across all wards to comply with the requirements of the new national data set.</td>
<td>April 19</td>
<td>Achieved</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>By June 2019 all wards will be using Safety Crosses to monitor any incident and the type of restrictive practice that has occurred.</td>
<td>June 19</td>
<td>Complete Monitoring will take place in operational committees and at restrictive practice steering group to monitor impact.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>By September 2019 all wards will have in place a debriefing protocol after incidents for both service users and staff to ensure individual and organisational learning takes place following incidents.</td>
<td>Sept 19</td>
<td>Immediate debrief is currently held via huddles and handovers in operational services. The 6 month pilot via psychology for debriefing has been agreed by Executive Team. DATIX system revised to highlight areas where response is required and evaluations systems under developed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>By March 2020 the core strategies from the Reducing Restrictive Practice Guide will be implemented across all inpatient areas. Evidence of these strategies and their impact will be evaluated and reported to the Restrictive Practice Steering Group.</td>
<td>March 20</td>
<td>Session scheduled with inpatient services December 19 Restrictive Practice conference held for 10 December 2020. Scoping exercise led by Executive Nurse across inpatient services and action plan in place. Operational issues driven through Q IHub and monitored through operational forums. Restrictive practise training is currently under review to include Trust in the process of securing BILD accreditation as a training provider. Online programme developed to be launched April 2020. Intervention toolkits being developed and safety pods currently being piloted on 4 areas. Restrictive practice dashboard under development currently being</td>
<td></td>
</tr>
<tr>
<td>PROJECT</td>
<td>AMBITION</td>
<td>ACTIONS</td>
<td>Timescale</td>
<td>Progress</td>
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</tbody>
</table>
| Priority 3  
Suicide / Unexpected Deaths | As a result of the publication of the Trust’s Suicide Prevention Strategy and recommendations from working groups the following priorities have been identified to ensure successful implementation and embedding of the strategy into Trust services:  
1) Suicide Prevention Safety Tools and communication  
2) Suicide Prevention Learning Culture  
3) Suicide Prevention Family and Carer Involvement. | By August 2019 a suicide prevention action plan will be in place to track and monitor progress on the ten key parameters for safer mental health services.  
Dashboard to be developed against action plan to monitor delivery at service level  
By September 2019 a rolling programme of training will be available to support the development of competencies across the workforce  
By December 2019 a report will be produced to the Quality Committee on the effectiveness of the action plan outlining key areas of delivery  
By October 2019 the Trust’s Suicide and Self-harm policy will be updated. | Aug 19  
Mar 20  
Sept 19  
Dec 19 |  
Action plan in place supported by work streams to ensure delivery.  
Discussions ongoing to develop consistency with quality priority dashboards. Dashboard agreed and underdevelopment.  
Complete  
Complete |
### PROJECT AMBITION ACTIONS Timescale Progress

<table>
<thead>
<tr>
<th>PROJECT AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During 2019/20</strong> work will be undertaken leading to a strong integrated suicide plan with local stakeholders</td>
<td>Q4 2020</td>
<td>Work with stakeholders ongoing. Development pathways in place</td>
<td></td>
</tr>
<tr>
<td>By December 2019 work in relation to a Staying Alive suicide prevention app will be in place and mechanisms agreed for evaluation.</td>
<td>Dec 19</td>
<td>Soft launch of the App August 2019 leading up to a more formal launch on suicide prevention day 10th September. Over 350 hits to the app have been received. Monitoring arrangements in place. App launched to EPUT user phones, impact to be evaluated.</td>
<td></td>
</tr>
</tbody>
</table>

### PROJECT AMBITION ACTIONS Timescale Progress

<table>
<thead>
<tr>
<th>PROJECT AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is recognised that in order to operate as an outstanding organisation it is essential that the Trust works collectively with its staff, service users and system partners to plan, deliver and evaluate the quality of care and associated outcomes that is provided. The development of a just/learning culture and making continuous improvement everyone’s busy will support this but in addition the following priorities have been identified:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By June 2019 two cohorts of senior leadership teams from across the system will have completed NHSI Transforming Change through System Leadership and have identified transformation change areas to drive forward change</td>
<td>June 19</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Locality hubs will be developed for system partners to collectively drive forward the transformation agenda</td>
<td>June 19</td>
<td>Complete. Hubs representative of STP footprints</td>
<td></td>
</tr>
<tr>
<td>All staff will be given the opportunity to undertake develop and to work collectively with colleagues to implement quality improvements.</td>
<td>Dec 19</td>
<td>Directorate hubs in development. Projects agreed within specialist and mental health services.</td>
<td></td>
</tr>
<tr>
<td>Collective leadership will be embedded into organisational development frameworks and form part of team development.</td>
<td>Dec 19</td>
<td>Complete – built into programmes from October 2019</td>
<td></td>
</tr>
</tbody>
</table>
### Priority 5
#### Continuous Improvement

Our aim is to embed continuous improvement within the culture of the organisation and empower all staff, service users and carers to work together to enhance the reliability of service provision. To support this priority the work programme for 2019/20 will incorporate the following actions:

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>By March 2020 all members of the Trust Board to undertake NHSI’s Board level quality improvement programme</td>
<td>March 20</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop quality improvement hubs across all Directorates to drive continuous improvement at a local level</td>
<td>Dec 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide Quality Champion training with the aim to train a further 120 staff in quality improvement methodology</td>
<td>March 20</td>
<td>Further training programmes have been scheduled commencing July 2019. QSIR programme commences 18 November 2019. Second cohort dates in circulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop 30 Gold level Quality Champions to provide coaching/mentorship to new recruits</td>
<td>March 2020</td>
<td>Arrangements in place, support driven though Directorate hubs. Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide quality improvement awareness sessions and provide the opportunity for service users and carers to take part in continuous improvement initiatives</td>
<td>March 2020</td>
<td>Sessions completed. Further sessions to be embedded within directorate hubs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By September 2019 to have in place a dashboard against all quality priorities.</td>
<td>Sept 19</td>
<td>Dashboard in place against a number of priorities with further work scheduled for roll out against all areas.</td>
</tr>
</tbody>
</table>

Click here to return to Summary
## Priority 6: Effective Use of Technology

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Through the effective use of technology the Trust will implement improved mechanisms of acquiring, reviewing, understanding, analysing and exchanging patient safety data and knowledge through the following work plan.</td>
<td>Development of dashboard for all quality priorities incorporating data from the new Patient Safety Incident Management System.</td>
<td>Sept 2019</td>
<td>Dashboard under development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduction of Perfect Wards and the development of systems to respond to real time data alerts.</td>
<td>Sept 2019</td>
<td>Roll out to commence 1 July 2019. First review August 2019. Further audits added to system and adapted to support PHSO action plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of ESR, safer staffing and safe care systems to gain assurance that staffing levels can support the delivery of organisational priorities.</td>
<td>August 2020</td>
<td>Programme plan under development. First wave to commence 1 September 2019. Action plan reviewed. All areas to be live by April 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of EPUT Lab to drive use of improvements in technology to create the concept of Safe Wards in all setting</td>
<td>March 2021</td>
<td>Initial discussions took place with EPUT Lab December 2019. Steering group established.</td>
</tr>
</tbody>
</table>

## Priority 7: A Just and Learning Culture

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A just and learning culture will be developed to embed the Trust's agreed approach in response to incidents and errors to protect both staff and people that use our services. The following actions have been identified for 2019/20</td>
<td>By June 2019 elements of a just and learning culture will be embedded into induction, leadership and quality champion training</td>
<td>June 19</td>
<td>Just culture built into programme - complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>From July 2019, within one week of a serious (amendment agreed with Faye) incident, a copy of its 72 hour review will be shared with all members of the relevant teams</td>
<td>July 19</td>
<td>100% consistency in sharing 3 day report with managers who are responsible for cascading.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Good practice stories will be published every month in order that we can extract the maximum possible learning from things that go well and things that do not go as expected.</td>
<td>July 19</td>
<td>Quality Matters Newsletter in place and further enhanced. Publication every 3 months. Focusing on snap shots of good news stories on intranet and displayed in team areas.</td>
</tr>
</tbody>
</table>

[Click here to return to Summary]
The Trust is committed to the provision of the very highest quality of care for people with advanced life threatening illnesses. They and their families should expect good end of life care, whatever the cause of their condition and all those identified as end of life should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death.

Through the implementation of the End of Life Care Framework we will:

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>AMBITION</th>
<th>ACTIONS</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 8</td>
<td>End of Life Care</td>
<td>Implement a competency framework for staff, regardless of their grade to enhance knowledge, skills for both end of life care and care in the last days of life.</td>
<td>March 20</td>
<td>Competencies are being rolled out across services and ongoing training continues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work with systems and partners to create best approaches with regard to advanced care planning and individualised care plans.</td>
<td>March 20</td>
<td>The Trust is in the process of piloting the Always Events to gather feedback from patients and carers. The Patient Experience Manager is working with a team in West Essex to develop the approach. Joint working with hospices and MH teams to support MDT and learning and support of specialist palliative care patients for inpatient services in MH.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Convene an End of Life Forum for clinical staff.</td>
<td>Sept 19</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expand the number of End of Life Care Champions</td>
<td>March 20</td>
<td>Recruitment of champions continues across services with the number currently at 20. Further meetings/workshops have been planned on a quarterly basis. <strong>Update December 19:</strong> The number of champions continues to rise. There are currently 25 across mental health and CHS. The last Forum had good attendance.</td>
</tr>
</tbody>
</table>

[Click here to return to summary page]
### Financial Risk Rating / Use of Resources

For 2019/20 the Trust is assessed against the Use of Resources Rating, good performance is indicated by a rating of 1. At the end of Month 9 - December 2019, the Trust was predicting an actual risk rating of 1 versus the planned risk rating of 1. This result demonstrates the Trust remains in strong financial health.

### Operating Income and Expenditure

The Trust's Continuing Operating performance at the end of Month 9 is a surplus of £2,989k and includes forecast Provider Sustainability Fund (PSF) of £1,603k for 2019/20. The Month 9 plan is a surplus of £2,072k and the financial performance is above plan by £917k.

### Planned improvement in productivity and efficiency

The Trust's CIP target for 19/20 is £11,661k. At the end of Month 9 - December 2019 £6,418k of CIP schemes were agreed of which the 19/20 impact is £7,163k. To address the 19/20 CIP target, at Month 9 £1,596k of CIPs (19/20 Part Year Effect) and £1,932k Recurrent Full Year Effect, have been identified as in Pipeline for consideration and progression to being CIP Schemes Fully Developed. In addition, the strong financial position continues to support the 19/20 CIP target.
<table>
<thead>
<tr>
<th>RAG</th>
<th>Ambition / Indicator</th>
<th>Position</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Control of Agency Costs</td>
<td>The Trust’s NHSI Agency target for 2019/20 is £14,118k. The total expenditure at Month 9 -</td>
<td><img src="image" alt="Monthly Agency Spend" /></td>
</tr>
<tr>
<td>Costs</td>
<td></td>
<td>December 2019 on Agency Staff was £10,834k against the NHSI plan of £10,602k giving an adverse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>variance of £232k. The 18/19 comparator is last year’s agency spend adjusted to remove the 18/19</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HMP Chelmsford agency costs to allow for meaningful comparison.</td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>Cash Balances</td>
<td>At the end of Month 9 - December 2019, the Cash balance is £73,976k against the plan of £67,548k.</td>
<td><img src="image" alt="Cash Balance" /></td>
</tr>
<tr>
<td>Balance</td>
<td></td>
<td>The cash balance is above plan by £6,428k mainly due to more prompt settlement from debtors and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>lower payment of trade creditors over the holiday period.</td>
<td></td>
</tr>
</tbody>
</table>

END
### Purpose of the Report

This report provides the Board of Directors with an overview of the action that is underway currently and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust’s in-patient estate.

<table>
<thead>
<tr>
<th>Approval</th>
<th>Discussion</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>

### Recommendations/Action Required

The Board of Directors is asked to:

- Discuss the contents of this report.
- Identify any further actions required.

### Summary of Key Issues

The report provides a summary of:

- Assurance on current risk management systems.
- Governance arrangements in place.
- Enhancements to risk management systems that have taken place.
- Ligature risk assessment policy and procedure implementation.
- Action taken to achieve risk reduced environmental standards.
- Staff training.
- Environmental improvement works.

### Relationship to Trust Strategic Objectives

| SO 1: Continuously improve service user experiences and outcomes | ✔ |
| SO 2: Achieve top 25% performance | ✔ |
| SO 3: Valued system leader focused on integrated solutions | ✔ |

### Which of the Trust Values are Being Delivered

1: Open ✔
2: Compassionate ✔
3: Empowering ✔
### Relationship to the Board Assurance Framework (BAF)

<table>
<thead>
<tr>
<th>Are any existing risks in the BAF affected?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, insert relevant risk</td>
<td>BAF 15 BAF 10</td>
</tr>
<tr>
<td>Do you recommend a new entry to the BAF is made as a result of this report?</td>
<td>NO</td>
</tr>
</tbody>
</table>

### 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 | |
| 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

<p>| |</p>
<table>
<thead>
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</thead>
</table>

### Supporting Documents and/or Further Reading

### Lead

**Sally Morris**

**Chief Executive**
LIGATURE RISK MANAGEMENT

1.0 Introduction

This report provides the Board of Directors with an update of the action that is underway and that which is planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust’s inpatient estate.

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture. The Board of Directors has identified the potential risk associated with this agenda as one of the most significant potential risks that may prevent achievement of the Trust strategic objectives and this potential risk is therefore recorded in the Board Assurance Framework (ref BAF10). An action plan is in place to mitigate this potential risk. Reports on the action that has been taken have been provided to the Board of Directors four times since April 2017, most recently in September 2019. This report aims to assure Board members that the focus on mitigating this potential risk continues to be a priority.

Whilst this report does confirm that the focus on mitigating risk continues to be strong and progress continues to be made, Board members are reminded that managing ligature risk associated with the physical environment must be considered in the wider context of care provision that includes staffing, security, patient risk assessment, observation and care planning. It also has to be recognised that the Trust’s inpatient environments (consistent with many providers of mental health services) will rarely be entirely free of fixed ligature points because most were not designed to mitigate the potential risks being identified currently and/or there are no design solutions to eliminate identified potential risk entirely from all infrastructure, fixtures and fittings.

2.0 Independent Assurance

Care Quality Commission (CQC)

The CQC carried out an inspection of Trust services in July / August 2019 and its findings were published in October 2019. Inspectors confirmed that “staff knowledge and management of ligature risks had improved since the last inspection” on acute adult in-patient wards. It was however, disappointing that inspectors did identify that not all ligature risks had been identified on ligature risk assessment documentation and improvements were still needed for governance processes to ensure staff updated ligature risk assessments in a timely way. It was pleasing to note that inspectors found that “Staff mitigated the risks posed by the environment, including blind spots and ligature risks” within older people’s in-patient wards and within child and adolescent in-patient wards inspectors confirmed that “all wards were safe….., well maintained and fit for purpose”.

Learning from the inspection has informed the action that has been taken since the last report and is set out in later sections of this report.
Internal Audit

BDO, the Trust’s internal independent auditors carried out testing of the Trust’s implementation of its ligature risk management policy and procedures in August 2019 and their findings were shared with the Trust in November 2019. The auditors reported:

- Both the Ligature Risk Assessment and Management policies and procedures compared favourably to good practice identified at other Mental Health Trusts
- All the wards achieved a high percentage completion rate for the Preventing Suicide by Ligature e-learning module (where sites did not achieve 100% this could be accounted for by long term staff absence, maternity leave or redeployment)
- Fixtures and fittings largely complied with those specified in the Ligature Risk Assessment and Management policy. Where there were exceptions they were highlighted on the anchor assessment forms, shown in the hot spot photos, located in communal/supervised areas or off limits to at-risk patients
- It was evident that all the staff spoke to understood the seriousness of remaining compliant with the Ligature Risk Assessment and Management Policies and Procedures, and demonstrated a positive attitude towards improvement.

3.0 Governance

The Trust continues to hold a Ligature Risk Reduction Group each month; chaired by the Chief Operating Officer. The group reports to the Health Safety and Security Committee and ensures:

- Ligature risk assessment inspections are robust with appropriate control measures in place
- The Trust remains compliant with all regulatory or legislative requirements and Safety Alerts
- Risks that are identified are managed and escalated as required.
- Governance structures of the Trust are appropriate and effective.

The Estates Expert Reference Group, chaired by the Executive Chief Finance Officer, has continued to meet at least monthly to oversee a wide range of environmental patient safety improvement works identified as a result of ligature risk assessment and setting of agreed standards by the Ligature Risk Reduction Group.

4.0 Enhancements To Risk Management Arrangements Requirements

4.1 Estates and Facilities Alerts

- **EFA/2018/005 Assessment of Ligature Points**
  The alert was issued in September 2018 requiring all providers to review the ligature risk management arrangements in place. An action plan was developed (content is reflected throughout this report) which has been monitored by the Health Safety and Security Committee. The Quality Committee was advised of progress via the Health Safety and Security Committee (HSSC) assurance report in October and December 2018 and February, April, June, August and October 2019. The Alert and action plan were completed and closed at the HSSC 30th September 2019.
- **EFA/2019/003 'Anti-ligature' type curtain rail systems**
  The alert was issued in March 2019. It identified potential risks from incorrect installation or modification of anti-ligature type curtain rail systems. The Trust was required to action the alert by the end of September 2019.

  The Quality Committee was advised of progress via the HSSC assurance report in June, August, October and December 2019. The Trust undertook an audit of all curtain rails in all inpatient wards and initiated a complete replacement programme where rails were not compliant with the alert requirements by the end of September 2019. There was a delay in developing a process for annual testing of the curtain rails and appointing a contractor (independent of the original supplier) to do this. The process is now in place and a contractor appointed. This did not expose the Trust to risk as the first annual tests are not required until the end of January 2020. A testing programme has been put in place. The alert is due to be closed by the HSSC when it meets 27 January 2020.

  4.2 **Learning**

  The Trust’s approach to identifying and mitigating potential risk is constantly subject to reflection and review, informed by independent review (as detailed above), incident data and internal scrutiny.

  The Ligature Risk Assessment and Management Policy and Procedure was launched in April 2019. Following a six month implementation period the policy was reviewed in October 2019 and changes made as follows:

  - Inclusion of bank and agency responsibilities.
  - Review of the risk stratification rating table.
  - Addition of EFA/2019/003 curtain rail system alert.
  - Appendix 4 Contents of the Red Tabbed Ligature Wallets updated
  - Ligature cutters - maintenance and cleaning procedure incorporated

  The ligature risk assessment tool being used is being refined to create more explicit reference to National Guidance, including Health Building Notes and relevant Estates and Facilities Alerts (EFAs). The revised tool will be presented to the HSSC in February 2020.

  Action is also being taken to review ligature risk assessments carried out in wards that have the same layout as each other to ensure that a consistent approach to identification and management of potential risks is consistent. This work will be completed by the end of January 2020.

  4.3 **Co-production**

  Two ligature risk assessments of inpatient wards have included a person with lived experience in the assessment team. This is an exciting development in the Trust's processes and more people with lived experience are being sought to provide a different perspective into the risk assessment process. A protocol is in place to carry out this activity safely.
5.0 Policy and Procedure Implementation

74 ligature risk assessments inspections were completed over the past year in line with policy on a bi-annual or annual inspection programme for all inpatient areas as follows:

- Medium and Low Secure Services – 6 monthly
- Acute Admission Wards – 6 monthly
- Health Based Place of Safety (HBPoS) – 6 monthly
- Psychiatric Intensive Care Unit (PICU) – 6 monthly
- Assessment Units – 6 monthly
- Young Person Units – 6 monthly
- Older Adult Functional Wards – 6 monthly
- Learning Disability In-patient Services – 6 monthly
- Older Adult Organic Wards – Annually
- Rehabilitation Wards - Annually

A schedule of ligature risk assessments completed and planned is provided in Appendix 1 to assure Board members that the programme is being delivered in line with policy.

Potential ligature risks identified in risk assessments are where possible removed and replaced with a reduced ligature design at the earliest opportunity. Where this is not possible local mitigation plans are required to be confirmed and the risk highlighted on the ward heat map.

Action required following a ligature risk assessment is recorded and monitored on a database held by the Risk Team through to completion. As of the 15th January 2020 there are 40 open actions.

Ligature assessment scrutiny audits have continued to be undertaken by the Compliance Team. These are designed to test compliance with policy and procedure but also to provide coaching and support to frontline staff to help them assess and manage risk appropriately. 24 scrutiny audits were completed in the quarter June to September 2019 and learning has been shared with the LRRG in respect of:

- Staff awareness of ligature risks and their management.
- Adherence to policy and procedure including the contents of the ligature wallets, accuracy of hotspots and heat maps and handover processes of the risks.
- Ligature risks are identified in the most recent inspection report and included for action.
- Remedial actions being completed in the required timeframe.

6.0 Risk Reduced Environmental Standards

The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust’s investment and patient safety improvement works programme. To date the following standards have been agreed:

**Sanitary Bins:** all inpatient mental health wards will have cardboard bins (Binny Bins) in all patient toilets within the inpatient areas. This standard has been achieved.

**Bedroom Doors:** all inpatient mental health wards will have at least 4 bedroom doors installed with door top alarms. This standard has been achieved. The standard is being reviewed in conjunction with the pilot of Oxihealth (a vital signs monitoring system).
**Bedroom and Bathroom Doors:** all doors must have:

- Piano hinges or pivot hinges or continuous hinges
- Ligature resistant door handles
- Ligature resistant door closures

Because the ligature risk assessment tool in place currently does not explicitly confirm that the standard regarding door hinges is being met, a re-audit of all bedroom door hinges has been undertaken and a replacement programme is being initiated where necessary.

**Ensuite Doors:** remove all doors within mental health wards (currently excluding older adult dementia wards) and install a reduced ligature track and rail system (JTrac) with cordless curtains. 146 ensuite doors have been identified for removal and a programme of work to remove the doors and replace with a curtain track commenced in January 2020 and will be completed mid February 2020.

**Toilets:** all mental health wards will have toilets with a moulded pan without a seat or lid; assisted bathrooms do not require this standard. This standard has been achieved with the exception of one toilet on the Christopher Unit.

**Paper Towel, Soap Dispensers and Toilet Roll Holders:** all inpatient patient bathroom and ensuite rooms will have fittings of sloping top design and held onto the wall by specific sticky pads. Unfortunately this proposed standard has failed and dispensers are coming away from the walls. An alternative solution of a metal plate and magnets was approved following testing (at the ligature reduction test site created at the AFC in Thurrock) by the Ligature Risk Reduction Group on the 22nd January 2020 and a programme of replacement is currently being developed.

**Ceiling Fixtures and Fittings:** all ceiling fittings in bedrooms and bathrooms will have short, non weight bearing cabling. After a significant testing programme to find the best solution, a programme of review and redesign of the cabling to every fitting is underway. Each ward takes approximately one week to complete and the programme based on this estimate is due to be completed in mid April 2020. Discussions are taking place with contractors to see if this programme can be accelerated by employing additional labour to complete the programme by 31 March 2020.

### 7.0 STAFF TRAINING

All staff working within a mental health/LD inpatient settings are required to complete the ligature awareness on-line training package (launched in March 2018) “Preventing Suicide by Ligature” on an annual basis. The training package details:

- Definitions relating to the management of ligature
- Background and trends in suicide and self-harm
- Ligature hazards and risks and there management
- Principles of good practice in the prevention of suicide
- Emergency procedures and equipment
- Policy and procedures, related training and links.

Compliance with training as at the end of December was 92% (864 out of 944 staff identified have completed it). Action is being taken to ensure that all inpatient staff who require it are accurately identified on the training tracker.
### 8.0 Additional Environmental Improvement Works

**Window replacement**

One of the major issues for in-patient services are windows as they are the most vulnerable; prone to attack, escape and present a high risk as a ligature point. Although the Trust has installed bespoke add-on restrictors in organic illness wards and has removed fixings and handles in adult, CAMHS and older peoples acute illness wards to mitigate identified risks, many windows are now falling short of the demands placed upon them; and adaptations made have also resulted in reduced ventilation and are a unsightly. Within the last 5-10 years the market for anti-ligature products has gained momentum and manufactures have responded by greatly improving their products. Until fairly recently there was little done to improve windows that would meet the in-patient needs. One such product made by Polar Architectural Glazing Specialists is the Humber window; this window has much improved ventilation, very secure and greatly reduces ligature and absconding risks and can withstand a higher level of physical abuse. A full audit of windows has been undertaken within the in-patient estate and a comprehensive replacement programme commenced at the end of November 2019 and is due to be completed by the end of March 2020.

**CCTV**

The Trust is currently reviewing the provision of CCTV across the organisation and additional provision is being considered for all female wards and Peter Bruff.

**Future Investment Programme**

A review is being undertaken of all ligature assessments to create a central register of all ligature risks that remain not covered by existing standards and improvement programmes. This long list will inform the development of future standards and future investment programme. Completion date January 2020

### 9.0 Conclusion

The summary of information provided in this report is by its nature only potentially a snapshot of the work that is taking place by frontline clinical staff, risk and estates specialists and the wider leadership team.

It is hoped that the information provided provides sufficient assurance that the Trust continues to take mitigating the risk of ligature seriously and a basis for agreeing what information may be required by the Board of Directors in future.

### 10.0 Action Required

The Board of Directors is asked to:

- Discuss the contents of this report
- Provide suggestions for future report content
- Identify any further actions required

**Report Prepared By:**

**Faye Swanson, Director of Compliance & Assurance/ Trust Secretary**

**On behalf of:**

**Sally Morris, Chief Executive**
### 6 MONTHLY LIGATURE INSPECTIONS
(August 2019 to January 2020)

<table>
<thead>
<tr>
<th>Site Name (&amp; teams covered)</th>
<th>Last Ligature Inspection Date</th>
<th>Ligature Inspection Next Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Aubyns - Larkwood Ward</td>
<td>18/09/2019</td>
<td>19/03/2020</td>
</tr>
<tr>
<td>St Aubyns - Longview Ward</td>
<td>18/09/2019</td>
<td>19/03/2020</td>
</tr>
<tr>
<td>Derwent Centre - Taymar Suite</td>
<td>09/09/2019</td>
<td>10/03/2020</td>
</tr>
<tr>
<td>Basildon MHU - Grangewaters Ward</td>
<td>09/01/2020</td>
<td>10/07/2020</td>
</tr>
<tr>
<td>Basildon MHU - Assessment Unit and HBPoS</td>
<td>05/09/2019</td>
<td>06/03/2020</td>
</tr>
<tr>
<td>Byron Court</td>
<td>19/09/2019</td>
<td>20/03/2020</td>
</tr>
<tr>
<td>Linden Centre - The Christopher Unit &amp; HBPoS</td>
<td>16/09/2019</td>
<td>17/03/2020</td>
</tr>
<tr>
<td>Derwent Centre – Stort Ward</td>
<td>09/10/2019</td>
<td>09/04/2020</td>
</tr>
<tr>
<td>Derwent Centre – Chelmer Ward</td>
<td>09/10/2019</td>
<td>09/04/2020</td>
</tr>
<tr>
<td>Basildon MHU - Kelvedon Ward</td>
<td>17/10/2019</td>
<td>17/04/2020</td>
</tr>
<tr>
<td>The Lakes – Ardleigh Ward &amp; HBPoS</td>
<td>06/11/2019</td>
<td>07/05/2020</td>
</tr>
<tr>
<td>The Lakes - Gosfield Ward</td>
<td>06/11/2019</td>
<td>07/05/2020</td>
</tr>
<tr>
<td>Linden Centre – Finchingfield Ward</td>
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<td>08/07/2020</td>
</tr>
<tr>
<td>Linden Centre – Galleywood Ward</td>
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<td>25/04/2020</td>
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<tr>
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<td>29/04/2020</td>
</tr>
<tr>
<td>St Margarets - Roding Ward (Functional)</td>
<td>13/12/2019</td>
<td>13/06/2020</td>
</tr>
<tr>
<td>Rochford Hospital - HBPoS</td>
<td>04/12/2019</td>
<td>04/06/2020</td>
</tr>
<tr>
<td>Linden Centre - Rainbow Unit</td>
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</tr>
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<td>Rochford – Cedar Ward</td>
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</tr>
<tr>
<td>Location</td>
<td>Start Date</td>
<td>End Date</td>
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<tr>
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<td>Brockfield House - Fuji</td>
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</tr>
<tr>
<td>Brockfield House - Causeway</td>
<td>15/10/2019</td>
<td>15/04/2020</td>
</tr>
<tr>
<td>Brockfield House - Dune</td>
<td>18/10/2019</td>
<td>18/04/2020</td>
</tr>
<tr>
<td>Brockfield House - Aurora</td>
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<td>22/04/2020</td>
</tr>
<tr>
<td>Woodlea</td>
<td>31/10/2019</td>
<td>01/05/2020</td>
</tr>
<tr>
<td>Robin Pinto</td>
<td>03/12/2019</td>
<td>03/06/2020</td>
</tr>
<tr>
<td>Kings Wood Centre – Henneage Ward</td>
<td>13/08/2019</td>
<td>12/02/2020</td>
</tr>
<tr>
<td>Rochford Hospital - Poplar Ward and HDU</td>
<td>21/08/2019</td>
<td>20/02/2020</td>
</tr>
<tr>
<td>Basildon MHU - Hadleigh Unit</td>
<td>07/08/2019</td>
<td>06/02/2020</td>
</tr>
<tr>
<td>Linden Centre – Edward House</td>
<td>21/08/2019</td>
<td>20/02/2020</td>
</tr>
<tr>
<td>Crystal Centre – Ruby Ward</td>
<td>13/08/2019</td>
<td>12/02/2020</td>
</tr>
<tr>
<td>Kings Wood Centre – Peter Bruff</td>
<td>13/08/2019</td>
<td>12/02/2020</td>
</tr>
<tr>
<td>Rochford Hospital - Beech Ward</td>
<td>21/08/2019</td>
<td>20/02/2020</td>
</tr>
<tr>
<td>Thurrock Hospital - Gloucester Ward</td>
<td>29/08/2019</td>
<td>28/02/2020</td>
</tr>
<tr>
<td>Site Name (&amp; teams covered)</td>
<td>Last Ligature Inspection Date</td>
<td>Ligature Inspection Next Due</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>St Margarets – Kitwood Ward</td>
<td>04/06/2019</td>
<td>03/06/2020</td>
</tr>
<tr>
<td>Crystal Centre – Topaz Ward</td>
<td>04/03/2019</td>
<td>03/03/2020</td>
</tr>
<tr>
<td>Thurrock Hospital – Meadowview Unit</td>
<td>13/03/2019</td>
<td>12/03/2020</td>
</tr>
<tr>
<td>Landermere Centre – Bernard Ward</td>
<td>20/02/2019</td>
<td>20/02/2020</td>
</tr>
<tr>
<td>Landermere Centre – Tower Ward</td>
<td>20/02/2019</td>
<td>20/02/2020</td>
</tr>
<tr>
<td>439 Ipswich Road</td>
<td>25/07/2019</td>
<td>24/07/2020</td>
</tr>
<tr>
<td>The Coach House - 439 Ipswich Road Annexe</td>
<td>25/07/2019</td>
<td>24/07/2020</td>
</tr>
</tbody>
</table>
SUMMARY REPORT

BOARD OF DIRECTORS
PART 1

29 January 2020

Report Title: Establishment Review Report
Executive/Non-Executive Lead: Natalie Hammond, Executive Nurse
Report Author(s): Gill Mordain, Strategic Advisor: Olga Mayinan/ Deba Misra, Senior Finance Officer
Report discussed previously at: Executive Committee
Level of Assurance: Level 1 ✓ Level 2 Level 3

Purpose of the Report
This report provides the Board of Directors with proposals for changes to the inpatient safe staffing levels as discussed and agreed by the Executive Team.

Recommendations/Action Required
The Board of Directors is asked to:
1. Note the contents of this report
2. Review and agree the proposals to change the establishments as set out in the report
3. Note that further work will be undertaken to establish and benchmark the full range of nursing and therapeutic input provided in some areas where changes have been proposed.

Summary of Key Issues
- Establishment reviews are to be undertaken yearly with a 6 month update as per updated guidance received from the National Quality Board
- SafeCare Module is to be implemented to support an evidence based triangulated approach to future reviews
- No changes are recommended to south mental health wards or community health inpatient units
- Changes proposed to Ardleigh Ward, Finchingfield Ward and Stort Ward are in consideration of levels of acuity. It is a change to the current system of linking up neighbouring wards for registered nurse support for acute inpatient wards in the north, providing increased registered nurse support during the evening and during the night
- Proposed change to Ruby Ward has the introduction of a housekeeper role to release clinical time to support physical health care and levels of frailty
- The proposed changes to Rawreth Court and Clifton Lodge bring the unit in-line with care/nursing home registered staffing levels. It builds the overall staffing levels over the twenty four hour period to ensure patient safety
- On Rainbow Mother and Baby Unit it is proposed to change one HCA to a nursery nurse to support the ongoing care of the babies on the unit
- Following work as part of a national collaborative in relation to reducing restrictive practices, Poplar Ward (CAMHS) have proposed changing a vacant 0.60 WTE HCA to an activity coordinator that will be used flexibly to support increased interventions at times of highest risk
- Forest Ward is a 16 bedded unit, with a number of patients who are stepping down from High Secure Hospital. It is proposed to increase the number of registered staff during the night shift to two to support a reduction in risk behaviours, cover the increased level of client interventions and client support
- Longview and Larkwood Ward do not have site cover arrangements in place. The proposal of an additional band 5 at night and activity coordinator at weekends has been agreed on a temporary basis. There are currently extremely high acuity levels and risk associated with CAMHS services and dedicated leadership for supporting safe care and direction for junior staff will be provided with dedicated site cover. A further skill mix review incorporating all therapy staff will be undertaken in 3 months
- Other changes proposed represent the most cost effective options for improving standards of care and patient safety
- It is recognised that there is no additional funding in place to support these changes and that
the additional cost pressure will reduce the overarching staffing budget available

- Further work will be undertaken to identify and review the full nursing and therapeutic input to some of the areas where proposals have been presented

### Relationship to Trust Strategic Objectives

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO 1: Continuously improve service user experiences and outcomes</td>
<td>✓</td>
</tr>
<tr>
<td>SO 2: Achieve top 25% performance</td>
<td>✓</td>
</tr>
<tr>
<td>SO 3: Valued system leader focused on integrated solutions</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Which of the Trust Values are Being Delivered

1: Open ✓
2: Compassionate ✓
3: Empowering ✓

### Relationship to the Board Assurance Framework (BAF)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are any existing risks in the BAF affected?</td>
<td>No</td>
</tr>
<tr>
<td>Do you recommend a new entry to the BAF is made as a result of this report?</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Impact Area</th>
<th>Assurance(s) against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</td>
<td></td>
</tr>
<tr>
<td>Data quality issues</td>
<td></td>
</tr>
<tr>
<td>Involvement of Service Users/Healthwatch</td>
<td></td>
</tr>
<tr>
<td>Communication and consultation with stakeholders required</td>
<td></td>
</tr>
<tr>
<td>Service impact/health improvement gains</td>
<td></td>
</tr>
<tr>
<td>Financial implications: The financial implications of proposed changes will be met from within the total budget available to inpatient services. Allocations will be made following further discussion with operational, quality and finance leads.</td>
<td>✓</td>
</tr>
<tr>
<td>Governance implications</td>
<td></td>
</tr>
<tr>
<td>Impact on patient safety/quality</td>
<td>✓</td>
</tr>
<tr>
<td>Impact on equality and diversity</td>
<td></td>
</tr>
<tr>
<td>Equality Impact Assessment (EIA) Completed?</td>
<td>YES/NO If YES, EIA Score</td>
</tr>
</tbody>
</table>

### Acronyms/Terms Used in the Report

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>MHOST</td>
<td>Mental Health Optimal Staffing Tool</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>HCA</td>
<td>Health Care Assistant</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Health Nurse</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescence Mental Health Services</td>
</tr>
</tbody>
</table>

### Supporting Documents and/or Further Reading

Lead

Natalie Hammond, Executive Nurse
1.0 Purpose of the Report

The purpose of this report is to update the Board of Directors on the establishment review undertaken across all 49 wards within the Trust.

This paper outlines the work undertaken since the last review, provides an update on findings and changes to the current establishments approved by the Executive Committee and outlines future review to be undertaken in relation to maintaining safe and productive staffing levels.

The nursing establishment is utilised as a minimum staffing guide for safe care dependent on calculations the full occupancy of the bed base. Variables occur in practice on a daily basis and the establishment is altered by increasing / decreasing dependent on occupancy and clinical needs of the patient group.

2.0 Background

The National Quality Board published ‘Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing’ in July 2016 which continues to be the current resource for safer staffing.

Further guidance was also produced in 2018 – National Quality Board, Safe Sustainable and Productive Staff, An Improvement Resource for Mental Health (January 2018); and NHSI Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing (October 2018). The NHSI October document states that they will assess trusts’ compliance with the ‘triangulated approach’ covering evidence based tools, professional judgement and outcomes, within the annual governance statement.

The Establishment Review is crucial to ensure the Trust complies with the Safer Staffing policy. The report also states that as part of the safer staffing review, the Director of Nursing and the Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.
NQB (2016) guidance states providers:

- Must deploy sufficient suitable qualified, competent, skilled and experienced staff to meet treatment needs of patients; safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required and keep them safe at all times.
- Must use an approach that reflects current legislation.

The guidance advocates that establishment reviews are undertaken at least every twelve months (it was previously required every six months). It is expected that a report on the outcome of the establishment reviews should be presented and discussed at a Public Board meeting; any emerging actions should be agreed and monitored then published alongside Public Board papers on the Trust’s public website.

3.0 Process

Following the last establishment review, it was agreed that staffing reviews should be aligned with budget setting and would take into account the following factors:

- Review of present funded establishment
- Review of the number of beds to Registered staff ratio
- The first 1:1 observation managed within establishments
- A review of linking up neighbouring wards in the north mental health wards for night shifts to ensure 3 Registered nurses on shift
- Professional judgement – advice sought from senior managers and clinicians within the unit
- Review of environment
- Reviewing supernumerary status of Band 7s
- Review of multi-disciplinary and therapeutic input to each area
- Benchmark against other similar units
- Utilising the MHOST (Mental Health Optimal Staffing Tool) issued in June 2019

The key approach to performing the establishment review is utilising a triangulated approach bringing together evidence-based tools with peer comparison and professional judgement.

The Mental Health Optimal Staffing Tool (MHOST) was used to measure acuity across specialist and mental health inpatient areas, and the Shelford Group Acuity Tool was used for the community services inpatient areas.

The data collection for the nursing establishment review was undertaken in September 2019. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period (with the exception of Byron Court, no national staffing tool available). This was then triangulated along with nationally recognised recommendations to assess appropriate nurse staffing levels for each inpatient ward.

Following the collection period of twenty days the scores were calculated and the indicative establishments were compared with the current budgeted establishment for each ward. It is recognised that one sample period of the MHOST data collection will only provide minimal assurance on typical acuity levels experienced, however it did show that the vast number of wards had recorded acuity that could be managed within the parameters of the set establishments. There were wards in both specialist and mental health services that were indicating that staffing levels were below those required for the levels of acuity at that time. A planned re-run of the MHOST tool will be undertaken for those wards.
It should be noted that through the current arrangements for safer staffing and daily SITREPS, staffing levels are varied on a daily basis to respond to pressures and ensure patient safety. All wards have access to increasing their daily staffing levels in line with clinically identified need.

Meetings were held with each ward manager, matron and senior clinical leads to discuss the findings from the data collection, areas of pressure, recruitment and retention and workforce development. A number of pressures were noted which included observations, level of escorts, physical health needs, management of breaks, reviews, tribunals and site management. Some requests were received for changes to the staffing structure to increase flexibility of recruitment to different/new roles and improve standards of care.

This information was triangulated with safer staffing data, incident data and information recorded in health roster and reviewed against current expenditure. Further work will be undertaken to develop a greater understanding of demand and acuity and the impact on staffing profiles and this will be aligned with the full implementation of SafeCare Module.

4.0 SafeCare

Future establishment reviews will be informed by SafeCare and a piece of work is being undertaken to align recording systems with finance and health roster. SafeCare has been awarded an endorsement statement by NICE as an effective tool to support safe staffing and will be used to inform future establishment reviews. Acuity/dependency will be measured on all inpatient wards twice a day using the MHOST and Shelford Group tools that are embedded into the system. The system will enable nursing staff to capture actual patient numbers by acuity and dependency and assess if staffing levels are appropriate. It will provide visibility across wards and sites transforming rostering into acuity based daily staffing process that unlocks productivity and safeguarding safety. It will replace and enhance the current arrangements for ensuring safer staffing.

5.0 Workforce Planning

The establishment review incorporated discussions in relation to workforce planning and development. The feedback will support the development of a skill structure and workforce development framework that will ensure internal capacity and capability to meet the needs of our populations. A co-ordinated piece of work has commenced based on the principles shown in Figure 2 that highlights the components of safe staffing as identified by National Quality Board.

Figure 2: The principles of Safe Staffing

<table>
<thead>
<tr>
<th>Expectation 1</th>
<th>Expectation 2</th>
<th>Expectation 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right Staff</strong></td>
<td><strong>Right Skills</strong></td>
<td><strong>Right Place and Time</strong></td>
</tr>
<tr>
<td>1.1 evidence – based workforce planning</td>
<td>2.1 mandatory training, development and education</td>
<td>3.1 productive working and eliminating waste</td>
</tr>
<tr>
<td>1.2 professional judgement</td>
<td>2.2 working as a multidisciplinary team</td>
<td>3.2 efficient deployment and flexibility</td>
</tr>
<tr>
<td>1.3 compare staffing with peers</td>
<td>2.3 recruitment and retention</td>
<td>3.3 efficient employment and minimising agency</td>
</tr>
</tbody>
</table>
A task group is being established to lead an ongoing piece of work on establishing ‘what is the right balance of staff’ in the varied settings treating those with mental illness. The work programme will look at the following:

- Take a multi-professional approach that takes into account all multi-professional staff involved
- Take into account that there are a range of care settings which can span organisational boundaries
- Develop a focus that is not just about filling rotas or looking only at numbers or input measures
- Remember that there is no ‘one size fits all’ approach for new models of care and the mix of staff we need
- That the work should be underpinned by the need for career progression for non-Registered staff, nurse retention and flexible working

### 6.0 Present Situation/Recommendations

In preparation for the establishment review all wards undertook dependency/acuity monitoring on a daily basis. The recommendations outlined are proposed in order to improve both patient safety and staff wellbeing.

#### Mental Health

**Ardleigh, Finchingfield and Stort Wards:**

Following introduction of the 12 hour shifts in the north of the county, arrangements were put in place to link up neighbouring wards for night shifts to ensure 3 Registered on shift. Following the review of acuity data, admissions and Datix incident reporting with discussions with ward management it is proposed that all acute admission units should have two registered nurses on every shift.

**Proposal** - An increase of one RMN during the night shift for Ardleigh, Finchingfield and Stort.

**Further action** - The use of temporary staff on the night shift in these adult acute wards will be monitored to ensure efficient use of staffing resources. A further re-run of the MHOST data collection will determine the acuity and staffing resource balance.

The Executive Committee have agreed to review the ‘therapeutic establishment’ of the adult acute ward determining optimum clinical care to be achieved. It is recognised that this is delivered by multi-professional groups and peer support workers to determine the purposeful admission. This review will be inclusive of the nursing establishment review process.

**Ruby Ward:**

Prior to the introduction of the long shifts the establishment on a day shift was 2:3. The acuity profile supports the establishment of 2:3 staffing levels during the long day. The ward has suggested that the role of a housekeeper would be the most beneficial role to the ward as it would release clinical time.

**Proposal** - to disestablish a vacant band 4 administrator role and covert into a housekeeper during the day shift. This post will not be included in the safer staffing figures.
Specialist Services

The acuity tool did indicate a number of shortfalls in staffing ratios across some wards in specialist services which are being managed at a local level within overall budget arrangements. This will be reviewed with the SafeCare acuity tool.

Following discussions with operational teams the following changes to establishments are proposed:

Rainbow Unit:

The current staffing establishment for Rainbow unit, a mother and baby unit has been agreed as follows:

<table>
<thead>
<tr>
<th>Day Shift</th>
<th>Night Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse</td>
<td>Nursery Nurse</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Women admitted to the mother and baby unit experience a range of serious mental health issues, such as severe depression, severe anxiety, including obsessive compulsive disorder and post-partum psychosis, or relapses in pre-existing mental health illnesses such as bipolar or psychosis. The babies may also be affected at birth by issues associated with the mother's illness. It is proposed that in order to provide appropriate care for the babies twenty four hours a day and support to the mothers' nursery nurse provision should be provided at night.

Proposal - to convert one Health Care Assistant on the night shift to a Nursery Nurse.

Poplar Unit:

As a result of Poplar Ward being involved in the restrictive practice collaborative with NHSI, efforts have been made to increase the level of interactions with the young people on the unit with a positive impact particularly on an evening and at weekends.

Proposal – to convert 0.60 HCA to 0.60 activity coordinator that can be used flexibly to increase interactions with the young people. This proposal does not have any financial impact.

Forest Ward:

Forest Ward is a 16 bedded unit, with a number of patients who are stepping down from High Secure Hospital. Following discussions with the Director and Associate Director of Specialist Services it was requested that staff levels should be increased.

Proposal - to increase the number of registered staff during the night shift to two. This additional resource provides an increased level of interventions with clients and will support a reduction in risk behaviours and the requirement for increased observations and client support.

Longview/Larkwood Wards:

Longview and Larkwood are located at St Aubyn Centre in Colchester. A request was for supernumerary site manager arrangements providing parity with other sites across the Trust.
There are currently extremely high acuity levels and risk associated with CAMHS services. Dedicated site leadership will support safe care and clinical direction for junior staff. Datix incidents have shown that peak risk times for the service are between 6pm – 12 midnight.

It is recognised that nationally child and adolescent services are managing young people with increasingly complex needs and high-risk behaviours with a paucity of more secure placements nationally.

**Proposal** - to increase nursing cover at night and an activity co-ordinator at peak times over the weekend on a temporary basis.

A more detailed skill mix review will be undertaken of the therapeutic skill mix across the unit. This will incorporate discussions with key stakeholders, including commissioners and a detailed review of nursing, psychology, allied health professional and medical input available.

**Edward House:**

Edward house has two adjoining wards and the proposal to reduce the Registered nurse establishment at night and increase the health care support workers matches the dependency levels on this unit.

**Proposal** - to change night shifts from 3RMN and 3HCA to 2RMN and 4 HCA to support client need.

**Nursing Homes:**

Rawreth Court and Clifton Lodge are now registered as nursing homes. As part of the establishment review a request was received to reduce the number of Registered staff per shift bringing in-line with nursing home staffing ratios across the county.

National standards have not been set for care homes although staffing levels are required to be in-line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 states that: ‘Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the set requirements’. Research undertaken by the Royal College of Nursing has indicated the number of registered nurses has reduced in care homes to approximately 25% of staffing. This corresponds to an average of 18.3 patients per registered nurse during the day and 26 at night.

**Proposal** - the proposed change of staffing levels for these units is as follows:

<table>
<thead>
<tr>
<th>Current Day Shift</th>
<th>Proposed Day Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>None Registered</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Qualified</td>
<td>None Registered</td>
</tr>
<tr>
<td>1 (plus supernumerary manager)</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Night Shift</th>
<th>Proposed Night Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified</td>
<td>None Registered</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Qualified</td>
<td>None Registered</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
The tables below detail presently funded establishments and recommended establishments as discussed earlier in the paper. The base line establishments cover nursing staff who are rostered to cover the minimum staffing. Changes are highlighted in blue. The associated staffing ratios are set out in appendix 1:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Ward Name</th>
<th>*</th>
<th>Current Funded Establishment</th>
<th>Recommended Establishment</th>
</tr>
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<tbody>
<tr>
<td>Mental Health</td>
<td>Beech</td>
<td>1.00</td>
<td>10.39</td>
<td>15.30</td>
</tr>
<tr>
<td></td>
<td>Cedar</td>
<td>1.00</td>
<td>10.39</td>
<td>12.76</td>
</tr>
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* No changes proposed to supernumerary WTE.

### 7.0 Recommendations

It is recommended that the Board of Directors:

1. Note the contents of this report
2. Review and agree the proposals to change the establishments as set out in the report
3. Note that further work will be undertaken to establish and benchmark the full range of nursing and therapeutic input provided in some areas where changes have been proposed.
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SUMMARY REPORT

BOARD OF DIRECTORS

PART 1

Agenda Item No: 6d
29th January 2020

Report title: Learning from Deaths – Mortality Review
Summary of Quarter 2 information

Executive Lead: Natalie Hammond, Executive Nurse

Report Author(s): Michelle Bourner, Mortality Review Project Co-ordinator

Report discussed previously at:
- Mortality Data Group (12/11/19)
- Mortality Review Sub-Committee (28/11/19)
- Quality Committee (12/12/19)

Level of Assurance: Level 1
Level 2 ✔
Level 3

Risk Rating: Low
Medium ✔
High

Purpose of the Report

The attached report presents:
- Information relating to deaths in scope for mortality review for Q2 2019/20 (1st July – 30th September 2019) together with updated information for Q1 2019/20 and for 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review in Q2.

Recommendations / Action Required

The Board of Directors is asked to:
- Note the information contained within the report; and
- Seek clarity where required.

Summary of Key Issues

The number of deaths continues to remain within the statistical control limits. There were 49 deaths which fell within scope for mortality review in accordance with the Trust’s Mortality Review Policy in Q2. Whilst slightly lower than quarters in 2018/19, this remains within control limits. It should also be noted that the refreshed Q1 data indicates a total number of deaths in scope of 49.

Of the 49 deaths, 11 were inpatient deaths and 2 were nursing home deaths. Of these 13 deaths, 9 deaths have been confirmed as due to natural causes. Confirmation of one cause of death is currently awaited. The remaining three deaths have been classified as Unexpected Unnatural deaths. These deaths are subject to serious incident investigation.

Of the total deaths in scope for Q2, 39% have so far been closed at Grade 1 following initial review by the Deceased Patient Review Group and 55% are undergoing Serious Incident Investigation (Grade 4). 2% are in the process of being subjected to Grade 2 (Case Note) review and the final grade of review for the remaining 4% of deaths is still under determination (to be considered by the Deceased Patient Review Group). This constitutes a significant improvement in the timeliness of consideration of deaths via the Trust’s governance processes (as at the same time of reporting for Q1, 57% of deaths were still under determination).

49% of deaths in Q2 have so far been deemed to have been definitely less likely than not to have been due to problems in care provided by EPUT. A problems in care score is still to be determined for 47% of deaths in Q2.

Please note, the above information is correct as at the date of preparing data for the report (2nd December 2019). It will be updated in future reports to the Board of Directors.
A detailed review has been undertaken of deaths in scope remaining open in 2018/19 and 2017/18 and positive progress has been made in concluding the review process for these deaths.

Refinements to the processes used by the Deceased Patient Review Group to improve timeliness of consideration of deaths and capacity (agreed by the Mortality Review Sub-Committee) have been implemented and it would appear are improving the timeliness of consideration of deaths in scope for mortality review.

Additionally, the pool of professional staff who can undertake a Grade 2 case note review has increased to over 60 staff including medical, nursing and AHP professionals. It is anticipated that this increase in capacity will support the commissioning and timely completion of Grade 2 Case Note Reviews.

The Mortality Review Sub-Committee has continued to give specific focus to ensuring learning from mortality review is implemented to improve practice and ultimately the quality of services.

**Relationship to Trust Strategic Priorities**

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<td>Achieve top 25% performance</td>
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**Which of the Trust Values are being delivered**

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**Relationship to the Board Assurance Framework**

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<td>Involvement of Service Users/ Healthwatch</td>
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<td>Impact on Patient Safety /Quality</td>
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<td>Equality Impact Assessment (EIA) Completed?</td>
<td>No</td>
<td>If YES, EIA Score</td>
<td>NA</td>
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**Governance Implications**

- ✓

**Impact on Patient Safety /Quality**

- ✓

**Impact on Equality & Diversity**

- ✓

**Equality Impact Assessment (EIA) Completed?**

- No

**If YES, EIA Score**

- NA
### Acronyms / Terms used in the report

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>DPRG</td>
<td>Deceased Patient Review Group</td>
</tr>
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<td>MRSC</td>
<td>Mortality Review Sub-Committee</td>
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<td>EPUT</td>
<td>Essex Partnership University NHS Foundation Trust</td>
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<td>SI</td>
<td>Serious Incident</td>
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<td>LeDeR</td>
<td>National Mortality Review Programme for Learning Disability Deaths</td>
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### Supporting Documents &/or Further Reading

**Attached** - Report on Mortality Information and Learning from Deaths for Q2 2019/20

- Annex A – 2017/18 Dashboard
- Annex B – 2018/19 Dashboard
- Annex C – 2019/20 Dashboard

“National Guidance on Learning from Deaths” Quality Board March 2017


“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](https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf)

### Executive Lead

Natalie Hammond  
**Executive Nurse**
1.0 PURPOSE OF REPORT

1.1 In support of ensuring that the Trust learns from deaths to improve the quality of services provided and in accordance with national guidance, this report presents:

- Information relating to deaths in scope for mortality review for Q2 2019/20 (1st July – 30th September 2019);
- Updated information relating to deaths in scope for mortality review in Q1 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review in Q2 2019/20.

2.0 BACKGROUND AND CONTEXT

2.1 The effective review of mortality is an important element of the Trust's approach to learning and ensuring the quality of services is continually improved. “National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care” (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. The Trust has subsequently implemented a Mortality Review Policy and agreed its approach to reporting mortality data.

2.2 In line with national guidance, quarterly reports are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q2 2019/20 (and updated Q1 2019/20, 2018/19 and 2017/18 data) as at the day the report was prepared (ie 2nd December 2019).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

3.1 The scope of deaths included within this report is in line with the scope defined in the Trust's Mortality Review Policy.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were 49 deaths which fell within scope for mortality review in accordance with the Trust’s Mortality Review Policy in Q2 2019/20. This is lower than quarters in 2018/19 but is consistent with Q1 2019/20 and remains within control limits. The total number of deaths in scope for Q1 2019/20 has increased from 36 (reported to Board of Directors in September 2019) to 49. An increase in the number of deaths for Q1 once data was refreshed was anticipated (outlined in the Q1 report to the Board of Directors).
Table 1: Breakdown of total deaths in scope for review 2017/18, 2018/19 and Q1 – Q2 2019/20

<table>
<thead>
<tr>
<th>Period</th>
<th>Total 2017/18</th>
<th>Total 2018/19 Q1 Total</th>
<th>Total 2018/19 Q2 Total</th>
<th>Total 2018/19 Q3 Total</th>
<th>Total 2018/19 Q4 Total</th>
<th>Total 2018/19 YTD</th>
<th>Total 2019/20 Q1 Total</th>
<th>Total 2019/20 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total deaths in scope</td>
<td>248</td>
<td>59</td>
<td>53</td>
<td>58</td>
<td>65</td>
<td>235</td>
<td>49</td>
<td>19</td>
</tr>
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</table>

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the 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. 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 1 below indicates that the number of deaths continues to remain within the control limits.

Figure 1:
Control chart of EPUT deaths “in scope” of Mortality Review Policy

4.3 Of the 49 deaths in Q2, 11 were inpatient deaths and 2 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. All deaths within EPUT inpatient / nursing home services in Q2, with the exception of four, have been confirmed as due to natural causes. Confirmation of cause of death is awaited for one death. The remaining three deaths were classified as Unexpected Unnatural. These deaths are being subjected to appropriate serious incident investigations.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed, as follows:
Of the 49 deaths in scope for Q2:

- 19 (39%) have been closed following a Grade 1 review by the Deceased Patients Review Group.
- 1 (2%) is being subjected to a clinical case record review (ie Grade 2 review) by an appropriate clinician.
- 10 (20%) have been subjected to a Serious Incident investigation (ie Grade 4 review) by an Investigating Officer; and 17 (35%) are in the process of being subjected to a Serious Incident investigation (ie Grade 4 review) by an Investigating Officer.
- The final review grade is still under determination for 2 deaths (4%). This will be deaths for which additional information is awaited by the Deceased Patient Review Group to be able to take a decision on an appropriate level of review (eg confirmed cause of death) or those which are awaiting consideration by the Deceased Patient Review Group. This constitutes significant positive progress in terms of the timeliness of consideration of deaths in scope via the Trust’s governance processes. At the same point in time for Q1, 57% of deaths in scope were still awaiting determination of a grade of review.

5.2 The Mortality Review Sub-Committee monitors the timeliness of consideration of deaths via the Deceased Patient Review Group. As reported to the Board of Directors in September 2019, processes are now in place for the consideration of deaths by the Deceased Patient Review Group to align exactly with the scope of review laid out in the Trust’s Mortality Review Policy. This has resulted in more timely review of deaths and an ability to subject each death to a greater degree of scrutiny.

5.3 The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to.

### Table 3: Breakdown of grade of reviews / investigations of deaths in scope

<table>
<thead>
<tr>
<th>Grade of review / investigation</th>
<th>2017/18 total</th>
<th>2018/19 Q1 total</th>
<th>2018/19 Q2 total</th>
<th>2018/19 Q3 total</th>
<th>2018/19 Q4 total</th>
<th>2019/20 Q1 total</th>
<th>2019/20 Q2 total</th>
<th>2019/20 Q3 total</th>
<th>2019/20 Q4 total</th>
<th>2019/20 YTD total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review by Deceased Patient Review Group (Grade 1)</td>
<td>148</td>
<td>41</td>
<td>25</td>
<td>25</td>
<td>39</td>
<td>130</td>
<td>20</td>
<td>7</td>
<td>9</td>
<td>3</td>
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<tr>
<td>Clinical Case Record Review (Grade 2)</td>
<td>11</td>
<td>6</td>
<td>4</td>
<td>4</td>
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<td>Critical Incident Review (Grade 3)</td>
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<td>Serious Incident Investigation (Grade 4)</td>
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<td>12</td>
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<td>22</td>
<td>69</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>9</td>
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<td>5</td>
<td>7</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>248</td>
<td>59</td>
<td>53</td>
<td>58</td>
<td>65</td>
<td>235</td>
<td>49</td>
<td>19</td>
<td>18</td>
<td>12</td>
</tr>
</tbody>
</table>
5.4 When considering the Q2 data, the Mortality Review Sub-Committee debated the proportion of deaths being subjected to Grade 2 case note review given that this is significantly lower than closure at Grade 1 or investigation at Grade 4. It was agreed that this would be kept under review. However it was noted that the Grade 1 closure audit was undertaken annually to provide assurance in terms of appropriateness of Grade 1 closures and that proactive steps were being taken to improve the ability of the Trust to undertake timely Grade 2 reviews (see paragraph 5.7 below).

5.5 Of the 49 deaths in scope in Q2, the review / investigation has been completed for 29 deaths (59%). This is a higher percentage than those closed at the same time of reporting for Q1 (31%), indicating again an improvement in the timeliness of consideration of deaths via the Trust’s governance processes. The review is in progress for the remaining 41% of deaths.

5.6 A detailed review of all 2018/19 deaths and 2017/18 deaths in scope remaining open has been undertaken to ensure that the reviews / investigations are all progressed to conclusion as soon as possible.

5.7 The Mortality Review Sub-Committee has recently taken action to widen the pool of professionals who can be commissioned to undertake Grade 2 case note reviews to include a broader range of professions including medics, nurses, allied health professionals and pharmacists. This was supported by delivery of a training session offered to all professionals newly joining the pool. There are now in excess of 60 professional staff who can be commissioned to undertake a review and it is anticipated that this significant increase in capacity will support the timely completion of Grade 2 case note reviews into the future.

6.0 ASSESSMENT OF THE EXTENT TO WHICH THE DEATHS WERE DUE TO “PROBLEMS IN CARE”

6.1 49% of deaths in Q2 have so far been deemed to have been definitely less likely than not to have been due to problems in care provided by EPUT. One death has been assessed with a score of 5 (“slight evidence”) and two deaths with a score of 4 (“not very likely”). A problems in care score is still to be determined for the remaining 47% of deaths.

6.2 71% of deaths in 2018/19 have now been deemed to have been definitely less likely than not to have been due to problems in care provided by EPUT. 20 deaths (9%) have been scored as a 5 (“slight evidence”), 11 deaths (5%) as a 4 (“not very likely”) and 6 deaths (3%) as a 3 (“probably likely”). The remaining 13% are still to be determined.

6.3 84% of deaths in Q3 and Q4 of 2017/18 have now been deemed to have been definitely less likely than not to have been due to problems in care provided by EPUT, 10% have been scored as a 5 (“slight evidence”), 2% have either been scored as a 3 (“probably likely”) or 4 (“not very likely”) and the remaining 4% are still to be determined.

6.4 Those deaths assessed with a score lower than a 6 (“definitely less likely than not”) have action plans associated with the findings of the review / investigation and their implementation is monitored. The families / carers of these deceased patients have been fully involved in the outcomes of the review / investigation and the actions resulting.
7.0 REFERRAL TO THE NATIONAL MORTALITY REVIEW PROGRAMME FOR LEARNING DISABILITY DEATHS (LeDeR)

7.1 Annexes A - C of this report detail the number of deaths that have been referred into the programme. Assurances can be given that all deaths meeting the criteria for referral to the LeDeR programme have been referred.

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS IN Q2

8.1 Learning from Individual Mortality Reviews

Detailed information on learning from serious incident investigations and other individual mortality reviews is presented and considered at the Learning Oversight Sub-Committee and Quality Committee to ensure actions are being taken to address the learning. Learning themes from Q2 have included risk assessments; patient / family engagement; record keeping and communication.

8.2 Learning from LeDeR

It was reported in the last report to the Board of Directors that the Mortality Review Sub-Committee had given consideration, at its meeting in August, to the Annual Report of learning from the national LeDeR programme together with learning themes from reviews undertaken of deaths within Essex (collated and provided by the LeDeR programme Essex Area Co-ordinator). An update on learning was discussed at the developmental meeting of the Mortality Review Sub-Committee in December 2019.

8.3 Learning from Thematic Reviews

The Mortality Review Sub-Committee has continued to oversee the progression of recommendations from the Serious Incident Deaths 2017/18 Thematic Review. In addition, the outcomes of the thematic reviews of deaths in Clifton Lodge / Rawreth Court 2018/19 and of expected deaths in West Essex Community Health Services 2018/19 have been considered by the Mortality Review Sub-Committee. These reviews indicated that the standard of care provided was of high quality with many examples of good practice identified. Some suggestions in terms of enhancements to practice / learning in Clifton Lodge / Rawreth Court were made and an action plan is being developed to take these forward.

8.4 General Learning from Morality Review

Developmental meetings of the Mortality Review Sub-Committee are now taking place on a bi-monthly basis. These have enhanced the ability of the Sub-Committee to focus on the learning emerging from mortality review and working towards the transformation of learning into changed clinical practice. This will continue to be a focus of the Sub-Committee over the coming months. For example, a presentation was considered at the December 2019 developmental meeting on learning themes emerging from deaths from 2017 to current date assessed with a problems in care score of 4 or below.

Dr Nuruz Zaman (Clinical Director Clinical Governance), Dr Feena Sebastian (Consultant Psychiatrist) and Michelle Bourner facilitated a session on learning from mortality review and considering changes to practice at a Trust-wide learning culture event on 6th November. Further opportunities to share learning across the Trust will continue to be explored.
9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q2 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – ie learning from deaths - is being achieved with examples of the learning themes being acted upon.

10.0 ACTION REQUIRED

10.1 The Board of Directors is asked to:

- Note the information contained within the report which sets out information relating to Q2 deaths within scope (and updated Q1 2019/20, 2018/19 and 2017/18 information); and
- Seek clarity where required.

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

December 2019
Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total number of deaths in scope</th>
<th>Total number of deaths in Scope in scope</th>
<th>Number of Other Deaths in Scope (excluding learning disability deaths)</th>
<th>Number of deaths in scope (excluding learning disability deaths) subjected to review by the Trust</th>
<th>Extent that these deaths deemed likely to be due to &quot;problems in care&quot;</th>
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</thead>
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<tr>
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<td></td>
<td>Grade 1 (DPRG) Complete In progress</td>
<td>Grade 2 (CRP) Complete In progress</td>
<td>Grade 3 (CIR) Complete In progress</td>
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<td>Complete In progress</td>
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<td>Complete In progress</td>
<td>Complete In progress</td>
</tr>
</tbody>
</table>

Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1-6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors.
### Learning from Deaths Dashboard - Breakdown for learning disability deaths

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total Number of Learning Disability Deaths (inc inpatient and community)</th>
<th>Total number of these LD Deaths subjected to national LeDeR programme</th>
<th>Number of these LD deaths subjected to review by the Trust</th>
<th>Extent that these LD deaths deemed likely to be due to “problems in care” (categorised according to National Guidance)</th>
<th>Under determination</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grade 1 (DPRG) Complete In progress</td>
<td>Grade 2 (CRP) Complete In progress</td>
<td>Grade 3 (CI) Complete In progress</td>
<td>Grade 4 (SI) Complete In progress</td>
</tr>
<tr>
<td>2017-18</td>
<td>Q1</td>
<td>13</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>YTD</td>
<td>13</td>
<td>0</td>
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</tr>
<tr>
<td></td>
<td>Q2</td>
<td>9</td>
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<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>YTD</td>
<td>22</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Q3</td>
<td>9</td>
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<td>9</td>
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</tr>
<tr>
<td></td>
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<td>YTD</td>
<td>31</td>
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</tr>
<tr>
<td></td>
<td>Q4</td>
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</tr>
<tr>
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<td></td>
<td></td>
<td>Total 2017-18</td>
<td>40</td>
<td>21</td>
<td>39</td>
</tr>
</tbody>
</table>

- **Learning Disability Deaths**
  - All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors.
### ANNEX B – MORTALITY DATA DASHBOARD 2018/19

#### 2018/19 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

**Total Deaths in Scope:**
- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria
- Deaths subject to a complaint / claim
- Deaths subject to a serious staff concern
- Severe Mental Illness as defined in Policy (not already included in above categories)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total number of deaths in scope</th>
<th>Number of Learning Disability deaths (breakdown detailed on separate sheet)</th>
<th>Number of deaths in scope (excluding Learning Disability deaths) subjected to review by the Trust</th>
<th>Extent that these deaths deemed likely to be due to &quot;problems in care&quot; (categorised according to National Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19</td>
<td>Q1</td>
<td>59</td>
<td>7</td>
<td>52</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 12 0 0 0 2 0 3 43 4</td>
</tr>
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<td>1 - Definitely more likely than not 2 - Strong evidence (significant more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
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<tr>
<td></td>
<td>YTD</td>
<td>59</td>
<td>7</td>
<td>52</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 12 0 0 0 2 0 3 43 4</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>2018-19</td>
<td>Q2</td>
<td>53</td>
<td>11</td>
<td>42</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
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<td>YTD</td>
<td>112</td>
<td>18</td>
<td>94</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>2018-19</td>
<td>Q3</td>
<td>58</td>
<td>4</td>
<td>54</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
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<td></td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significant more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
</tr>
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<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>YTD</td>
<td>170</td>
<td>22</td>
<td>148</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
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<td></td>
</tr>
<tr>
<td>2018-19</td>
<td>Q4</td>
<td>65</td>
<td>10</td>
<td>55</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significant more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 2018-19</td>
<td></td>
<td>235</td>
<td>32</td>
<td>203</td>
<td>Grade 1 (DPRG): Complete 0 2 4 0 0 19 0 5 0 0 3 3 4 25 7</td>
</tr>
</tbody>
</table>

**Note:** This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors
### 2018/19 Learning from Deaths Dashboard - Breakdown for learning disability deaths

#### Learning Disability Deaths
- All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total Number of Learning Disability Deaths (inc inpatient and community)</th>
<th>Total number of these LD Deaths subjected to national LeDeR programme</th>
<th>Number of these LD deaths subjected to review by the Trust</th>
<th>Extent that these LD deaths deemed likely to be due to “problems in care” (categorised according to National Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Grade 1 (DPRG) Complete In progress</td>
<td>Grade 2 (CRP) Complete In progress</td>
<td>Grade 3 (CI) Complete In progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018-19</td>
<td>Q1</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>2018-19</td>
<td>Q2</td>
<td>11</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>18</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>2018-19</td>
<td>Q3</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>22</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>2018-19</td>
<td>Q4</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>0</td>
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<tr>
<td><strong>Total 2018-19</strong></td>
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<td>32</td>
<td>31</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors*
# 2019/20 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

**Total Deaths in Scope:**
- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria
- Deaths subject to a complaint / claim
- Deaths subject to a serious staff concern
- Severe Mental Illness as defined in Policy (not already included in above categories)

## Table

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total number of deaths in scope</th>
<th>Number of Learning Disability deaths (breakdown detailed on separate sheet)</th>
<th>Number of deaths in scope (excluding Learning Disability deaths) subjected to review by the Trust</th>
<th>Extent that these deaths deemed likely to be due to &quot;problems in care&quot; (categorised according to National Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-20</td>
<td>C1</td>
<td>49</td>
<td>7 (42)</td>
<td>0 (3) 0 (0) 11 (2) 12 (0) 0 (0) 1 (0) 16 (25)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td></td>
<td>YTD</td>
<td>49</td>
<td>7 (42)</td>
<td>0 (3) 0 (0) 11 (2) 12 (0) 0 (0) 1 (0) 16 (25)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td>2019-20</td>
<td>Q2</td>
<td>49</td>
<td>3 (46)</td>
<td>0 (1) 0 (0) 10 (17) 0 (0) 0 (0) 1 (1) 22 (22)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td></td>
<td>YTD</td>
<td>98</td>
<td>10 (88)</td>
<td>31 (0) 0 (0) 4 (0) 0 (0) 21 (19) 12 (0) 2 (1) 38 (47)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td>2019-20</td>
<td>Q3</td>
<td>98</td>
<td>10 (88)</td>
<td>31 (0) 0 (0) 4 (0) 0 (0) 21 (19) 12 (0) 2 (1) 38 (47)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td></td>
<td>YTD</td>
<td>98</td>
<td>10 (88)</td>
<td>31 (0) 0 (0) 4 (0) 0 (0) 21 (19) 12 (0) 2 (1) 38 (47)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td>2019-20</td>
<td>Q4</td>
<td>98</td>
<td>10 (88)</td>
<td>31 (0) 0 (0) 4 (0) 0 (0) 21 (19) 12 (0) 2 (1) 38 (47)</td>
<td>1 - Definitely more likely than not</td>
</tr>
<tr>
<td><strong>Total 2019-20</strong></td>
<td></td>
<td>98</td>
<td>10 (88)</td>
<td>31 (0) 0 (0) 4 (0) 0 (0) 21 (19) 12 (0) 2 (1) 38 (47)</td>
<td>1 - Definitely more likely than not</td>
</tr>
</tbody>
</table>

**Note:** This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors.
### 2019/20 Learning from Deaths Dashboard - Breakdown for learning disability deaths

**Learning Disability Deaths**
- All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Quarter</th>
<th>Total Number of Learning Disability Deaths (Inc inpatient and community)</th>
<th>Total number of these LD Deaths subjected to national LeDeR programme</th>
<th>Number of these LD deaths subjected to review by the Trust</th>
<th>Extent that these LD deaths deemed likely to be due to “problems in care” (categorised according to National Guidance)</th>
<th>Under determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-20</td>
<td>Q1</td>
<td>7 7 6 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 6 1</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YTD</td>
<td></td>
<td>7 7 6 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 6 1</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20</td>
<td>Q2</td>
<td>3 3 2 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 2 1</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YTD</td>
<td></td>
<td>10 10 8 0 0 0 0 0 0 0 2 0 0 0 0 0 0 0 8 2</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20</td>
<td>Q3</td>
<td>10 10 8 0 0 0 0 0 0 0 2 0 0 0 0 0 0 0 8 2</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20</td>
<td>Q4</td>
<td>10 10 8 0 0 0 0 0 0 0 2 0 0 0 0 0 0 0 8 2</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 2019-20</td>
<td></td>
<td>10 10 8 0 0 0 0 0 0 0 2 0 0 0 0 0 0 0 8 2</td>
<td>1 - Definitely more likely than not 2 - Strong evidence (significantly more than 50:50) 3 - Probably likely (more than 50:50) 4 - Not very likely (less than 50:50) 5 - Slight evidence (significantly less than 50:50) 6 - Definitely less likely than not</td>
<td>Under determination</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: This data dashboard is subject to the data limitations outlined in detail in previous reports to the Board of Directors*
### Purpose of the Report

This report provides the Board of Directors with an overview of the 2019/20 Board Assurance Framework as at January 2020.

<table>
<thead>
<tr>
<th>Approval</th>
<th>Discussion</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Recommendations/Action Required

The Board of Directors is asked to:

1. Review the risks identified in the Board Assurance Framework 2019/20 in Table 1 and approve the risk scores (Appendix 1).
2. Approve the new risk recommended for inclusion on the BAF (section 1).
3. Note the mapping of BAF risks in Table 2 (Appendix 1).
4. Note the movement of the BAF risks in Table 3 (Appendix 1).
5. Note the summary of CRR risks in Table 4 (Appendix 2).
6. Approve the risks recommended for inclusion on the CRR (section 3).
7. Approve the risks recommended for closure from the CRR (section 3).
8. Approve the merger of BAF6 Just and Learning Culture and BAF35 Lessons Learnt.
9. Identify any further risks for escalation to the BAF, CRR or risk registers.

### Summary of Key Issues

- There are 13 risks on the Board Assurance Framework.
- 11 action plans are in place to mitigate potential risks. One risk requires an action plan to be developed, if required. One risk is not deemed to require an action plan by risk owners.
- One new risk is identified for inclusion on the BAF (High numbers of female inpatients with personality disorders).
- Two BAF risks are recommended for merger (BAF6 Just and Learning Culture, and BAF35 Learning Lessons).
- Three new risks are identified for inclusion on the CRR (HSE & recent inpatient deaths; increased regulatory scrutiny following serious inpatient patient safety incidents; IDTS disaggregation).
- Four CRR risks (CRR59, EU Exit; CRR27, Well-Led; CRR44, alignment with partners; CRR47, Capital Programme reduction) are identified for closure.
- Two CRR risks (CRR46, Medical staff pensions; CRR60, relationships with partners) are identified for closure and transfer to the Directorate Risk registers.

### Relationship to Trust Strategic Objectives

| SO 1: Continuously improve service user experiences and outcomes | ✓ |
| SO 2: Achieve top 25% performance | ✓ |
| SO 3: Valued system leader focused on integrated solutions | ✓ |
### Which of the Trust Values are Being Delivered

<table>
<thead>
<tr>
<th>Value</th>
<th></th>
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<tbody>
<tr>
<td>1: Open</td>
<td>✓</td>
</tr>
<tr>
<td>2: Compassionate</td>
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</tr>
<tr>
<td>3: Empowering</td>
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### Relationship to the Board Assurance Framework (BAF)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Are any existing risks in the BAF affected?</td>
<td>All</td>
</tr>
<tr>
<td>If yes, insert relevant risk</td>
<td>See report</td>
</tr>
<tr>
<td>Do you recommend a new entry to the BAF is made as a result of this report?</td>
<td>Yes</td>
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### Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

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<thead>
<tr>
<th>Impact Area</th>
<th>Assurance(s)</th>
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</thead>
<tbody>
<tr>
<td>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</td>
<td>✓</td>
</tr>
<tr>
<td>Data quality issues</td>
<td>✓</td>
</tr>
<tr>
<td>Involvement of Service Users/Healthwatch</td>
<td></td>
</tr>
<tr>
<td>Communication and consultation with stakeholders required</td>
<td></td>
</tr>
<tr>
<td>Service impact/health improvement gains</td>
<td>✓</td>
</tr>
<tr>
<td>Financial implications:</td>
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</tr>
<tr>
<td>Capital £</td>
<td></td>
</tr>
<tr>
<td>Revenue £</td>
<td></td>
</tr>
<tr>
<td>Non Recurrent £</td>
<td></td>
</tr>
<tr>
<td>Governance implications</td>
<td>✓</td>
</tr>
<tr>
<td>Impact on patient safety/quality</td>
<td>✓</td>
</tr>
<tr>
<td>Impact on equality and diversity</td>
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</table>

### Equality Impact Assessment (EIA) Completed?

<table>
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<tr>
<th>YES/NO</th>
<th>If YES, EIA Score</th>
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</table>

### Acronyms/Terms Used in the Report

<table>
<thead>
<tr>
<th>Acronyms/Terms Used in the Report</th>
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### Supporting Documents and/or Further Reading

- Appendix 1 – Summary of BAF
- Appendix 2 – Summary of CRR

### Lead

<table>
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<tr>
<th>Lead</th>
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<tbody>
<tr>
<td>Sally Morris</td>
</tr>
<tr>
<td>Chief Executive Officer</td>
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BOARD ASSURANCE FRAMEWORK 2019/20 AS AT JANUARY 2020 INCORPORATING Q3

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework for 2019/20 as at 29 January 2020.

UPDATE AS AT JANUARY 2020


The Board Assurance Framework (BAF) provides a comprehensive method for the effective management of the potential risks that may prevent achievement of the key aims agreed by the Board of Directors. The full BAF and CRR are available on request.

Following discussion with the Director of People and Culture it is recommended that BAF6 Just and Learning Culture and BAF35 Learning Lessons are merged due to their close alignment with learning.

One new risk is recommended for inclusion on the BAF by EOSC (Dec 19):

BAF36 “If the Trust continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety & length of stay.” $5 \times 3 = 15$

The EOSC recommended that the BAF10 (Ligature) risk score increase from $5 \times 3 = 15$ to $5 \times 4 = 20$ at the December meeting following the addition of actions from the latest CQC report.

Table 1 BAF 2019/20 Summary of risks, Table 2 Mapping against 5 x 5 risk scoring matrix, and Table 3 Movement on scoring are attached to this paper as Appendix 1.

2. BAF Action Plans

Potential risks on the BAF should (in most cases) have a detailed risk mitigation action plan. There are currently 13 risks on the BAF. 11 action plans are already in place. One risk requires an action plan to be developed, (BAF34 Transformation Recruitment). One risk is deemed not to require an action plan at this stage (CIPs).

Action plans are required to be reviewed each month by Executive Leads or delegated leads to ensure that action is contributing to risk mitigation. Standing Committees last received action plans for overview and scrutiny as detailed in Table 1 (Appendix 1 attached).

The Quality Committee considered all relevant action plans at its December meeting, and all other action plans were presented to Finance & Performance Committee at its January 2020 meeting for consideration and review. Further updates to action plans presented to F&PC have been made following comments on overdue actions.
3. Corporate Risk Register

A summary of the CRR is provided as Appendix 2.

The following risks have been identified for inclusion on the CRR:

“If the HSE considers recent inpatient deaths as part of its case against the Trust, there is a risk that EPUT’s mitigation case may be impacted, potentially resulting in the HSE taking increased regulatory or legal action against the Trust.”

**Recommended for inclusion on the CRR (EOSC Dec 2019)**

“If there are further serious inpatient patient safety incidents then there is a risk that the Trust could be subject to increased regulatory scrutiny with respect to clinical care and governance processes, impacting the Trust’s reputation and potentially CQC rating.”

**Recommended for inclusion on the CRR (EOSC Dec 2019)**

“If the IDTS service is not transferred to the new provider (CRG) in an orderly manner then EPUT may be unable or unwilling to continue delivering the service beyond the current contractual period, impacting service delivery, the Trust’s financial position and the Trust’s reputation.”

**Recommended for inclusion on the CRR (EOSC Dec 2019)**

The following risks have been identified for closure:

**CRR59** “If EPUT does not assess the potential implications of EU Exit as no deal or other then there may be unforeseen circumstances resulting in an impact on service delivery.”

All EU Exit activity has been stood down. A debrief session has been held with the Task and Finish Group and a report will be submitted to Board for assurance.

**Recommended for closure (EOSC Dec 2019).**

**CRR27** “If the Trust fails to deliver its Governance Development Plan this could impact on the CQC ‘well led’ domain.”

The Deloitte Well Led Review and recent CQC Well Led ‘Good’ rating provide assurance that there are no significant risks or issues.

**Recommended for closure. (EOSC Jan 2020)**

**CRR44** “If EPUT is unable to align with Provide and NELFT on reaching an agreement for wheelchair and continence services then the South and Mid ‘at scale’ commissioning review may be at risk resulting in a commissioning/system level risk putting EPUT in conflict with the STP.”

The Executive Chief Operating Officer is well aware of larger issues around working with NELFT and Provide.

**Recommended for closure. (EOSC Jan 2020)**

**CRR47** “If NHS England demand more than a 13% reduction in EPUT’s capital programme then a review of this programme will be required resulting in transformation projects being delayed or stopped.”

The Executive Chief Finance Officer advised that NHS England have confirmed no further reduction will requested this year.

**Recommended for closure. (EOSC Jan 2020)**
The following risks have been identified for de-escalation to a DRR:

**CRR46** “If medical staff cannot be retained in light of changes to tax arrangements then there will be an increased turnover of medical staff resulting in vacancies, use of locums, the potential for poor patient experience and an impact on finance and reputation.”

EPUT has completed all actions within its control, including writing to all eligible staff to inform them of national developments and agreeing a local medical retention scheme with the JLNC. **Recommended to de-escalate to Medical Risk Register to retain under review as risk may develop further in new financial year. (EOSC Jan 2020)**

**CRR60** “If the Trust does not effectively manage relationships with partners the Trust will not be seen as a key system player and decisions affected the organisation may be taken that adversely affect the sustainability of the Trust.”

The Well Led Assessment carried out by Deloitte identified broadly positive relationships. CEO followed up feedback with individual partners with no issues currently identified. **Recommended to de-escalate to Strategy & Transformation Risk Register. (EOSC Jan 2020)**

### 4. Directorate/Specialist Risk Registers

All Directorate/Specialist Risk Registers are updated on a monthly basis as far as practicable. Trust Secretary/Risk, Compliance and Assurance Risk Register was presented to EOSC in December and the Finance and Resources Risk Register was presented to EOSC in January.

### 6. Recommendations

The Board of Directors is asked to:

1. Review the risks identified in the Board Assurance Framework 2019/20 in Table 1 and approve the risk scores (Appendix 1).
2. Approve the new risk recommended for inclusion on the BAF (section 4)
3. Note the mapping of BAF risks in Table 2 (Appendix 1).
4. Note the movement of the BAF risks in Table 3 (Appendix 1).
5. Note the summary of CRR risks in Table 4 (Appendix 2)
6. Approve the risks recommended for inclusion on the CRR (section 3)
7. Approve the risks recommended for closure from the CRR (section 3).
8. Approve the merger of BAF6 Just and Learning Culture and BAF35 Lessons Learnt
9. Identify any further risks for escalation to the BAF, CRR or risk registers.

Report prepared by:

Thomas Way - Compliance, Assurance & Risk Assistant/Policy Controller  
Susan Barry - Head of Assurance

On behalf of:

Sally Morris  
Chief Executive
### Appendix 1

#### Table 1 – BAF 2019/20 Summary of Risks as at January 2020

<table>
<thead>
<tr>
<th>Code</th>
<th>Potential Risk</th>
<th>Exec Lead</th>
<th>Overview update</th>
<th>Risk scoring status (consequence x likelihood)</th>
<th>Action plan overview &amp; scrutiny/ date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Priority 1:</strong> To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corporate Objective 3:</strong> Maintain a 'Good' rating and progress towards 'Outstanding'</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| BAF4 | If fire safety systems and processes are not suitable and sufficient there is a potential risk of injury or death to patients, staff and visitors, and that enforcement action could be taken by the Fire Authority in the form or restrictions, forced closure of premises, fines, and prosecution/ custodial sentencing for ‘Responsible’ persons | MM | • 8 Actions on BAF action plan  
• 4 completed actions  
• 4 actions in progress within timescales  
• 1 action not yet due | Current Risk Score 5 x 3 = 15 | Finance and Performance January 2020 |
| BAF15 | If the HSE investigations into the actions taken by former NEP in respect of patient safety identify failings in the systems in place prior to merger this could result in prosecutions and/or fines being imposed on EPUT impacting on financial sustainability and reputation. | NL | • 9 Actions on BAF action plan.  
• 8 actions are complete.  
• 1 Action progressing within timescale | Current Risk Score 5 x 4 = 20 | Quality Committee December 19 |
| BAF20 | If there is insufficient adult mental health capacity then in-patient activity levels may exceed funded capacity and continued bed occupancy levels above 85% with high numbers of out of area placements, this may impact on the quality and effectiveness of services delivered as well as the Trust meeting its statutory financial duties. | AB | • 9 Actions on BAF action plan  
• 5 Actions added following latest CQC report  
• 5 Actions completed  
• 4 Actions progressing within timescales | Current Risk Score 5 x 3 = 15 | Finance and Performance January 2020 |
| BAF10 | If the Trust fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services. | MM/AB | • 14 Actions on BAF Action Plan  
• 4 Actions added following latest CQC inspection report; 1 added in response to PHSO / HSE.  
• 5 Actions completed  
• 7 Actions in progress within timescales  
• 2 Actions overdue (Policy review; identification of staff for ligature training) | Risk score increased EOSC December 2019, to be approved at Board January 2020 | Quality Committee December 19 |
| BAF6 | If EPUT does not develop a just, and learning culture to embed its agreed approach in response to incidents and errors then protection of both staff and patients is reduced resulting in poor quality services and patient experience | NH / SL | • 11 Actions on BAF Action Plan  
• 8 Completed actions  
• 2 Actions not yet due  
• 1 Action overdue (post-incident debriefing protocol) | Current Risk Score 4 x 3 = 12 | Quality Committee December 19 |
<table>
<thead>
<tr>
<th>Code</th>
<th>Potential Risk</th>
<th>Exec Lead</th>
<th>Overview update</th>
<th>Risk scoring status (consequence x likelihood)</th>
<th>Action plan overview &amp; scrutiny/ date</th>
</tr>
</thead>
</table>
| BAF9  | If EPUT does not embed a No Force First strategy through comprehensive and sustainable structures to monitor, deliver and integrate the approach in clinical practice then a reduction in conflict and restraint may not be achieved resulting in work related staff sickness and poor patient experience | NH        | • 14 Actions on BAF Action Plan  
• 9 new actions added following latest CQC report  
• 5 completed actions  
• 7 actions either in progress within timescale or recently following CQC inspection report.  
• 2 Actions overdue (Agree governance process for Restrictive Practice; review Datix reporting regarding restraints)                                                                                                    | Current Risk Score  
4 x 4 = 16                                           | Risk score unchanged  
Quality Committee December 19                       |
| BAF33 | If the national lack of CAMHS PICU and Low Secure beds continues then young people may be required to be routinely admitted to adult facilities within the Trust resulting in a poor care experience and increased regulatory scrutiny | AB        | • 5 Actions on BAF Action Plan  
• All actions are complete                                                                                                                           | Current risk score  
3 x 4 = 12                                           | Risk score unchanged  
Quality Committee December 2019                      |
| BAF35 | If the Trust is unable to demonstrate that lessons are being learnt as a result of incidents, then action may not be taken consistently to prevent future occurrences and the CQC rating of the Trust / services is unlikely to improve | AB / NH / SM | • 11 Actions on BAF Action Plan  
• 4 Completed actions  
• 4 actions overdue (Establishment of workshop; Initiate QI Programme; changes to RCA and Clinical Risk Training; Review Safety Alerts system)  
• 3 actions not yet due                                                                 | Current Risk Score  
4 x 4 = 16                                           | New risk added to BAF October 2019  
To be merged with BAF6 – agreed at EOSC January 2020 | Quality Committee December 2019                      |
| BAF36 | If The Trust continues to experience high numbers of female patients with personality disorders being admitted to inpatient services then there is a risk that the ward environment may become more volatile and difficult to manage, impacting patient safety and length of stay. | AB / NH / SM | • Increased relational security  
• Increased usage of CCTV  
• Trial of Body-Worn Cameras  
• Ward-based risk assessments & blanket rules  
• Increase staffing levels  
• Increased provisions of activities  
• Increased access to psychological therapy                                                                 | Current Risk Score  
5 x 3 = 15                                           | Proposed new risk added to BAF December 2019 (EOSC) – to be approved at January Board. | Quality Committee December 19                      |

**Strategic Objective 2:** To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts

**Corporate Objective 4:** Be an employer of choice

<table>
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<th>Risk scoring status (consequence x likelihood)</th>
<th>Action plan overview &amp; scrutiny/ date</th>
</tr>
</thead>
</table>
| BAF31 | If EPUT does not have the skills, and capacity to deliver high quality services then the ability to achieve top 25% performance is reduced                                                                                                                                                                                                     | All Execs | • 28 Actions on BAF action plan  
• 9 Actions completed  
• 13 actions progressing within timescale  
• 3 Actions not yet due  
• 3 Actions overdue (implement revised leadership structure; develop locality hubs for collective leadership; deliver transformation workshops)                                                                                                                                  | Current Score  
5 x 3 =15                                           | Risk score unchanged  
Finance and Performance January 2020                  |
<table>
<thead>
<tr>
<th>Code</th>
<th>Potential Risk</th>
<th>Exec Lead</th>
<th>Overview update</th>
<th>Risk scoring status (consequence x likelihood)</th>
<th>Action plan overview &amp; scrutiny/ date</th>
</tr>
</thead>
</table>
| BAF13  | If services are unable to identify efficiencies through CIPs then the organisation will not be financially sustainable. | MM        | • Total CIP requirement is £11.661m. End of M8 FYE - £6.256k CIP schemes fully developed; £2.224k schemes identified as Pipeline; At M8 the 19/20 part year effect is £6.785k of CIP schemes fully developed; £1.888k identified as Pipeline. In year shortfall will be addressed by utilising underspends and reserves. Circa £3million shortfall.  
• The Trust is still forecasting achievement of the financial plan taking the shortfall into account. | Current Risk Score 4 x 4 = 16 | Risk score unchanged  
Finance and Performance January 2020 |
| BAF18  | If EPUT focusses leadership and clinical capacity on its huge transformation programme across 7 CCGs and 3 STPs then a balance may not be achieved in managing operations resulting in a risk to safe and effective services | NL/AB     | • 26 Actions on BAF action plan  
• 23 Complete actions  
• 3 Actions progressing within timescale | Current Risk Score 4 x 3 = 12 | Risk score unchanged  
Finance and Performance January 2020 |
| BAF32  | If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation | All Execs | • 13 Actions on BAF Action Plan  
• 3 Complete Actions  
• 9 Actions in progress within timescale  
• 1 ongoing action. | Current risk score 4 x 4 = 16 | Risk score unchanged  
Finance and Performance January 2020 |
| BAF34  | If the Trust is unable to recruit new / additional staff to deliver new services and care pathways developed as part of the Transformation programme then the success of new services may be impacted or existing services may not be able to retain staff | AB/NL     | • Action plan to be developed  
• Mapping of all new posts/ vacancies underway  
• Recruitment campaign being finalised  
• Detailed action plan to be developed and summarised as a BAF action plan  
• Alternative plans to be considered where appropriate for posts the Trust is unable to recruit to. | Current risk score 4 x 4 = 16 | New risk added to BAF October 2019  
New Risk Finance and Performance January 2020 |
### Table 2: Mapping of risks against 5 x 5 scoring matrix

<table>
<thead>
<tr>
<th>RISK RATING</th>
<th>Consequence</th>
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</thead>
<tbody>
<tr>
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</table>
Table 3: Movement on scoring – 2 year period from February 2018 to January 2020 (rolling two year period)

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<th>Real Risk</th>
<th>Exec Lead</th>
<th>Update</th>
<th>Risk scoring status CxL</th>
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</thead>
<tbody>
<tr>
<td><strong>Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services</strong></td>
<td></td>
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<tr>
<td>CRR51 If staff are not alert whilst on duty then high quality care will not be delivered resulting in poor patient experience</td>
<td>AB</td>
<td>• Reported incidents have reduced during Q3. Update report being presented to ET by 31 January 2020 with recommendation to de-escalate to DRR. • Spike in incidents in December</td>
<td>3 x 3 = 9</td>
</tr>
<tr>
<td>CRR55 If The Trust does not have sufficient resources in place to manage and review the data required for the HSE mitigation this could result in a delay in submission and result in mitigation not being considered by the HSE which could reduce a potential prosecution.</td>
<td>NL</td>
<td>• All actions complete and data submitted within timescales. • Recommended for closure at EOSC December 2019</td>
<td>5 x 3 = 15</td>
</tr>
<tr>
<td>CRR58 If Each in-patient ward does not fill shifts consistently to a minimum of 90%, patient care, staff morale and compliance with CQC regulations could be adversely impacted.</td>
<td>AB</td>
<td>• De-escalated from BAF (BAF21) October 2019</td>
<td>5 x 3 = 15</td>
</tr>
<tr>
<td>CRR59 IF EPUT does not assess the potential implications of EU Exit as no deal or other then there may be unforeseen circumstances resulting in an impact on service delivery</td>
<td>MM AB NL MK SL</td>
<td>• All EU Exit preparations now stood down following instructions from NHSE/I • Debrief meeting held • Debrief / status report paper to be submitted to Board for Assurance • Recommended for closure EOSC December 2019</td>
<td>4 x 5 = 20</td>
</tr>
<tr>
<td><strong>Corporate Objective 1: Drive our quality agenda</strong></td>
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<tr>
<td>CRR11 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</td>
<td>NH</td>
<td>• Performance data developed displaying identified data on Out of Area Placements and 48 Hour Follow Up. • Rolling programme of training in place to support development of competencies across workforce. • Draft Suicide Prevention Clinical Guidelines developed • Self-harm Review sub-group to review Clinical Guidelines by March 2020 • Staff Alive App embedded with plan for evaluation in 2020 • Active involvement in NHSE Suicide Prevention Learning Set and STP Mental Health Board</td>
<td>4 x 4 = 16</td>
</tr>
<tr>
<td>Corporate Objective 2: Advance our Research and Innovation Strategy</td>
<td>Exec Lead</td>
<td>Update</td>
<td>Risk scoring status CxL</td>
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</tbody>
</table>
| CRR39 If EPUT does not drive improvement through clinical research then an outstanding rating may not be possible resulting in the Trust not reaching its aspiration in the desired timeframe | MK        | • Second QI Innovation and Research Workshop was scheduled for 23/10/19  
• Ongoing promotion of research through NIHR Funded Research and Innovations team attendance and presentation at conferences / careers days Trustwide  
• 3 Applications received for Biannual Clinical Innovation Prize  
• News and events page included on webpage.  
• RfPB Grant Joint application with University of Essex submitted 22nd July  
• Research and Innovation Strategy with implementation plan agreed by QC | 3 x 3 = 9 |

<table>
<thead>
<tr>
<th>Corporate Objective 3: Maintain a ‘Good’ rating and progress towards ‘Outstanding’</th>
<th>Exec Lead</th>
<th>Update</th>
<th>Risk scoring status CxL</th>
</tr>
</thead>
</table>
| CRR1 If effective management of medical devices does not happen then equipment may not be available or correctly maintained or calibrated that may impact on patient safety | SM        | • There is ongoing liaison with the Medical Devices Contractor and operational services to ensure asset registers are up to date and servicing takes place when required.  
• Establishment of a single contractor is progressing.  
• Monitoring of incident activity relating to medical devices.  
• Awaiting confirmation of sign-off of main medical device contract with Althea. Ad hoc contracts continue for some specialist equipment.  
• Cross-referencing exercise to determine accuracy of Althea’s data regarding EPUT device service history. | 4 x 3 = 12 |

<p>| CRR12 If physical health goes unmonitored by patients prescribed high dose antipsychotic drugs there is a risk of serious harm and non-compliance with NICE guidelines | MK NH AB  | • No further update received                                                                                                                                                                         | 4 x 4 = 16 |</p>
<table>
<thead>
<tr>
<th>Real Risk</th>
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<th>Update</th>
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</table>
| CRR16 If violence and aggression is not managed there is a risk of severe harm or death, as well as impacting on reputation and staff survey results. | MM | • Violence and aggression workshops held every 6 months across Trust.  
• Body Worn Video trial underway for 4 months, soon to be trialling another provider on four wards.  
• All staff affected by incidents receive support letter from LSMS and Staff Engagement.  
• LSMS attends Essex Crisis Concordat and local police meetings  
• Joint newsletter with police developed and added to LSMS InPut page.  
• BDO internal audit recommendations action plan developed and implemented.  
• Appropriate use of Datix promoted at Datix training and Workshops  
• Staff awareness of processes in relation to V&A promoted via flowchart and discussion at workshops and local police meetings. | 4 x 3 = 12 |
| CRR40 If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT | MM | • High level BAF action plan completed  
• Capital funding secured and projects underway | 4 x 2 = 8 |
| CRR27 If the Trust fails to deliver its Governance Development Plan this could impact on the CQC well led domain | SM | • Governance Development Plan under review  
• CQC Well-Led domain (Oct 19 report) was rated Good and confirmed that governance arrangements are robust  
• Deloitte Well Led Review (July 2019 report) did not identify any significant risks or issues  
• Recommended for closure EOSC January 2020 | 4 x 2 = 8 |
| CRR37 If the hospital transport contractor does not pick up patients or drop them off in a safe and timely manner then patients may be left waiting, be dropped off in unsafe places, or miss appointments/groups, resulting in potential harm, disengagement from services and complaints | NL | • System wide review and procurement and issues are highlighted to the CCG – no change  
• Ongoing discussions at system level outside of EPUT’s control. | 4 x 4 = 16 |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| CRR42 If the CQC intelligence system (Insight) continued to identify poor performance or risks that do not correlate with EPUT internal data this could result in an unannounced inspection of services or missed opportunities for improvement | SM MM     | • Initial analysis of latest report appears to show report data is more accurate than previous Insight Reports.  
• Paper going to QC in January with brief summary on content, full analysis paper in February. | 3 x 4 = 12             |
| CRR53 If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences. | AB MM     | • Detailed project plan in place  
• Staff consultation underway following Phase 1. | 3 x 4 = 12             |
| CRR56 If blanket restrictions continue to be operated in in-patient mental health services, then the experience of patients will be impacted and the CQC rating of the Trust / in-patient services is unlikely to improve | AB NH     | • Restrictive Practice group ToR to be presented next month with identified Medical lead  
• Restrictive Practice Clinical Policy under development  
• Paper to go to ET detailing Restrictive Practice Framework Implementation Plan  
• Trust working with RCPsych as part of collaborative around Restrictive Practice – Christopher Unit (PICU) and Poplar Ward (CAMHS) involved  
• Work underway to identify ward with worst Restrictive Practice incident figures, with a view to developing action plan and then sharing learning with other wards.  
• Staff encouraged to use safety tools e.g. safety crosses  
• Implement national training standards for restrictive practice  
• Online learning package and communications package being developed  
• Explore technological options e.g. wristbands for bedroom access. | 3 x 4 = 12             |
<p>| Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts |           |                                                                                                                                                                                                         |                        |
| Corporate Objective 4: Be an employer of choice                            |           |                                                                                                                                                                                                         |                        |
| CRR14 If staff morale is low it could impact on the trust’s track record of delivering high quality services and impact on ability to deliver transformation change required | SL        |                                                                                                                                                                                                         | 4 x 3 = 12             |</p>
<table>
<thead>
<tr>
<th>Real Risk</th>
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</table>
| CRR34 If there are insufficient avoidable death trainers and staff are not trained effectively in avoidable deaths then there is a risk that staff may not have the necessary skills to safely support a suicidal patient, resulting in self-harm or suicide. | NH | - 2 additional trainers (inclusive of dedicated substantive trainer) have been trained to deliver all 3 modules of Connecting with People (CwP).  
- 7 previously trained trainers have completed CwP revalidation training  
- 2 training sessions a month booked throughout 2020  
- Bespoke training sessions being offered to teams e.g. newly established Urgent Care Teams.  
- Trust is exploring development of a refresher session for staff who completed CwP training over a year ago, to ensure they are confident and competent in the application of the tool. | 3 x 3 = 9 |
| CRR45 If the revised mandatory training policy requirements are not achieved this could impact on the Trust’s ability to maintain a ‘good’ rating. | AB | - Mandatory training is monitored closely with monthly reports sent to a range of committees throughout the Trust.  
- Mandatory training policy is undergoing a rigorous but lengthy approval process which should ensure the policy is fit for purpose and meets the needs of the Trust.  
- Managers are aware of the need to release staff and are advised accordingly.  
- Course availability is calculated so that sufficient places are available for operational staff.  
- The new database should ensure that the compliance is as live and up to date as possible.  
- The tracker demonstrates compliance and is available for managers to see at any time. | 4 x 3 = 12 |
| CRR46 If medical staff cannot be retained in light of changes to tax arrangements then there will be an increased turnover of medical staff resulting in vacancies, use of locums, the potential for poor patient experience and an impact on finance and reputation | MK | - All eligible staff to be written to in January 2020 to advise them of new national arrangements  
- Local medical retention scheme for pension scheme – annual and allowance in place and communication to all affected has been issued  
- Recommended for closure and move to Medical DRR | 3 x 3 = 9 |
<table>
<thead>
<tr>
<th>Real Risk</th>
<th>Exec Lead</th>
<th>Update</th>
<th>Risk scoring status CxL</th>
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</table>
| CRR48 If Consultant cover cannot be maintained in North East Essex then there will an increase in use of locums resulting in increased costs | MK                         | • Paper going to ET in January 2020 with actions taken re medical cover on PBU  
• Further meetings taking place in January with the Consultant body to look at filling vacancies and for consistent senior cover to be in place.  
• Progress has started with appointment cover to Ardleigh with immediate effect.                                                                                          | 5 x 4 = 20             |
| CRR57 If Equality & Diversity is not embedded into the culture and conversation of the Trust then staff and patient experience may be negatively impacted and the CQC Well Led rating of the Trust is unlikely to improve | All Execs, SL leading     | • Equality strategy being refreshed to include a BE YOU campaign to bring all equality strands together  
• Anti-bullying programme of work  
• Continued promotion of and recruitment to staff networks  
• Continued recruitment of Equality Champions, Anti-bullying ambassadors and Lived Experience Library contributors  
• Review of Board Development Programme to include inclusion  
• Equality committee to be refreshed and implemented in 2020  
• Quarterly Equality Report for BoD and EDs starting January 2020                                                                                                          | 3 x 4 = 12             |

**Corporate Objective 5: Deliver the Trust’s financial plan and control total for 2019/20**

**Corporate Objective 6: Achieve contract targets and objectives**

| CRR28 If mental health clinical activity is not entered into patient admin systems on a timely basis this could impact on monitoring and reporting key performance measures which could result in breaches on regulatory or contractual requirements | AB/ MK                     | • Missing outcomes live report established  
• Continue to have late data entry, no improvement seen  
• Data Quality Task & Finish Group established  
• Paris & Mobius users remain below local timeliness target 2019-20 YTD (Jan 20)                                                                                          | 5 x 3 = 15             |
| CRR30 If data entry is incorrect, late or recorded on paper then managers may not have sufficient information for decision making, data from paper records cannot be reported on, impacting on contractual obligations and the risk of financial penalties | MM                         | • Data Quality Task & Finish Group established  
• Adequate assurance from 2019 internal audit of Data Quality  
• Paris and Mobius users remain below local timeliness target 2019-20 YTD (Jan 20)                                                                                          | 4 x 3 = 12             |
<table>
<thead>
<tr>
<th>Real Risk</th>
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<th>Update</th>
<th>Risk scoring status CxL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRR49 If access and assessment services receive high levels of referrals which do meet the threshold for secondary services then the ability to respond is reduced resulting in poor patient experience</td>
<td>AB</td>
<td>• Escalated from Mental Health Directorate Risk Register&lt;br&gt;• Task and Finish Group in place&lt;br&gt;• Management plan in place&lt;br&gt;• Breaching commissioner waiting time targets</td>
<td>3 x 3 = 9</td>
</tr>
<tr>
<td>CRR50 If EPUT’s Special Allocation Service cannot access SystmOne then patient records and e-prescription services are inaccessible resulting in an unsafe patient experience</td>
<td>MM</td>
<td>• ITT looking at resolving access issues to SystmOne for Special Allocation Services</td>
<td>4 x 3 = 12</td>
</tr>
<tr>
<td>CRR54 If current delays in sending dementia diagnosis letters are not addressed then patient care could be impacted resulting in a breach of contractual requirements</td>
<td>AB NH</td>
<td>• Dementia Task &amp; Finish Group in place&lt;br&gt;• Mid letter backlog cleared&lt;br&gt;• New processes agreed&lt;br&gt;• Delays in letters in Mid, NE &amp; West Essex.</td>
<td>3 x 3 = 9</td>
</tr>
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</table>

**Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve**

**Corporate Objective 7: Participate as a valued partner in the STPs**

<table>
<thead>
<tr>
<th>Real Risk</th>
<th>Exec Lead</th>
<th>Update</th>
<th>Risk scoring status CxL</th>
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<tbody>
<tr>
<td>CRR44 If EPUT is unable to align with Provide and NELFT on reaching an agreement for wheelchair and continence services then the South and Mid ‘at scale’ commissioning review may be at risk resulting in a commissioning/system level risk putting EPUT in conflict with STP</td>
<td>AB/NL</td>
<td>• This is an ongoing issue and EPUT is still awaiting a decision from Commissioners as to the next steps&lt;br&gt;• Recommended for closure</td>
<td>3 x 3 = 9</td>
</tr>
<tr>
<td>CRR52 If EPUT, as the lead in the consortium, is unable to manage overruns or delays in the implementation of HSCN, then this may weaken relationships with partners resulting in a threat to reputation and a financial cost pressure</td>
<td>MM</td>
<td>• Monitored at monthly operational and Strategic partner meetings&lt;br&gt;• Additional time slots have been offered&lt;br&gt;• All partners have indicated their willingness to accept the first slot offered for migration&lt;br&gt;• Ongoing intermittent issues with HSCN delaying migrations</td>
<td>3 x 4 = 12</td>
</tr>
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### Corporate Objective 8: Transform services through the use of new clinical models and pathways and techniques

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</table>
| CRR36 If the provision of primary care services in different areas of the Trust includes a range of varying models then this presents an associated challenge to corporate services in providing performance management information and responding to data requests, resulting in a resource and capacity issue impacting on contract requirements and financial sustainability. | MM | • Assess the risks to corporate functions  
• Align strategies and frameworks to wider health economy  
• Take account of in well led assessment | 4 x 4 = 16 |
| CRR47 If NHS England demand more than a 13% reduction in EPUT’s capital programme then a review of the programme will be required resulting in transformation projects being delayed or stopped. | MM | • 13% reduction agreed with NHS England for 2019/20  
• NHS England have confirmed no further reduction will happen this year  
• Recommended for closure | 3 x 3 = 9 |
| CRR60 If the Trust does not effectively manage relationships with partners the Trust will not be seen as a key system player and decisions affecting the organisation may be taken that adversely affect the sustainability of the Trust. | SM/ NL | • Well Led Assessment carried out by Deloitte identified broadly positive relationships  
• CEO followed up feedback with individual partners and has held meetings / conversations as necessary. No issues currently identified  
• Recommended for closure and move to Strategy & Transformation DRR | 4 x 1 = 4 |

### Corporate Objective 9: Drive our commercial strategy
### Purpose of the Report

This report provides: Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.

### Recommendations/Action Required

The Board of Directors is asked to:

1. To note the contents of the report
2. To confirm acceptance of assurance given in respect of risks and actions identified
3. To request further action/information as required.

### Summary of Key Issues

- Minutes of meeting held on the 14 November 2019
- Internal Audit Progress Report 2019/20
- LCFS Progress Report
- External Audit
- IFRS 16 (Lease Accounting)
- Waiver of Standing Orders
- Statement of Financial Position Write Offs/Backs
- Impaired Debt Write Offs
- Finance Procedures

### Relationship to Trust Strategic Objectives

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Status</th>
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<tr>
<td>SO 1: Continuously improve service user experiences and outcomes</td>
<td>✔</td>
</tr>
<tr>
<td>SO 2: Achieve top 25% performance</td>
<td>✔</td>
</tr>
<tr>
<td>SO 3: Valued system leader focused on integrated solutions</td>
<td>✔</td>
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### Which of the Trust Values are Being Delivered

1: Open ✔
2: Compassionate ✔
### 3: Empowering

**Relationship to the Board Assurance Framework (BAF)**

| Are any existing risks in the BAF affected? | No |
| If yes, insert relevant risk | |
| Do you recommend a new entry to the BAF is made as a result of this report? | No |

### 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 £ | Nil |

| Governance implications | ✓ |
| Impact on patient safety/quality | ✓ |
| Impact on equality and diversity | |
| Equality Impact Assessment (EIA) Completed? YES/NO | YES/NO |
| If YES, EIA Score | No |

### Acronyms/Terms Used in the Report

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### Supporting Documents and/or Further Reading

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### Lead

Janet Wood  
Chair of Audit Committee
ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

This report is provided by the Chair of the Audit Committee, a sub-committee of the Board of Directors to provide assurance to Board members that the duties of the Audit Committee which include Governance, Risk Management and Internal Control have been appropriately complied with.

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 7 January 2020

The Audit Committee met on the 7 January 2020 and approved the minutes of the meeting held on 14 November 2019. These minutes are available to Board members on request.

At the meeting held on 7 January 2020 the following matters were discussed:

1. Internal Audit

   **Internal Audit Progress Report 2019/20**
   The following reports have been finalised and issued with the following assurance:

   - Key Financial Systems (Patient Monies) – Moderate assurance issued
   - Data Quality – Moderate assurance issued.
   - Health & Safety – Moderate assurance issued.

   The following reports are due to be presented to the Audit Committee in March 2020.

   - Equality and Diversity
   - Data Security and Protection Toolkit

   **LCFS Progress Report**

   **Procurement Exercise**
   The first phase of the procurement exercise has now been completed. The second phase is due to take place in April 2020.

   **Referrals**
   The Trust’s LCFS updated the Committee on the current investigations.

   **Fraud Champions Network**
   Clare Barley, Head of Financial Accounts, has been nominated as the Trust’s Fraud Champions Network lead.
2. **External Audit**

   **External Audit Plan 20/21**
   The external Audit Plan is due to be presented to the March Audit Committee Meeting.

   **2019/20 Annual Accounts**
   The final annual accounts for 2019/20 are due to be audited at the end of April 2020.

   **Final Charitable Fund Accounts 2018/19**
   The final accounts are in the process of being reviewed by the external auditors.

3. **IFRS16 (Lease Accounting)**
   The above return is due to be submitted to NHSI by the 15 January 2020.

4. **Waiver of Standing Orders**
   CB reported that during the period from 1st November to 30 November 2019, standing orders for competitive quotations were waived on one occasion to the value of £43,187 (including VAT).

5. **Statement of Financial Position Write Offs/Backs**
   A credit balance has been received of £9k relating to staff parking permits

6. **Impaired Debt Write Offs**
   The Executive Chief Finance Officer approved the write off £11,562.42 relating to staff and trade debts as at the 31st December 2019.

7. **Finance Procedures**
   The following procedures were approved:
   - Monitoring of the Internal & External Audit Contract Protocols (FP09/05)
   - Interest Free Loan for Season Tickets
   - Purchase Card Procedure

3.0 **MANAGEMENT OF RISK**

The Audit Committee is not responsible for managing any of the Trust’s significant risks (as identified in the Board Assurance Framework).

4.0 **NEW RISKS**

There are no new risks that the Audit Committee has identified that require adding to the Trusts’ Assurance Framework, nor bringing to the attention of the Board of Directors.
5.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the summary of the meeting held on 7 January 2020
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee
Report Title: Finance & Performance Committee Assurance Report

Executive/Non-Executive Lead: Manny Lewis  
Chair of the Finance and Performance Committee  
Sally Morris  
Chief Executive Officer

Report Author(s): Janette Leonard  
Director of ITT, Business Analysis and Reporting

Purpose of the Report
This report provides:
- Assurance to the Board of Directors that the Finance and Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust’s objective and impact on quality are being managed effectively.

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

Summary of Key Issues
The Committee considered the following key issues:

Quality & Performance Report (including contractual exceptions performance)
The committee noted the following:
- 9 Hotspots
- 2 Emerging Risks
- 1 Contractual Performance Notice

Contractual Performance
A Contract Performance Notice (CPN) was issued by Mid & South Essex CCG’s on Risk Assessment within 4 hours. A recovery action plan has also now been put in place and agreed with the Commissioners to bring this indicator back on target. Since the last report the Trust has also been made aware that the Commissioners will be issuing another CPN for patients not seen within 28 days by the first response team.

Financial Performance Report
The Trust is reporting a surplus of £3.0m against a planned £2.1m surplus, this being a £0.5m improvement from the Month 7 financial position (£0.3m improvement from month 8). The delegated position continues to improve and is currently an adverse variance of £0.1m, however there is an adverse income variance of £0.6m from contract and CQUIN underperformance. Central reserves are offsetting these overspends, and the underspend in non-delegated budgets remains the key driver for the surplus.
Sub-Committee Reports
The committee received 6 sets of the Executive Operational Sub Committee part one minutes for noting:

- 5th November 2019
- 19th November 2019
- 26th November 2019
- 3rd December 2019
- 17th December 2019
- 7th January 2020

BAF Action Plans
The risks still open were presented to the Committee for discussion and the associated action plans. The committee expressed some concern that actions to mitigate risk are not progressing in line with agreed timescales and requested that the action plans are reviewed before the final position is reported to the board.

5 Risks have been closed in the last quarter: BAF14, BAF21, BAF22, BAF23 & BAF30.

Any Risks or Issues
There are no risks or issues.

Any other Business
There was no other business.

Relationship to Trust Strategic Priorities
| SP 1: Continuously improve patient safety, experience and outcomes | ✓ |
| SP 2: Achieve 25% performance | ✓ |
| SP 3: Co-design and co-produce service improvement plans | ✓ |

Which of the Trust Values are Being Delivered
1: Open ✓
2: Compassionate
3: Empowering ✓

Relationship to the Board Assurance Framework (BAF)
Are any existing risks in the BAF affected?
If yes, insert relevant risk
Do you recommend a new entry to the BAF is made as a result of this report? NO

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 Documents and/or Further Reading

Lead

Manny Lewis
Chair of Finance & Performance Committee
1.0 Purpose of Report

This report is provided by the Vice Chair of the Finance and Performance Committee, Nigel Turner to provide assurance to Board members that the performance operational, financial and governance as at Month 9, December 2019 were subject to appropriate and robust scrutiny.

The Finance and Performance Committee (FPC) is constituted as a standing committee of the Board of Directors. The Board of Directors has delegated responsibility to this committee for the oversight and monitoring of the Trust’s financial, operational and organisational performance in accordance with the relevant legislation, national guidance, the Code of Governance and current best practice from 1 April 2017.

The Committee is required to ensure that risks associated with the performance and governance arrangements of the Trust are brought to the attention of the Board of Directors and/or to provide assurance that these are being managed appropriately by the Executive Directors.

The minutes of the meeting held on the November 2019 were agreed as an accurate record.

2.0 Quality and Performance Report

The Chief Executive presented the committee with a summary of performance as at month 6, 2018/19 of the Essex Partnership NHS University Foundation Trust.

Quality and performance headlines for December 2019 are listed below.

The Deputy Chief Executive reported that the Trust had identified 9 hotspots and 2 emerging risk in month 9.

The hotspots and emerging risks identified are monitored through various Task & Finish groups across the Trust and reported back to Executive Operational Committee on a monthly basis. Below is a list of those hotspots and emerging risks:

**Hotspots**

9 hotspots have been identified as a result of reviewing performance relating to December 2019 against agreed targets.

- Timeliness of Data Entry (MH Services)
- Cardio Metabolic Assessment
- Referral to Treatment MH Crisis & Routine
- Readmissions
- Out of area Placements
- Agency Breaches
- CPA Reviews
- Inpatient Capacity (Mental Health Adults and Older People)
- CQC Action Plan
The above hotspots are all being monitored via Service Management Boards and recovery dates have been agreed with action plans to support any changes needed to meet the agreed timescales.

Operational Leads and the Medical leads are both using the live dashboards to monitor compliance of Cardio Metabolic Assessments. There has also been considerable work spent on looking at the Cardio Metabolic indicator construct following publication of national technical guidance and this requirement being removed for MH providers from the NHSI Oversight Framework.

Under the new technical guidance there are 6 parts which make up a full cardio metabolic assessment:

- **PART 1** - a measurement of weight (BMI or BMI + waist circumference)
- **PART 2** - a blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate)
- **PART 3** - a blood lipid including cholesterol test
- **PART 4** - a blood glucose test (blood glucose or HbA1c)
- **PART 5** - an assessment of alcohol consumption
- **PART 6** - an assessment of smoking status

Future additions are expected to this list and these have already been built into the trust Electronic Records.

We are now in a position to collect data on patients who refuse any of these tests and that blood test has been taken but no result received. Where data was previously being put in the wrong forms this has been rectified and now when data is recorded on other forms it will automatically update the Cardio Metabolic and Physical Health Check forms to ensure no data is missed and is counted against the target.

All of the above parts have to be completed within the last 12 months for the assessment to count as compliant. Operational services continue to focus on physical health and overall proportions of people with a physical health assessment are continuing to rise in Inpatient Services and People with First Episode Psychosis Services. However there continues to be challenges completing all 6 parts for full compliance. Trust reporting now includes a figure showing both % with all parts 1-6 completed and figure showing % with a physical health assessment but not all parts 1-6 completed.

The technical guidance is clear that undertaking of cardio metabolic assessments is the responsibility of primary care services except for inpatients and people within the first 12 months of secondary MH care. Technical guideline does not give a target for secondary MH providers but sets an overall target of 60% of people on the GP SMI register. Local targets have been set using those previously issued in the NHSI Oversight Framework, it should be noted that these are more challenging than the 60% set in the Technical Guidance. Discussions with our Commissioners are continuing to take place regarding this target.

Operational leads are monitoring the compliance through live dashboards. Community Mental Health Services patients who are due to be seen for a CPA Review in the last quarter of this financial year will also help to improve the compliance against the target set.

Although Blood Tests results is not the only indicator not compliant the organisation has agreed to trial Mobile Blood Test Analysers which will enable bloods to be taken immediately and then uploaded onto the patient record.
Emerging Risks

2 Emerging risks have been identified as a result of reviewing performance relating to December 2019 against agreed targets:

- Safer Staffing
- Admissions of under 16’s to adult wards

Contractual Performance

A Contract Performance Notice (CPN) was issued by Mid & South Essex CCG’s on Risk Assessment within 4 hours. A recovery action plan has also now been put in place and agreed with the Commissioners to bring this indicator back on target. Since the last report the Trust has also been made aware that the Commissioners will be issuing another CPN for patients not seen within 28 days by the first response team. This indicator will be part of the discussions for the review of this year’s contractual performance and current KPIs, as the transformation projects in primary care will change the way this first appointment will be offered and will therefore need different metrics for monitoring.

3.0 Financial Performance Report

Year to date financial position:

The Trust is reporting a surplus of £3.0m against a planned £2.1m surplus, this being a £0.5m improvement from the Month 7 financial position (£0.3m improvement from month 8). The delegated position continues to improve and is currently an adverse variance of £0.1m, however there is an adverse income variance of £0.6m from contract and CQUIN underperformance. Central reserves are offsetting these overspends, and the underspend in non-delegated budgets remains the key driver for the surplus.

Forecast Financial Position:

On target to deliver NHSI Control Total surplus of £2.1m, including PSF of £2.5m.

CIP Position:

£8.8m potential schemes identified against £11.7m target. At the end of M9 £7.2m CIP schemes have been agreed of which £6.4m is recurrent savings. £6.6m has been actioned in the general ledger with full year effect £6.0m. Our forecast outturn position includes the impact of the savings shortfall, which is being offset by non-recurrent underspends in various budgets.

Agency Spend:

Currently remains above plan but with expenditure reducing slightly in November and December. Increased pressure on agency budgets is anticipated in Q4 as new services are mobilised. However, year-end agency spend is still forecast to be within the £14.1m ceiling set by NHSI.

CAPEX:

The net expenditure forecast for year end is £7.2m; this is a reduction from the £8m forecast at month 7 due to capital receipts for sale of a property in December 2019. The gross expenditure forecast remains unchanged.
Cash:

The Trust cash balance was £6.4m above plan at month 9

UoRR:

The M9 UOR rating is 1 and the Trust anticipates meeting all planned metrics for year end.

4.0 Sub-Committee Reports

The committee received 6 sets of the Executive Operational Sub Committee part one minutes for noting:

- 5th November 2019
- 19th November 2019
- 26th November 2019
- 3rd December 2019
- 17th December 2019
- 7th January 2020

5.0 BAF Action Plans

The Finance and Performance Committee is currently responsible for scrutiny and oversight of its 5 BAF action plans in place to mitigate risks. 5 Risks have been closed in the last quarter: BAF14, BAF21, BAF22, BAF23 & BAF30.

The risks still open were presented to the Committee for discussion and the associated action plans.

The committee expressed some concern that actions to mitigate risk are not progressing in line with agreed timescales and requested that the action plans are reviewed before the final position is reported to the board.

6.0 Any Risks or Issues

- No risks or issues were identified

7.0 Any Other Business

- There was no other business

Report prepared by:

Janette Leonard
Director of ITT, Business Analysis and Reporting
On behalf of:

Manny Lewis
Chair of the Finance and Performance Committee
SUMMARY REPORT

BOARD OF DIRECTORS
PART 1

29 January 2020

Report Title: Board of Directors Quality Committee Assurance Report

Executive/Non-Executive Lead: Amanda Sherlock, NED and Chair of Quality Committee

Report Author(s): Natalie Hammond, Executive Nurse

Report discussed previously at: 

Level of Assurance: Level 1 Level 2 ✔ Level 3

Purpose of the Report

This report provides assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust’s objectives and impact on quality, are being managed effectively.

Re

At the meeting held on 12 December 2019, the Quality Committee:

- Received a patient story that outlined a proactive collaborative and integrated systems approach to a service users experience on an adult acute inpatient ward. The team worked with the service user holistically, focusing on her physical diagnosis and physical health needs, and provided opportunities for her to engage in activities that supported her wellbeing. Partnership approach was taken with the service user, her family and physical healthcare teams. The service user’s wellbeing improved and she made no attempts to take her own life or attempt deliberate self-harm. It was noted that the key successes in relation to this story regarding a holistic approach and partnership working should be used as measures to promote ongoing success with other patients.

Received the following reports:

- Clinical Governance & Quality Sub-Committee Assurance Report
- End of Life Group Assurance Report and Terms of Reference
- CQC Exception & Assurance Report
- Health & Safety Sub-Committee Assurance Report
- Physical Healthcare Sub-Committee Assurance Report
- Healthcare Worker Flu Vaccination Best Practice Management Checklist
- Learning Oversight Sub-Committee Assurance Report
- Suicide Prevention Strategy Update
- Research and Innovation Group Assurance Report
- Mortality Data & Learning
- Recognizing and Rewarding Quality
The Committee deferred review of policies and procedures until the next meeting.

The Committee:

- Identified that there were no additional risks for the CRR/BAF
- Considered that medicine management should be reviewed as part of next year’s internal audit
- AW asked for the Restrictive Practice Conference to be recognised as an example of best practice particularly work undertaken at Byron Court.

At the meeting held on 16 January 2020, the Quality Committee:

- Received a patient story where the Christopher Unit’s Multi-Disciplinary Team provided individualised, good quality care for a patient with complex needs. The male patient was admitted to the Christopher Unit on 25/05/2019 from a 136 Suite in Wakefield, West Yorkshire, after being found sleeping in his car on a motorway. He has a long standing diagnosis of treatment resistant paranoid schizophrenia and has had many hospital admissions. The patient continued to be non-compliant with medications and eventually as a last resort a period of seclusion was commenced. During seclusion it was agreed to apply for a license for IM Clozapine due to ongoing violence and non-compliance with oral medications; this was granted and the treatment was initiated. As a result the patient’s mental state settled, seclusion was terminated and he began to engage more appropriately with staff and peers. Currently the patient has 2 hours unescorted leave daily which he has been utilising without issue and is compliant with medications. His future plan is hopefully to be accepted for a long term rehabilitation facility where he can continue to be supported with his mental health and medications whilst leading a greater quality of life with the least restrictions.

Received the following reports:

- Quality Report
- Quality Priority - Deteriorating Patient Update Report
- CQC Compliance Exception Report
- Deep Dive Reducing Restrictive Practices.

Approved the following policies and procedures:

- CLP37 Safeguarding Children Policy
- CPG2 Complaints Policy
- CLPG13 CHS Safe Handling of Medication Policy
- CLPG13 MH Safe Handling of Medication Policy
- RM10 Safety Alert Bulletins Policy
- CLP8 Engagement and Supportive Observation Policy
- CPG9G Form Management Procedure

Risks/Hotspots:

The Committee identified:

- No risks for escalation on the CRR or BAF
- RH to feedback to Strategy & Planning that there were no objections to innovation being moved to the Strategy & Planning agenda going forward.
- No recommendations to the Audit Committee linked to the internal audit programme
- Identified today’s patient story as an area of good practice.
### Relationship to Trust Strategic Objectives

| SO 1: Continuously improve service user experiences and outcomes | ✓ |
| SO 2: Achieve top 25% performance | ✓ |
| SO 3: Valued system leader focused on integrated solutions | ✓ |

### Which of the Trust Values are Being Delivered

1: Open ✓
2: Compassionate ✓
3: Empowering ✓

### Relationship to the Board Assurance Framework (BAF)

Are any existing risks in the BAF affected? ✓

If yes, insert relevant risk:

**BAF 6** - If EPUT does not develop a just and learning culture to embed it agreed approach in response to incidents and error then protection of both staff and patients is reduced resulting in poor quality services and patient experience.

**BAF 10** - If the Trust fails to provide high quality services from premises that are safe, then the risk related to ligatures is not minimised and this may impact on the safety of patients in inpatient services.

**BAF 15** – If the HSE investigations into the actions taken by former NEP in respect of patient safety identify failings in the systems in place prior to merger, this could result in prosecutions and or fines being imposed on EPUT impacting on financial sustainability and reputation.

**BAF 16** – If the Trust does not take account of current and emerging guidance relating to dormitory accommodation, single sex accommodation, and the size of the wards, then this could impact on privacy and dignity, patient safety and quality and compliance with CQC standards.

**BAF 30** – If EPUT fails to maintain a ‘Good’ rating then it may not maintain compliance with CQC standards resulting in a failure to aspire to ‘Outstanding’ and be unable to compete in a system wide transforming health economy, poor reputation and patient experience.

**BAF 32** - If EPUT does not drive quality improvement through innovation then maintaining good and moving towards an outstanding rating is more difficult resulting in the potential stagnation of services and falling behind in whole system transformation.

Do you recommend a new entry to the BAF is made as a result of this report? No

### 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

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<th>Acronym</th>
<th>Description</th>
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<td>Corporate Risk Register</td>
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Supporting Documents and/or Further Reading

Lead

Amanda Sherlock
NED and Chair of the Quality Committee
1 Purpose of Report

This report is provided to the Board of Directors by the Chair of the Board of Directors Quality Committee. As an integral part of the Trust’s agreed assurance system, the report is designed to provide assurance to the Board that:

- risks that may affect the achievement of the Trust's objectives and impact on quality are being managed effectively. This is an integral part of the Trust's agreed assurance system;
- the Committee is discharging its terms of reference and delegated responsibilities effectively.

2 Executive Summary

Assurance from Quality Committee Meeting that took place on 12 December 2019

2.1 Minutes of previous meeting

The minutes of the Quality Committee meeting held on 14 November 2019 were approved at the meeting held on 12 December 2019.

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting held on 14 November 2019:

2.2.1 Patient Story: The Committee received a patient story that outlined a proactive collaborative and integrated systems approach to a service users experience on an adult acute inpatient ward. The team worked with the service user holistically, focusing on her physical diagnosis and physical health needs and provided opportunities for her to engage in activities that supported her wellbeing. Partnership approach was taken with the service user, her family and physical healthcare teams. The service user's wellbeing improved and she made no attempts to take her own life or attempt deliberate self-harm. It was noted that the key successes in relation to this story regarding a holistic approach and partnership working should be used as measures to promote ongoing success with other patients.

2.2.2 Clinical Governance & Quality Sub-Committee Assurance Report: The Committee received and noted the contents of an assurance report covering meetings that took place in October and November 2019. The Committee noted that a number of hotspots had been identified; a number of which were in relation to restrictive practices. Following discussion, the Committee was assured that a work plan was in place in relation to all hotspots and these would continue to be monitored by the Clinical Governance & Quality Sub-Committee.

2.2.3 End of Life Assurance Report: The Committee considered the contents of the report and noted that End of Life could now be seen as a good news story within the Trust. Through the work of a proactive sub-committee, hotspots had been identified. Work is taking place in relation to the development of End of
Life Dashboards to reflect the variance in commissioning and STP requirements. It was noted that End of Life Leads have been invited to participate in the NACEL Mental Health Project Reference Group which is the first time mental health have been invited to participate. It provides an opportunity for involvement in an advisory capacity on the specialist circumstance and context of deaths occurring within mental health inpatient settings. The Trust is also implementing the PEACE Programme which has been initially developed for residents in care homes in relation to planning for their future care, and evidence from the recent DNACPR audit indicates that the majorities of patients at end of life in our care has the opportunity to have difficult conversations and are active participants in DNACPR decisions.

The Committee noted the importance of supporting staff working in End of Life care and were advised that supervision and support were provided by Tracy Reed.

2.2.4 CQC Exception and Assurance Report: The Committee received an update on the activities being undertaken to maintain compliance with CQC standards and requirements and work required to support the Trust’s ambition of achieving an outstanding rating by 2022. The Executive CQC Action Group would be dissolved but a new group with the working title ‘Towards Outstanding’ is being established to include high performing staff that are passionate about improving services.

A new action plan has been developed merging previous and new actions and it was noted that 70 of the actions this month (November) were completed with 5 actions overdue. Four areas have been identified as key themes; learning lessons, equalities, data quality and restrictive practices.

The Committee noted that a CQC PIR request had been received for Rawreth Court on 5 November 2019 and all data had been collated and submitted in line with the deadline of 6 December 2019.

2.2.5 Health & Safety Sub-Committee Assurance Report and Work Plan: The Committee received and noted the content of the report. It was noted that two new risks had been identified; RIDDOR reporting to the HSE and door top alarms at Basildon MHU, and the Committee was assured that both issues were being addressed. Visits to other trusts had taken place to share and learn from other experiences.

2.2.6 Physical Healthcare Assurance Report: The Committee received an update and assurance on progress being made in relation to the physical health agenda and noted there were hotspots in relation to SI falls, cardio metabolic screening and intervention and path lab results. It was noted that interventions had been made in relation to all three hotspots. The Committee also noted the appointment of Angela Wade as Director of Nursing who would galvanize the agenda.

2.2.7 Healthcare Worker Flu Vaccination Best Practice Management Checklist: The Committee received assurance that a comprehensive range of actions were being taken to encourage staff to engage with the Flu Vaccination Programme. A request was issued by NHS England for trusts to complete a self-assessment and submit to Trust Boards by December 2019. The report gave full assurance that vaccination programmes were being executed.

It was noted that the flu vaccination for all EPUT staff has been high on the
Board agenda, with board members receiving the flu vaccination and some trained as peer vaccinators. The number of Trust Peer Vaccinators has trebled enabling a wide range of delivery sites.

A Flu Team was formed at the beginning of 2019, with the inaugural planning meeting taking place in February 2019 where previous actions were considered and steps taken to build in improvements to connect with staff across all Trust sites. It is recognised that the uptake of staff having the flu vaccination is an issue across mental health trusts, and in light of this, a number of options have been taken to incentivise staff to have the vaccination.

All staff have been encouraged to complete an electronic EPUT Staff Flu Immunisation Form. To facilitate future courses of action the form allows staff to state whether or not they are having the flu jab and if not, why not.

The flu vaccines were ordered and the Trust took delivery week commencing 23 September 2019. In order to speed up the receipt of the vaccinations, deliveries were made directly to peer vaccinators (where possible) or to nearest locations to them where storage is available.

Assurance was given that a clear communications plan is in place with all Executive Directors having a lead role for ongoing communications. The drop in clinic schedule has been published on a dedicated Flu Page on the Trust’s intranet site and Facebook page, and the flu plan has been featured on screensavers, posters, pop up messages, pay slip messages and in newsletters. Feedback on uptake has been presented to the Executive Team on a weekly basis.

The Committee noted that the last reported uptake of the flu vaccination is 56% and rising, and was assured that uptake and actions were reviewed on a weekly basis.

2.2.8 Learning Oversight Sub-Committee Assurance Report The Committee received the Learning Oversight report that provided feedback on risks reported at meetings that took place on 1 October and 5 November 2019. Three hotspots had been identified and assurance was given that work streams have been established reporting into the Suicide Prevention Group. It was noted that learning lessons is one of the priority areas of focus and will be considered by the ‘Towards Outstanding’ Group that will be established within the New Year.

2.2.9 Suicide Prevention Strategy Update: The Committee received a comprehensive update of work being undertaken to implement the suicide prevention strategy. A number of workstreams have been identified that are taking forward the ten factors identified in the National Confidential Enquiry with the aim of improving safety, and a Dashboard is under development to inform and drive progress. It was noted that following the appointment of a suicide prevention trainer, training modules are being reviewed and uptake has increased. A trajectory is under development to ensure staff receive the appropriate levels of training and a conference in being planned for 2020.

2.2.10 Mortality Data & Learning: The Committee noted that the number of deaths continues to remain within the statistical control limits. There were 49 deaths which fell within the scope for a mortality review in accordance with the Trust Policy in quarter 2. It was reported that a network system is being developed
to ensure support is in place and learning continues for the reviews and change is being embedded within clinical practice. The Committee was assured that steps were being taken to secure a supplier for data management.

2.2.11 Recognising and Rewarding Quality: The Committee noted that this year’s categories had been approved by the Executive Committee and had been advertised in the Chief Executive Message Forum.

The Committee deferred approval of policies and procedures until January 2020.

2.3 Risks/Hotspots:

The Committee:

- Identified that there were no additional risks for the CRR/BAF
- Considered that medicine management should be reviewed as part of next year’s internal audit
- AW asked for the Restrictive Practice Conference be recognised as an example of best practice particularly work undertaken at Byron Court

Assurance from Quality Committee Meeting that took place on 16 January 2020

2.4 Minutes of previous meeting

The minutes of the Quality Committee meeting held on 12 December 2019 were approved at the meeting held on 16 January 2020 following a few small text amendments.

2.5 Summary of discussions and issues identified as well as assurances provided at the meeting held on 16 January 2020:

2.5.1 Patient Story:

The Committee received a patient story where The Christopher Unit’s Multi-Disciplinary Team provided individualised, good quality care for a patient with complex needs. The male patient was admitted to The Christopher Unit on 25/05/2019 from a 136 Suite in Wakefield, West Yorkshire, after being found sleeping in his car on a motorway. He has a long standing diagnosis of treatment resistant paranoid schizophrenia and has had many hospital admissions. The patient continued to be non-compliant with medications and eventually as a last resort a period of seclusion was commenced. During seclusion it was agreed to apply for a license for IM Clozapine due to ongoing violence and non-compliance with oral medications; this was granted and the treatment was initiated. As a result the patient's mental state settled, seclusion was terminated and he began to engage more appropriately with staff and peers. Currently the patient has 2 hours unescorted leave daily which he has been utilising without issue, is compliant with medications. His future plan is hopefully to be accepted for a long term rehabilitation facility where he can continue to be supported with his mental health and medications whilst leading a greater quality of life with the least restrictions.

2.5.2 Quality Report:

The Committee received a report detailing hotspots and key indicators specific for this Committee. The report was presented in a new format incorporating Statistical Process Control (SPC) charts to facilitate trend analysis as agree at the Trust Board Development Sessions.
The Quality Report has been developed based on the performance/quality indicators that were reported in the Performance and Quality Report to the Executive Team, of the 49 performance/quality indicators 29 were identified as Quality Indicators for review by the Quality Committee. The following hotspots were identified as performing below target/benchmark: cardio metabolic assessments, emergency readmission within 28 days and inappropriate out of area placements. Remedial actions were taking place against all hotspot to mitigate risk. It was noted that there have been 4 serious incidents reported in November in mental health and in community health there have been 4 serious incidents reported year to date. The Committee were advised that the February Board Development Session would have a focus on processes and procedures; the Early Implementation Framework had been presented to the Executive Committee and would be presented to the Quality Committee in the near future.

The Committee was advised that work was taking place to review the progress made against the quality priorities to ensure that in future all quality priorities would have clear aims and outcome measures to ensure that future reporting arrangements demonstrate that ambitions are being achieved. Following discussion the Committee was assured that a work plan was in place in relation to all hotspots and these would continue to be monitored.

2.5.3 Quality Priority - Deteriorating Patient Update Report: The Committee received and noted the contents of an assurance report covering work undertaken on the use of a modified early warning scoring system (MEWS) to monitor vital signs (physical health observations) to detect early signs of physical deterioration. The Committee noted that the result of a recent audit indicated that we do not have a steady position across all services and it was agreed that a targeted piece of work would be carried out against a detailed action plan to give the relevant level of assurance required. It was agreed that future reports should contain a higher level of detail and incorporate previous years’ scores in order that improvement could be monitored.

2.5.4 CQC Compliance Exception Report: The Committee received an update on the activities being undertaken to maintain compliance with CQC standards and requirements and work required to support the Trust’s ambition of achieving an outstanding rating by 2022. The Committee were assured that appropriate actions were being taken and noted that 115 actions had been closed at the end of December with 13 actions that did not achieve closure. It was also noted that the CQC had published the Insight Report on 19 December 2019 which provides an update on data currently held by the CQC in relation to the Trust and forms a profile that will be used to target inspections or instigate if a risk is seen as developing.

2.5.5 Deep Dive Restrictive Practices: The Committee received an update on work being undertaken in relation to the reduction of restrictive practices across the Trust. Assurance was given that the detailed action plan was in line with the principles of 'No Force First' and Kevin Huckshorn’s six core strategies. It was noted that to be successful this work required both cultural and system change and it was agreed that use of John Kotter’s 8-Step Change Model could provide a useful structure. It was noted that further work was required to ensure that corporate and operational services were working in partnership to deliver this agenda and steps would be taken to ensure a consistent narrative was cascaded.
2.6 The Committee approved the following policies and procedures

- CLP37 Safeguarding Children Policy
- CPG2 Complaints Policy
- CLPG13 CHS Safe Handling of Medication Policy
- RM10 Safety Alert Bulletins Policy
- CLP8 Engagement and Supportive Observation Policy
- CPG9G Form Management Procedure

2.7 Risks/Hotspots:

The Committee:

- Identified that there were no risks for escalation on the CRR or BAF
- RH to feedback to Strategy & Planning that there were no objections to innovation being moved to the Strategy & Planning agenda going forward.
- No recommendations to the Audit Committee linked to the internal audit programme
- Identified today's patient story as an area of good practice.

3. Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Confirm acceptance of assurance given in respect of risks and action identified
3. Request further action/information as required

Report prepared by:

Natalie Hammond
Executive Nurse

On behalf of:

Amanda Sherlock
Non-Executive Director Chair of the Quality Committee
SUMMARY REPORT

BOARD OF DIRECTORS

PART 1

29 January 2020

Report Title: Strategy & Planning Committee Assurance Report

Executive/Non-Executive Lead: Dr Alison Rose-Quirie
Non-Executive Director and Chair of Committee

Report Author(s): Nigel Leonard
Executive Director Strategy & Transformation

Report discussed previously at: N/A

Level of Assurance: Level 1 ✓ Level 2 Level 3

Purpose of the Report

This report is provided to the Board of Directors by the Chair of the Strategy & Planning Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the identification and/or achievement of the organisation's objectives are being managed effectively.

Recommendations/Action Required

The Board of Directors is asked to:

1. To note the contents of the report.
2. Approve the action to delegate authority to the Chief Executive and Executive Chief Finance & Resources Officer to finalise the draft operational plan
3. To confirm acceptance of assurance given in respect of risks and actions identified.
4. To request further action/information as required.

Summary of Key Issues

The Strategy & Planning Committee met on 15 January 2020, and discussed the following key issues:

- Terms of Reference Review and Committee Business Schedule 2020
- EPUT's Operational Plan
- EPUT's Commercial Strategy Progress
- Transformation Update
- Contract Negotiation and Tender Submissions Update
- EU Exit

Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes ✓
SO 2: Achieve top 25% performance ✓
SO 3: Valued system leader focused on integrated solutions ✓

Which of the Trust Values are Being Delivered

1: Open ✓
2: Compassionate ✓
3: Empowering ✓
**Relationship to the Board Assurance Framework (BAF)**

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**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: | Nil |
| Governance implications | ✓ |
| Impact on patient safety/quality | ✓ |
| Impact on equality and diversity | ✓ |
| Equality Impact Assessment (EIA) Completed? | YES/NO | If YES, EIA Score | No |

**Acronyms/Terms Used in the Report**

| STP | Sustainability and Transformation Partnership |

**Supporting Documents and/or Further Reading**

None

**Lead**

Dr Alison Rose-Quirie  
Chair of the Strategy & Planning Committee
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STRATEGY & PLANNING COMMITTEE

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the Strategy & Planning Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisation’s objectives are being managed effectively.

EXECUTIVE SUMMARY

Strategy & Planning Committee Meeting 15 January 2020

The Strategy & Planning Committee met on 15 January 2020. The Committee had a successful and positive debate on a number of key areas. The following matters were considered:

1. Terms of Reference Review and Committee Business Schedule 2020
   Strategy & Planning Committee members discussed draft Terms of Reference, which had been updated following changes to the Trust Board of Director committee structure.
   
   There was also discussion about the draft Schedule of Business 2020, which included the proposal to transfer some items from other committees to the Strategy & Planning Committee. Discussions with the Trust Secretary will now take place to ensure that the transfers are coordinated effectively.

2. EPUT’s Operational Plan
   Strategy & Planning Committee members received an update on the production of EPUT’s Operational Plan 2020/21.
   
   The deadline for submission of the first draft was confirmed as 21 February 2020, and it would be circulated to Strategy & Planning Committee members before this date for comments/feedback. Delegated authority is requested from the Board for the Chief Executive and Executive Chief Finance & Resources Officer to finalise the draft plan prior to submission.
   
   The deadline for submission of the first draft was confirmed as 21 February 2020, and it would be circulated to Strategy & Planning Committee members before this date for comments/feedback. Delegated authority to submit the draft Plan would then be requested from the Chief Executive and Executive Chief Finance & Resources Officer.
   
   The deadline for submission of the final plan was confirmed as 17 April 2020. It was agreed that the date of the Strategy & Planning Committee meeting may be revised to enable Committee members to discuss and approve the plan before this deadline – a decision would be made in due course.

3. EPUT’s Commercial Strategy Progress
   Strategy & Planning Committee members received a verbal update on the production of a Trust Commercial Strategy.
The initial procurement process had unfortunately been unsuccessful, therefore the specification had been revised and re-advertised with a new deadline of 17 January 2020. Evaluation of the bids received would take approximately two to three weeks, after which it was hoped that the contract would be awarded.

4. **Transformation Update**
Strategy & Planning Committee members received updates on the Transformation programme, including:

- Costed Strategy Mid & South
- Mental Health Assurance Report
- Community Services Assurance Report

A full update on the Mental Health & Community Health Services Transformation Programme would be provided to the Board of Directors on 29 January 2020.

Committee members agreed that it would be useful to hold a Board Development Session to explore the potential effects of the transformational programme on EPUT, how the Trust will achieve integrated services within the new system which will include housing issues, and what the services would look like after the transformation, and the possible impact on the Trust’s finances.

5. **Contract Negotiation and Tender Submissions Update**
Strategy & Planning Committee members received a report providing an overview of the current status of contract negotiations, key issues and business development activities.

Committee members noted that negotiations for 20/21 had commenced with North East Essex CCG and West Essex CCG, and a further update would be provided once negotiations had sufficiently progressed.

Committee members also noted that the Integrated Drug Treatment Service would be terminating in March 2020. The disaggregation process was being managed alongside Commissioners and the CRG.

6. **EU Exit**
Strategy & Planning Committee members received a brief verbal update on EU Exit preparations. A report would be provided to the Board of Directors on 29 January 2020.

**ACTIONS REQUIRED**

The Board of Directors is asked to:

1. Note the summary of the meeting held on 15 January 2020.
2. Approve the action to delegate authority to the Chief Executive and Executive Chief Finance & Resources Officer to finalise the draft operational plan.
3. Confirm acceptance of assurance given in respect of risk and the action identified.
4. Request further action/information as required.

Report produced by:
Nigel Leonard
Executive Director of Strategy & Transformation

On behalf of:
Dr Alison Rose-Quirie
Chair of the Strategy & Planning Committee
SUMMARY REPORT | BOARD OF DIRECTORS PART 1

Report Title: Mental Health & Community Health Services Transformation

Executive/Non-Executive Lead: Nigel Leonard
Executive Director of Strategy & Transformation

Report Author(s): Mark Travella, Associate Director Business Development & Service Improvement
Chris Dicketts, Senior Contracts Manager

Report discussed previously at: n/a
Level of Assurance: Level 1 ✓ Level 2 Level 3

Purpose of the Report

To provide an update on the Mental Health and Community Health Services Transformation.

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<tr>
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<th>Discussion</th>
<th>Information</th>
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<tr>
<td></td>
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Recommendations/Action Required

The Board of Directors is asked to note the content and progress of the Mental Health and Community Health Services Transformation.

Summary of Key Issues

The Mental Health and Community Health Services Transformation Programme covers three STP areas and within them seven CCGs, two local unitary authorities and one County Council. The Programme has been reported regularly to the Board. The Strategy and Planning Committee also discusses the transformation programme and the Finance and Performance Committee considers the financial implications of the programme.

The Mental Health Transformation Portfolio comprises four major programmes, and within these, 18 projects. Since the implementation of the STPs some of these schemes have remained broadly Essex wide whilst others are being developed to reflect the PLACE based care and the individual needs of each locality.

Within each STP the four major programmes are:
1. Emergency Response and Crisis Care Service
2. Personality Disorders
3. Older People & Dementia
4. Community (Primary) Care

The Trust will need to appoint to nearly 140 posts Essex wide and this excludes a number of new service development projects and the future requirements for Community (Primary) Care. A tracker is now in place alongside a number of recruitment initiatives and the Trust has recognised this challenge on the Board Assurance Framework.

Relationship to Trust Strategic Objectives

| SO 1: Continuously improve service user experiences and outcomes | ✓ |
| SO 2: Achieve top 25% performance | ✓ |
| SO 3: Valued system leader focused on integrated solutions | ✓ |
Which of the Trust Values are Being Delivered

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<td>2: Compassionate</td>
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<td>3: Empowering</td>
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Relationship to the Board Assurance Framework (BAF)

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

| 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                                                          | ✔       |
| Governance implications                                                         | ✔       |
| Impact on patient safety/quality                                                | ✔       |
| Impact on equality and diversity                                                | ✔       |

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

Acronyms/Terms Used in the Report

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<th>Acronym</th>
<th>Definition</th>
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<td>Cognitive Analytic Therapy</td>
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<td>CCG</td>
<td>Clinical Care Group</td>
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<tr>
<td>QIPP</td>
<td>Quality Improvement Productivity Prevention</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<tr>
<td>REACT</td>
<td>Relatives Education &amp; Coping Toolkit</td>
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<td>Service Development and Improvement Plan</td>
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<td>Princess Alexandra Hospital</td>
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<td>STP</td>
<td>Sustainability &amp; Transformation Partnership</td>
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Supporting Documents and/or Further Reading

Lead

Nigel Leonard
Executive Director of Strategy and Transformation
TRANSFORMATION - ASSURANCE REPORT

1 Purpose of Report

This report provides an update on the Trust’s Mental Health and Community Services Transformation Programmes. Appendices are attached pertaining to each scheme for more detail where required.

2 Executive Summary

This report is written in 3 sections to cover the Transformational activity in:

- Mental health services across Essex
- Community transformation projects in South East Essex
- Community transformation projects in West Essex

2.1 Mental Health Services Across Essex

The mental health transformational schemes across the three STPs comprise a portfolio of programmes as shown below. Each STP will oversee the programmes of work through an SDIP. The Trust is developing ‘system’ programme documentation to support transparent and shared control documents for the future.

Urgent and Emergency Care
This programme at STP level is made of three separate projects for West Essex, MSE, NE Essex. All three projects are now due to go live on 1 April 2020. NE Essex have delayed slightly to align with changes across Essex and to enable staff training.

Due to workforce challenges the services will develop across 2020/21 as the full workforce is recruited. The provision Introduces aligned access points through 111 including joined up pathways with police and ambulance services. The model for 24 hour crisis assessment and treatment services extending to the patients home will link in with the current Home Treatment Teams. Crisis cafes will be provided by the third sector and provide an option to support people in crisis and interface with EPUT services. All these projects have been funded through successful business cases. Recruitment for NE Essex has been excellent to date but the other two systems are struggling to recruit with alternative plans under consideration.

Community (Primary Care)
This programme at CCG level comprises 6 projects to transform community mental health services. Mental health community services are being transformed to provide Mental Health expertise at GP surgery level, organised against the emerging PCNs. This will ensure that physical and mental health will be joined up, GPs and their patients will have rapid access to mental health expertise at surgery level, supporting the aspirations of Five Year Forward View and the NHS Long Term Plan. Thurrock
and Southend/CPR CCGs have started local work as pilots. Southend plans to submit a business case following pilot evaluation later in 20/21 or the following financial year. Thurrock will roll out to all PCNs Q1,2,3 and a business case for funding is imminent. West Essex commences roll out mid-February this year having successfully applied for funds offered by the CCG last financial year. The West Essex model links to a national pathway pilot. NEE and BB commence project work Q4 19/20 and business cases will follow later in 2020/21.

**Older People and Dementia**

This programme is at CCG level. SE Essex and Mid Essex have developed and are implementing transformed community teams to manage patients and carers at home instead of hospital. SE Essex data shows very significant falls in inpatient use to the point that admission is now an unusual event. SE Essex and Mid Essex have progressed work through successful business cases. Later tranches of development will be funded through business cases in the future. The other CCGs are all in the process of setting up project teams to implement similar community models and business cases will follow as required in due course across 20/21.

**Personality Disorder**

This Essex wide model will transform the way staff across entire systems understand and treat people with a personality disorder. The model comprises training and consultation support across local systems, from GPs and the third sector to specialist mental health staff in secondary care. New model of care, delivering DBT and CAT and other psychotherapeutic approaches are being introduced and rolled out across the workforce. This outcome is a range of benefits including better supported patients and carers, improved rates of recovery and independence and fewer admissions to hospital. This programme of work is delayed due to the need to fully engage with all stakeholders, including medical staff, so that all parties understand and support the proposed model. A major workshop is being set for March 2020 to fully engage with, and co-plan the detail of the model prior to implementation. Three business cases have been required. The Business Case for MSE was approved last year and the West and NE Essex in progress.

**Risks and Issues**

The significant risk relates to recruitment in all three STPs and Appendix 1 shows the current position on the posts required and the current recruitment. Due to workforce challenges the Trust is considering examining options to improve recruitment but is also considering alternative staffing structures with commissioners to enable service initiatives to commence in 2020/21. A major recruitment plan is in place and is showing some signs of success but this will need to be monitored closely and weekly monitoring is now in place. Preparedness plans are also being developed where required to predict any workforce shortfalls and review skill mix and options for providing a safe and effective service, in the interim and long term.

Communications plans are also in place to ensure that the public, patients and carers as well as wider system health, social care and third sector staff are aware of the changes and access the new service appropriately.
2.2 Community Transformation Projects in South East Essex

A range of initiatives are in progress to support community transformation and investment plans led by the CCGs.

Transformation is currently managed within operational services with internal project support and a Programme Director appointed across the two CCGs Southend Hospital and EPUT to lead on QIPP. The Trust meets on a monthly basis with the CCGs to review the progress of the QIPP schemes in the EPUT SDIP. A summary of the schemes is attached in Appendix 2.

Within Adult services, all schemes are currently on track with agreed milestone dates, apart from five of the twenty schemes in development. In the Care Co-Ordination services, agreement is pending of the Care Navigator posts being relocated to Southend Borough Council. In Community Respiratory Nursing, the service specification is currently being refreshed and is on track for its end of February deadline, which also includes the activity and monitoring of the service. The Occupational Therapy service review is ongoing, with internal development with EPUT and with engagement from the CCGs. Continenence service offering, a meeting is being arranged between EPUT and the CCG, and discussions have taken place at SDOG re ensuring that the offer is the same across Essex.

Children’s services is more complex due to the number of stakeholders that now need to be involved in this, with Children’s services being delivered by EPUT, Southend Borough Council and Virgin Health for Essex County Council. Therefore timescales have been revised by Ross Gerrie, Children’s Commissioner for Southend and Castle Point and Rochford CCG in conjunction with Morag Stycharczyk, Head of Children’s Services for the Trust. The revised timescales has taken the majority of the Children’s SDIP items to April 2020 for completion.

Within the Neurodevelopment SDIP item there is one item showing as overdue, but was actually completed in November 2019 as joint data processing has been agreed for Southend. Specialist School Nursing has an overdue action, for mobilisation at the end of January, this has now been agreed to be end of April due to the sign-off through the CCGs of the business case that has been produced. In regards to the review key pathways milestones it has been agreed to split these out to enable each pathway to be shown individually, with revised milestone dates of March and April 2020 to better reflect the progress being made by each individual element.

2.3 Community Transformation Projects in West Essex

Within west Essex Community Services there are a range of initiatives in places for community transformation and investment.

In west Essex there are some SDIP items that are purely for EPUT to develop and there are some that are STP wide and involve partnership working from PAH as well as neighbouring CCGs e.g. East and North Herts CCG. A summary of the schemes is attached in Appendix 3.

For the Catheter Pathway the Trust is playing an active role in the system partner discussions for the agreed pathway and passports to be implemented. The Trust will
also join meetings with Hertfordshire CCGs to ensure that there is no duplication on pathways across the STP.

The Case Management of Complex Patients, service specification is being reviewed in partnership between the Trust and the CCG, and a new Integrated Community Team Service Specification is anticipated to be varied into the contract in Q3 following finalisation. The Trust continues to escalate the GP practices that do not refer complex patients where identified for case management, this is mainly in the Harlow localities.

By the end of quarter two the Trust had completely implemented the new leg ulcer provision across West Essex, with clinical oversight provided by the Tissue Viability Nurses.

The Cars review is one of the more complex transformation projects in west Essex community services, and EPUT are fully engaged and participating in the development of the new REACT service, which is being taken forward as part of the Urgent Care/Frailty work stream. The Trust have been given notice on the existing Cars service, and are working with PAH and West Essex and East and North Herts CCGs for the new service, it is anticipated that PAH will be the lead provider and sub-contract the Trust for service delivery.

The Gastro-GP Constipation pathway work began in quarter two with a meeting between Trust leads, GP leads and the CCG to agree the new pathway. It is the Trusts recommendation for a review of all functional bowel patients. East and North Herts CCG are interested in working with West Essex CCG to ensure a system wide pathway is in place. A task and finish group is being established by the CCG which EPUT will be part of.

Q3 SDIP updates are due to be provided to the CCG contract monitoring meeting on 27 January.

3 Action

The Board of Directors is asked to note the contents of this report.

Report prepared by:

Mark Travella
Associate Director Business Development & Service Improvement

Chris Dicketts
Senior Contracts Manager

On behalf of:

Nigel Leonard
Executive Director of Strategy & Transformation
### Staff Grade Details

<table>
<thead>
<tr>
<th>Staff Description</th>
<th>Staff Grade</th>
<th>WTE Req'd</th>
<th>WTE Still Required</th>
<th>Recruitment Rating</th>
</tr>
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<tbody>
<tr>
<td>Psychiatric Support Band 4</td>
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</tr>
<tr>
<td>Qualified nurses - Team Leader</td>
<td>Band 7</td>
<td>1.20</td>
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<td>Qualified nurses - Outreach</td>
<td>Band 6</td>
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<tr>
<td>Qualified nurses - Support Band 7</td>
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<tr>
<td>Qualified nurses - Support Band 8</td>
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<tr>
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<td>Crisis North East Total</td>
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### Core 24 - Staffing for the Core 24 MSE is provided by the voluntary sector.

<table>
<thead>
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<th>Staff Grade</th>
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<tbody>
<tr>
<td>Qualified Nurses - Adult</td>
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</tr>
<tr>
<td>Staff Grade</td>
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</table>

### Crisis Café MSE

- Staffing for the Crisis Café MSE is provided by the voluntary sector.
- Core 24 - Core 24 MSE Total 1.00
- Crisis Café MSE North East Total 1.25

### Core 24 - Staffing for the Core 24 West is provided by the voluntary sector.

<table>
<thead>
<tr>
<th>Staff Grade</th>
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<th>Recruitment Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses - Adult</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Staff Grade</td>
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### Core 24 - Staffing for the Core 24 North East is provided by the voluntary sector.

<table>
<thead>
<tr>
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<th>Recruitment Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses - Adult</td>
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### Personal Disorder Transformation Project - PD

<table>
<thead>
<tr>
<th>Staff Grade</th>
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<tbody>
<tr>
<td>Embedded within main Core 24 Model</td>
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</table>

### West

<table>
<thead>
<tr>
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<th>Recruitment Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nurses - Adult</td>
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<td>-</td>
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<tr>
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### North East

<table>
<thead>
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<tr>
<td>Staff Grade</td>
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### Business Case awaiting NSHE approval

- Core 24 MSE Total 1.00
- Core 24 West Total 3.30
- Core 24 North East Total 0.40

### Core 24 - For Adult and Other

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Staff Grade</td>
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</table>

### Personal Disorder Transformation Project - PD

- Embedded within main Core 24 Model | -                  | -                  |

### West

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>WTE Still Required</th>
<th>Recruitment Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Grade</td>
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### North East

<table>
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<th>Staff Grade</th>
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<tbody>
<tr>
<td>Staff Grade</td>
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</table>
Primary Care Wave 1 - Adult Community Mental Health Care

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>Staff Description</th>
<th>MSE - Mid Essex &amp; South East</th>
<th>MSE - Mid Essex &amp; South East</th>
<th>MSE - Mid Essex &amp; South East</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Band 3</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>AHP Band 7</td>
<td>Occupational Therapist</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Band 6</td>
<td>Admin Band 4</td>
<td>-</td>
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<td>Band 6</td>
<td>Support Band 4</td>
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<td>-</td>
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Business cases will be developed during 2020/21 with some pilot projects commencing earlier. This is to be completed by the CCGs with input from EPUT. Currently there are 2 non recurrent pilots each with band 7 posts.

Primary Care Wave 2 - Freed Model/Enhanced Comma Eating Disorder Service (EDS)

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>Staff Description</th>
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<th>MSE - Mid Essex &amp; South East</th>
<th>MSE - Mid Essex &amp; South East</th>
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<tbody>
<tr>
<td>AHP Band 8a</td>
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<td>-</td>
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<td>Band 6</td>
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<tr>
<td>Band 6</td>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

EDS will be part of an Essex wide review and Business Case to follow in 2020/21.

North East - This is an enabling project linked with the Clacton Hospital Redevelopment.

<table>
<thead>
<tr>
<th>Staff Grade</th>
<th>Staff Description</th>
<th>MSE - Mid Essex &amp; South East</th>
<th>MSE - Mid Essex &amp; South East</th>
<th>MSE - Mid Essex &amp; South East</th>
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</thead>
<tbody>
<tr>
<td>Support Band 3</td>
<td>Support to Clinical staff (Support)</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>AHP Band 7</td>
<td>Occupational Therapist</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Band 6</td>
<td>Admin Band 4</td>
<td>-</td>
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<tr>
<td>Band 6</td>
<td>Support Band 4</td>
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</tbody>
</table>

Business cases will be developed during 2020/21 with some pilot projects commencing earlier. This is to be completed by the CCGs with input from EPUT. Currently there are 2 non recurrent pilots each with band 7 posts.
### Top Summary North East

<table>
<thead>
<tr>
<th>Staff Categories</th>
<th>WTE Req'd</th>
<th>WTE Rec'd</th>
<th>WTE Diff</th>
<th>Recruitment Rating</th>
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</thead>
<tbody>
<tr>
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<td>Admin Band 5</td>
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</tr>
<tr>
<td>Admin &amp; Clerical</td>
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<td>0.00</td>
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### Top Summary West

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<th>WTE Diff</th>
<th>Recruitment Rating</th>
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<td>-</td>
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</tr>
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<td>Admin Band 4</td>
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<td>1.00</td>
</tr>
<tr>
<td>Admin &amp; Clerical</td>
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<td>-</td>
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<td>-</td>
</tr>
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### Top Summary North/West

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<tr>
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<th>WTE Rec'd</th>
<th>WTE Diff</th>
<th>Recruitment Rating</th>
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</thead>
<tbody>
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<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Admin Band 4</td>
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<td>Admin &amp; Clerical</td>
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<tr>
<td>Total</td>
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<td>1.00</td>
<td>1.20</td>
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</tbody>
</table>

### Recruitment Rating Key

- **Recruited**: WTE Still Required
- **WTE Still Required**: WTE Still Required
- **On track**: WTE Still Required
- **Not on track**: WTE Still Required
- **Position Totally Recruited**: WTE Still Required
- **No action required**: WTE Still Required
- **Minimal monitoring**: WTE Still Required
- **Monitoring**: WTE Still Required

### Support to Clinical Staff

<table>
<thead>
<tr>
<th>Staff Categories</th>
<th>WTE Req'd</th>
<th>WTE Rec'd</th>
<th>WTE Diff</th>
<th>Recruitment Rating</th>
</tr>
</thead>
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<td>1.00</td>
</tr>
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<td>Total</td>
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### Allied Health Professionals

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<tr>
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<th>Recruitment Rating</th>
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<tr>
<td>AHP Band 6</td>
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<td>0.00</td>
<td>1.00</td>
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<tr>
<td>Total</td>
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<td>1.00</td>
<td>1.00</td>
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### Recruitment Rating

- **Rating**: Recruitment Rating
- **Note**: Recruitment Rating

### Action

- **No action required**: Recruitment Rating
- **Monitoring**: Recruitment Rating
- **Monitoring**: Recruitment Rating
- **Active monitoring**: Recruitment Rating
- **Action monitoring**: Recruitment Rating

### Grand Total

- **Top Summary North东**: 1.00
- **Top Summary West**: 2.40
- **Top Summary North/West**: 3.40
- **Total**: 82.40

---

**Note**: The table above provides a summary of staff categories and their respective WTE requirements and recruitments in the North East, West, and North/West regions. The recruitment rating key is used to indicate the status of recruitment for each category.
South East Essex Community Services - Transformation Projects

Update January 2020

<p>| Transformation Projects aligned to Corporate Objectives, Service Development Plans and System-wide priorities |
|---|---|
| <strong>Project</strong> | <strong>Update</strong> | <strong>Due Date</strong> |
| 1. Community Crisis Response | Establish and test <strong>comprehensive community response team SWIFT</strong> (that includes Falls OT response provision) that impacts on reducing acute hospital activity. | Service having demonstrable impact and now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round. The Falls response service now fully operational. | March 2020 |
| | In 2020/21 we will project manage: a) Enhancing the SWIFT Crisis response impact by looking specifically at proving sub-cut hydration, neutropenic sepsis and step up beds in community, and; b) Aligned our Crisis Response to our comprehensive Intermediate Care (IC) Transformation program to improved integration and collaboration across all of IC services. | Project group in place with Project Plan to steer development of enhancements into next year. Progress already made on Neutropenic Sepsis and Falls response. Work plan for IC (including Crisis Response now agreed through project board) | 2020/21 |
| 2. Comprehensive Community Palliative Care Offer in South East Essex | Establish a comprehensive population-health management model for <strong>Community Palliative Care / EOL Services</strong> that includes management of EOL register (finding those in last 12 month of life) and delivering of high quality front line EOL care | Services now fully operational as a consolidating single offer and deliver demonstrable system impact and demonstrated in recent CQC achievement of ‘outstanding, recognises the high quality ‘caring’ front line service We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round. | March 2020 |</p>
<table>
<thead>
<tr>
<th>2020/21</th>
<th>In 2020/21 we will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Ensure consolidated service focus delivers on achieving 1% of population target for End of Life Register and meet all new challenging contractual KPIs.</td>
</tr>
<tr>
<td>b)</td>
<td>Work with CCG and local hospice to develop pathways that maximise access to the new hospice beds (to be opened March 2020)</td>
</tr>
</tbody>
</table>

**Monthly steering Group meeting to drive transformation and improve performance.**

<table>
<thead>
<tr>
<th>2020/21</th>
<th>3. ‘Anticipatory Care’ (population health) model for frailty Care Coordination Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Establish an effective <strong>population health model</strong> of anticipatory care for those who are frail in South East Essex entitled <strong>‘Care Coordination’</strong> services. These services were originally commissioned separately across the two CCGs in South East Essex.</td>
</tr>
<tr>
<td></td>
<td>We are now working to streamline under a single South East Essex</td>
</tr>
</tbody>
</table>

**Services now fully operational with project plan to streamline under one operational model**

| March 2020 | We are now working with commissioners to mainstream into SEECHS contract. Specification and KPIs agreed with CCG with plans to mainstream in the forthcoming contracting round. |

<table>
<thead>
<tr>
<th>2020/21</th>
<th>In 2020/21 we will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Be working with CCG and PCNs to deliver new ‘Primary Care Network’ national specification for ‘anticipatory care’ by aligning to our Care Coordination service.</td>
</tr>
</tbody>
</table>

**The PCN specification for Anticipatory Care now published (in draft), and it is clear that Community services will have a ‘contracted’ dedicated role requiring focussed project methodology to deliver.**

<table>
<thead>
<tr>
<th>Sept 2020</th>
<th>4. Respiratory Care - Build single comprehensive community service model for respiratory care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish <strong>Integrated Community Respiratory Nursing Service.</strong> A redefined sustainable service able to deliver a quality service against updated service specification with dedicated medial leadership, closer Integration between Respiratory Nursing, Hospital Oxygen Team, Pulmonary Rehabilitation and Spirometry services</td>
</tr>
</tbody>
</table>

**Draft specification has been developed and dedicated steering group overseeing transition to new model**

<table>
<thead>
<tr>
<th>2020/21</th>
<th>Continue to deliver on this priority project next year to transform our respiratory services and embed in contract. Priorities remain as above.</th>
</tr>
</thead>
</table>

**Dedicated project group in place with the accountability to STP work programme.**

<table>
<thead>
<tr>
<th>March 2020</th>
<th>5. Develop single streamlined 24/7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With movement of palliative care and respiratory out of Integrated Nursing specification, opportunity exists to re-</td>
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**Work plan in place informed by workshop and new specification in draft**

<p>| March 2020 | |</p>
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<tr>
<th>Community Nursing Offer</th>
<th>Establish core activity and develop unique specification KPIs and outcome measures.</th>
<th>Mainstream 2018/19 CCG investment to enhance 24/7 DN cover into core emerging specification</th>
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<td><strong>2020/21 Project continues as above.</strong></td>
<td>Dedicated workgroup to finalise specification and contractualise.</td>
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<td><strong>6. Heart Failure Service</strong></td>
<td>Key system QIPP scheme that sees additional investment and expansion of the team which includes the increased provision of IV diuretic is the community</td>
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<td></td>
<td>Final review of Service Specification and agreement of baseline activity and cost in order to close the project and CV into contract to be actioned imminently Implementation of the IV Diuretic Service fully mobilised Implementation of the enhanced CHFS.</td>
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<td><strong>2020/21 As above.</strong></td>
<td>Envisaged project complete March 2020.</td>
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<td><strong>6. Care Home Training (inc Sepsis management)</strong></td>
<td>To review and refocus our EPUT Sepsis and care home education service in line with local authority offer (and other partners) to maximise the reduction in A&amp;E and NEL admissions and improve patient outcomes</td>
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<td>Plans and developments for the future:</td>
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<td>1. Care Home Education Workshop (Dec 2019)</td>
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<td>2. Agree timely information sharing and regular monitoring arrangements (Dec 2019)</td>
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<td>4. Care Home attendance planner to be developed (Jan 2020) Review current running costs (Jan 2020) Review service specification (Feb 2020)</td>
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<td><strong>March 2020</strong></td>
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### 2020/21 Renewed focus which includes:

1. To work with commissioners to secure Long Term support for Care Homes Training.
2. Align EPUT care home services to emerging Primary Care Network specification for Enhanced Care in care homes.
3. Care Homes training team now part of unique project in partnership with UCL to test technology and pathways for ‘Managing the Deteriorating Patient’.

### 7. Aligning EPUT services to emerging SEE Intermediate Care Strategy

We will work with community provider partners in the STP to build our respective Intermediate Care Strategy and associated service offer including:
- Improved Single Point of Access (SPA);
- Aligning crisis response (using SWIFT) to SPA;
- Acute based Pathway coordinators
- Streamlined Access intermediate care beds;
- Collaboration and Partnership with Reablement provider
- Enhanced domiciliary rehab services, and
- Aligning Care Coordination services.

Key actions in train include:
- EPUT Steering Group
- Develop / review service specification (consider in unique spec or refreshed SPOR to SPA spec)
- Identify and agree KPIs
- Agree monthly reporting
- Quality team assurance
- Key stakeholder engagement for effective use of the role

### 2020/21

To undertake a comprehensive transformation of our Intermediate Care service offer to improve services and deliver in line with NICE Guidance (2019) and emerging South East Essex IC Strategy. Project has 10 dedicated work streams including above.

Full transformation project programme now being mobilised.
| 8. | Integrated Community Wound Care Service | Consolidate Tissue Viability and Leg Ulcer services under unique specification that improves and enhances service offer to population of South East Essex | Key Actions in train: 1. Agreed SDIP with CCG that formalises shared commitment to these service transformations 2. Established Project Group for each workstream with representation from CCG 3. Agreed work plan for project with key milestones 4. Delivering as per work plan 5. Reporting progress through SDOG 6. Close to varying new specifications into contract“ | March 2020 |
|  |  |  |  |  |
| 2020/21 As above. | Envisaged project complete March 2020. | March 2020 |
| 9. | Occupational Therapy Offer | Develop new specification and mobilise health community OT offer that covers all elements under one service umbrella (including inpatient, falls crisis response, Care Co) and aligns with Social Care OT under comprehensive Intermediate Care Offer (See also project 7) | Key actions underway include: • Reviewing Specification and consider redraft that move to comprehensive offer • Considering single OT clinical leadership for all elements • Meeting with social care OT services to consider integrated / collaborative opportunities and models | Sept 2020 |
|  |  |  |  |  |
| 2020/21 Commitment now to CCG support to continue as above and will be included in SDIP priority next year. | Project Group to be established to deliver as above. | 2020/21 |
| 10. | Continence Service | Addressing long standing non-compliant KPIs by undertaking detailed service review that will deliver new service model in line with national guidance and deliver on KPI the ensure annual reviews are completed | Key actions underway: • Develop specification in line with national guidance • Developing work plan that deliver new operational arrangements that sees full compliance with all KPIs inc annual reviews | March 2020 |
|  |  |  |  |  |
| 2020/21 As above. | Envisaged project complete September 2020. | March 2020 |
| 11. | Primary Care Networks inc | Align community services offer to emerging PCNs and build relationship and alliances with PCN Clinical Directors | Key Actions to date: • Aligned core teams to PCNs • Early engagement with PCN clinical directors | March 2021 |
| Mobilising new joint PCN specifications for ‘Anticipatory Care’ and ‘Enhanced Care in Care Homes’ | • Ensure all specifications reference PCN commitment  
• Develop monitoring arrangements for activity/population health management data within each PCN  
• Develop Alliance agreement document that can be used to formalise community offer for each emerging PCN |
|---|---|
| **2020/21**  
*Draft PCN specifications now published that identify roles for community service to support delivery. Dedicated project methodology required to implement.* | **Emerging national framework for delivery of specifications will be adopted locally for implementation. It is likely to priority within SDIP as impacts contracted service delivery**  
*The Actions listed above still remain priority in next financial year.* |
| **12. Giving frontline staff ability to capture QI proposals** | **We would introduce and support a quality improvement methodology that ensures front-line staff are able to suggest QI ideas/suggestions and these are processed** |
| **2020/21**  
*Remains priority and is being looked at by the Trust’s Organisational Development Team.* | **Currently reviewing App technology i.e. Improve Well that uses App to capture and process QI proposals form frontline staff** |
| **13. Speech & Language (Adults)** | **2020/21**  
*Once CCG commissioning support secured for the investment mobile arrangements to roll out service in line with specification* |
| | **Business Case with CCG for consideration** |
| **2020/21**  
*STRATEGY: Development of Children Strategy for South East Essex with delivery plan that will require project methodology to implement.* | **Will require renewed focus to ensure delivery next financial year.** |
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| **NEURO-DEVELOPMENT:**  
Immediate First 6 Months Implement Neurodevelopment Pathway across South East Essex. Locally Commissioned Full Pathway by 1st April 2020 as part of consolidated offer.  
2020/21 |
| **SCHOOL NURSING:**  
Following successful business case submission progress the mobilisation of service expansion  
2020/21 |
| **IMMUNISATION PROGRAMME:**  
Maintain delivery of challenging Imms targets  
Awaiting decision on Bedfordshire contract  
2020/21 |
| **Frailty**  
2020/21  
Work with partners to develop a strategy for frailty for South East Essex alongside delivery plan. SEECH will be involved in all work streams including:  
- Population segmentation and risk stratification  
- Managing mild frailty and ‘Age Well’ programme  
- Supporting people living with ‘moderate’ frailty  
- Supporting people living with ‘severe frailty’  
- Reducing hospital length of stay  
- Falls and Fragility Fractures management  
- Delirium, dementia and cognitive disorders  
- Personalised Care  
- Patient Experience  
Strategy in draft  
Emerging Proposal sees EPUT developing locality in CPR to become vanguard for frailty  
2020/21 |
| **Locality Development**  
2020/21  
With a renewed focus within CCGs to build comprehensive locality neighbourhood teams and alliances in line with emerging PCNs.......EPUT will be play a crucial role to aligning Teams to the emerging PCN localities and the development of multi-disciplinary localities teams.  
Community Services being mapped to PCNs  
Workshops planned for Feb 2020  
2020/21 |
### A. EPUT - Service Development and Improvement Plans

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Timescales</th>
<th>Expected Benefit</th>
<th>Consequence of Achievement/Consequence of Breach</th>
<th>Quarter One Progress</th>
<th>Quarter Two Progress</th>
</tr>
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<tbody>
<tr>
<td><strong>1) West Essex Catheter Pathway</strong></td>
<td>Pathway to be agreed by CCG &amp; EPUT &amp; PAH to include provision of TWOC Draft pathway being agreed by partners. Non-complex pts to be supported by community integrated teams. Complex pts to receive specialist support to be included in pathway</td>
<td>30th June 2019 to sign off pathway</td>
<td>Q3 2019-20 A more streamlined patient service which is more cost effective and reduction of specific out patient procedures in PAH. Improved support for both non-complex and complex patients with bladder and bowel conditions</td>
<td>WE system working group in place for catheters in addition EPUT bladder and bowel Clinical Lead has supported the UroGynae STP pathway group established defined and shared with system partners - EPUT attending meetings chaired by J Knight 30th July 2019 first meeting</td>
<td>EPUT continues to participate in system partner meetings to progress the pathway - Catheter passport agreed and funding agreed and passports to be implemented - MM from WECCG has requested joint meetings with Herts to avoid duplication</td>
</tr>
<tr>
<td><strong>2) EPUT Input in Specialist MDT</strong></td>
<td>Agreement in principle to take part in specialist MDT. EPUT will participate where appropriate for our caseload Specialist MDT Pilot in Harlow has commenced - lessons learnt will be rolled out in other neighbourhoods following evaluation. MH and respiratory is a separate meeting in Harlow</td>
<td>To review frequency of input by community team following Harlow specialist MDT pilot evaluation in Apr, 2019</td>
<td>September 2019. Systems Benefit Integrated care model – support Reduction in A&amp;E and NELS for this group of pts. Baseline and evaluation of the outcome of the pilot to be completed by Harlow specialist MDT lead.</td>
<td>Included Integrated team service spec.</td>
<td>EPUT has not received sight of the Harlow MDT evaluation report - EPUT Integrated teams continue to support MDT’s within practices + respiratory MDT’s</td>
</tr>
<tr>
<td>3) Integrated Care Home Support Model</td>
<td>CCG to review all elements of support to care homes. Care home LES, care home pharmacists + community matron and care home practitioners + CPN. To determine To determine the impact across the system</td>
<td>To go in MH &amp; EPUT SDIP</td>
<td>Review in Q2 19-20 Integrated Care model – support to reduce A&amp;E and NELS for care home patients</td>
<td>Included in Integrated team service spec.</td>
<td>NR raised at July SPQRG the planned care home review by the CCG has not commenced - LH to investigate - GP and CCG lead to be identified</td>
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<td>4) Case Management of Complex Patients</td>
<td>Agreed there needs to be a standard system offer / specification for case management which also links into hospital responsibilities. Primary care to share complex patients list with EPUT. EPUT to provide case management approach to complex patients. Agree with EPUT on reporting requirement, jointly developed and presented to EOG ICP Transformation Board for sign off</td>
<td>Q1 2019-20</td>
<td>Systems Benefit Integrated care Model Reduction in A&amp;E &amp; NELS</td>
<td>To be reviewed &amp; included in Integrated team service spec Need baseline activity to monitor impact (CCG producing baseline)</td>
<td>New draft ICT spec to be agreed with CCG during Q2</td>
</tr>
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<td>6) Expansion of Community Cancer Services</td>
<td>Business case to support increase in capacity for community surveillance for prostate cancer – Investment required</td>
<td>Q1 Implement 2019-20</td>
<td>KPI’s already in place to support monitoring</td>
<td>To include in EPUT contract if agreement of business case</td>
<td>EPUT to submit BC to WECCG</td>
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<td>7) Continuation of HF Rehab Pilot</td>
<td>Pilot for HF rehab to continue for 2019-20.</td>
<td>Q3 evaluation</td>
<td>Determine if any cost benefit + patient experience/quality impact</td>
<td>Monthly performance data and agreed evaluation</td>
<td>Due Q3</td>
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### 8) Review of Tissue Viability – Dressings

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<td>EPUT has worked with Herts STP partners to agree a STP wound dressing formulary</td>
<td>Finalists in the Nursing Times Award with STP colleagues</td>
<td>STP wound formulary to be agreed on 12th November 2019</td>
<td>Meeting held EPUT and Herts to agree formulary an</td>
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<td>Planned - Meeting NR + Anurita to discuss future risk share with wound care/dressing supplies across WE 06/08/2019</td>
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### 9) Review of Leg Ulcer Capacity and Provision across WE

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<td>To include changes in EPUT contract 2019/20 if review completed and agreed with CCG.</td>
<td>EPUT have established a dedicated team to support Leg ulcer clinics across the 3 localities to ensure equity of provision from existing community resources with clinical oversight from Specialist TVN’s</td>
<td>Complete - new leg ulcer clinic model operating from 1st October 2019 across all 3 localities with clinical oversight from Specialist TVN’s</td>
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<td>To review impact of dedicated team monthly post implementation</td>
<td>To include changes in EPUT contract 2019/20 if review completed and agreed with CCG.</td>
<td>EPUT are continuing to participate in the development of the REACT model - as part of the Urgent Care/Frailty transformation programme - financial modelling underway awaiting East and North Herts CCG confirmation of contribution to the new model of care - Current CARS team are engaged &amp; support new model of care</td>
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<td>All Providers in STP have an aligned dressing formulary. To work with CCG and STP partners to determine most cost effective method of dressing supply and cost – FP10 or Budget to services Meeting held EPUT and Herts to agree formulary an</td>
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<td>11) DTOC in community Hospitals to achieve 3.5% - bed days lost</td>
<td>To review impact on D2A model on community hospital capacity</td>
<td>Q1</td>
<td>Appropriate use of community bed capacity to support system flow</td>
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<td>12) Therapy review for D2A pathways 1 and 2</td>
<td>Funding for pathway 2 ends 31st August Evaluation in Q2</td>
<td>Q2</td>
<td>Appropriate support to pts and improved outcomes for pts post acute admission – reduction in re-admissions</td>
</tr>
<tr>
<td>13) Community IV</td>
<td>Commence Q1 with plan for new model in Q3</td>
<td>Implement Q3</td>
<td>Reduce LOS, Improved pt experience &amp; admission avoidance</td>
</tr>
<tr>
<td>14) Participation with Newton Europe Int Care Work programme</td>
<td>Due to commence July 2019</td>
<td>Programme due in Q2</td>
<td>Effective use of existing system resources to deliver Int Care</td>
</tr>
<tr>
<td>15) EOG Gastro - GP Constipation pathway - NEW Q2</td>
<td>PAH devised original pathway 2-3 years - requires pathway review to support more care in the community due to increase in A&amp;E for constipation - EPUT B&amp;B lead with PAH developing new pathway for OOH care</td>
<td>Reduce A&amp;E attends, improved pt experience, reduction of outpatient appts, improved support to primary care</td>
<td>Not established in q1</td>
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<tr>
<td>16) Development with SPA to support Integration with EPUT Adult MH , 2) Co-location with HUC for 111, OOH &amp; CAS 3) EPUT support to development of BC for System capacity overview</td>
<td>Re-location of SPA by 30th Nov 2019</td>
<td>Improved pt experience, support delivery of UC in the community, integrated response, supports MH transformation</td>
<td>Delay in transformation of current SPA</td>
</tr>
<tr>
<td>17) EPUT has supported CCG/Cardiology EOG with development of Integrated HF service</td>
<td>Integrated model of care to be implemented Q4/Q1 2020-21</td>
<td>Improved integrated care pathway pt experience</td>
<td>No improvement across system HF pathway</td>
</tr>
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</table>
SUMMARY REPORT

BOARD OF DIRECTORS

PART 1

29 January 2020

Report Title: Draft Mid and South Essex Health and Care Partnership – 5 Year Strategy and Delivery Plan

Executive/Non-Executive Lead: Nigel Leonard, Executive Director of Strategy and Transformation

Report Author(s): Professor Mike Thorne, Independent Chair, Mid and South Essex Health and Care Partnership

Report discussed previously at: Partnership Board

Level of Assurance: Level 1

Level 2 ✔ Level 3

Purpose of the Report

The Mid and South Essex Health and Care Partnership has asked that its final draft 5 Year Strategy and Delivery Plan is considered and approved by partner organisations.

Recommendations/Action Required

The Board of Directors is asked to:

1. Receive and approve the final draft of the Mid and South Essex Health & Care Partnership 5-year Strategy and Delivery Plan, noting that this has been approved by the organisation’s representative on the Partnership Board.
2. Request any further information or action.

Summary of Key Issues

BACKGROUND

The NHS Long Term Plan set the expectation that all Sustainability and Transformation Partnerships (STP)/Integrated Care Systems (ICS) would develop a plan that described the delivery of commitments made within the Long Term Plan.

In mid and south Essex, we took the opportunity to refresh our original STP plan, created in 2016, and to develop in partnership, a new plan to set our direction for the coming 5 years.

DEVELOPING THE STRATEGY & DELIVERY PLAN

In order to inform the development of the strategy and delivery plan, a small “design group” was established from the Mid and South Essex Partnership Board (the Partnership Board), comprising representatives from each sector:

- Jo Cripps, Interim Programme Director, Mid & South Essex Health & Care Partnership
- Nick Faint. Southend-on-Sea Borough Council
- Peter Fairley, Essex County Council
- Claire Hankey, Director of Communications & Engagement, Mid & South Essex Health & Care Partnership
- Roger Harris, Thurrock Council
- Terry Huff, Southend & Castle Point & Rochford CCGs
- Brid Johnson, NELFT
- Ashley King, Mid & South Essex CCGs
- Simon Leftley, Southend-on-Sea Borough Council
- Nigel Leonard. EPUT
- John Niland, Provide CIC
- Caroline Rassell, Mid-Essex CCG
- Charlotte Williams, Mid & South Essex Hospital Group
- Ian Wake, Thurrock Council (public health)

As the plan developed, members of the core Partnership team visited the Board/Governing Body or relevant sub-committee of each organisation/partnership within the system to talk through the key points of the plan and to receive comments and feedback. This was a valuable exercise and helped to shape the final strategy.

The strategy and delivery plan was also subject to a peer review process with NHS England and NHS Improvement, supported by many senior colleagues from across the system.

Both the Partnership Board, and the Chairs’ Group were kept abreast of developments over the summer and autumn of 2019.

5-YEAR STRATEGY & DELIVERY PLAN

The 5-Year Strategy and Delivery Plan was approved by the Partnership Board in December 2019, and is in line with NHSE/I expectations on finance and key trajectories. The final draft document presented here (Annex 1) is in two parts:

- Part 1 is our 5-year strategy, which sets out why and how we will work together for the benefit of our 1.2m population. This section describes our vision, and commitments to reduce inequalities by focusing as a partnership on addressing the wider determinants of health; it also describes the emerging plans of the four “places” in mid and south Essex –Basildon and Brentwood, Mid-Essex, South East Essex and Thurrock.

- Part 2 of the document describes how we will deliver the foundational requirements of the NHS Long Term Plan.

There are a number of appendices which have not been included here; these can be made available on request.

Alongside this narrative plan, NHS organisations were required to submit detailed information on finance (following the control totals set for the system), activity and workforce. Chief Finance Officers/Directors of Finance were fully engaged in this process.

There was also a submission describing the trajectories we would achieve on key Long Term Plan commitments. These documents are not attached here, but can be made available on request.

Annex 2 provides the draft summary version of the 5-Year Strategy.

GOVERNANCE

The Partnership Board has approved the strategy, and the final draft is attached here for noting and approval.

Individual partners within the system have shown excellent engagement with the strategy as it has developed and we have been extremely grateful for their expertise and input.

It is clearly important that the strategy and delivery plan is owned by all partners within the system and it was felt important for each Board, Governing Body or Alliance Group to formally receive and approve the final draft document. It is hoped that each organisation/partnership will see their own plans and aspirations reflected in the document.
built, as it is, from our place-based plans.

The date of publication will be advised shortly.

**Relationship to Trust Strategic Objectives**

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<th>SO</th>
<th>Objective</th>
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<tr>
<td>1</td>
<td>Continuously improve service user experiences and outcomes</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Achieve top 25% performance</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Valued system leader focused on integrated solutions</td>
<td>✓</td>
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**Which of the Trust Values are Being Delivered**

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<tr>
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</tr>
<tr>
<td>2</td>
<td>Compassionate</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Empowering</td>
<td>✓</td>
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**Relationship to the Board Assurance Framework (BAF)**

- Are any existing risks in the BAF affected?  No
- If yes, insert relevant risk  N/a
- Do you recommend a new entry to the BAF is made as a result of this report?  N/a

**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  ✓
- Governance implications  ✓
- Impact on patient safety/quality  ✓
- Impact on equality and diversity  ✓

**Equality Impact Assessment (EIA) Completed?**

- YES/NO  YES/NO
- If YES, EIA Score  N/a

**Acronyms/Terms Used in the Report**

<table>
<thead>
<tr>
<th>STP</th>
<th>Sustainability and Transformation Partnerships</th>
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<td>Long Term Plan</td>
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<td>ATT</td>
<td>Alcohol Treatment Team</td>
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<td>Integrated Care Systems</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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**Supporting Documents and/or Further Reading**

- Annex 1 FINAL DRAFT Mid and South Essex Health and Care Partnership - 5 Year Strategy
- Annex 2 FINAL DRAFT SUMMARY Mid and South Essex Health and Care Partnership - 5 Year Strategy

**Lead**

- **Nigel Leonard**
  - Executive Director of Strategy and Transformation
Our 5 Year Strategy & Delivery Plan

Working together for better lives
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Welcome from the Independent Chair of the Mid & South Essex Health & Care Partnership

As the newly appointed Independent Chair of the Mid & South Essex Health & Care Partnership, I am delighted to present this strategy to you. Over the past three years, the Partnership has had many successes. I hope you will see from our strategy that we plan for our Partnership to go from strength to strength.

We recognise that an individual’s ability to live a happy and healthy life is heavily impacted by factors such as housing, education and employment. We want our communities to thrive, for our residents to manage their own lives and to help each other. That’s why we are changing the way we work to address these wider determinants and to support people to live well.

Of course, we still must make sure that our health and care services are there for people when needed and offer a high quality, easily accessible route to getting help.

We have already started to reform and improve our acute hospital services. We have bold plans for redesigning the rest of the health and care system through our four places, with primary care networks as the bedrock of person-centred care and support.

An important part of our development will be to achieve Integrated Care System status - and we are working to achieve this by April 2021.

I commend this strategy to you and I look forward to working with our partner organisations to deliver our ambitious programme of improvement.

Professor Michael Thorne
Independent Chair
Mid & South Essex Health & Care Partnership

About this Document

This document is in two parts;

Part 1 describes our vision and objectives for the further development of our Health and Care Partnership; it sets out how, by working together, we expect to improve the health and wellbeing of our 1.2m residents.

It also provides detail on our operating model, and the role of our four places and primary care networks.

Part 2 provides a more detailed delivery plan, outlining how the Partnership will work to deliver the commitments in the NHS Long Term Plan. It also describes the work we will undertake to achieve Integrated Care System designation, in order to bring further benefits for our residents and staff.
Mid & South Essex Health & Care Partnership – who we are

The Mid and South Essex Health and Care Partnership serves a population of 1.2 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

Our Partnership comprises the following partners:

- **Mid Essex**
  - 390k population
  - 9 Primary Care Networks:
    - 3 - Chelmsford
    - 2 - Braintree
    - 2 - Maldon/Chelmsford
    - 1 - Maldon/Braintree
    - 1 - Braintree/Chelmsford

- **Thurrock**
  - 176k Population
  - 4 Primary Care Networks:
    - Tilbury & Chadwell
    - Grays
    - Purfleet
    - Corringham

- **Basildon & Brentwood**
  - 276k Population
  - 6 Primary Care Networks:
    - 5 - Basildon
    - 1 - Brentwood

- **South East Essex**
  - 370k Population
  - 9 Primary Care Networks:
    - 2 - Castle Point
    - 2 - Rochford
    - 5 - Southend

Over 150 GP practices, operating from over 200 sites, forming 28 Primary Care Networks.

Three main community and mental health service providers

One hospital group with main sites in Southend, Basildon and Chelmsford

One ambulance trust

Five clinical commissioning groups

Three top tier local authorities

Seven district and borough councils

Three Healthwatch organisations

Nine voluntary and community sector associations
Our Population

Our public health teams have created a Mid & South Essex Population Profile (see appendix 1) to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint Strategic Needs Assessments and strategies of our three top tier Health & Wellbeing Boards, has helped to define our priorities.

// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

// The total population size of Mid and South Essex is projected to increase by 5.22% over the next 5 years and 14.70% over the next 20 years.

// In 2017 the life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.
Education, Employment & Prosperity

- Deprivation has increased across the 1.2m population.
- Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work.
- The productivity gap is increasing between mid and south Essex and national comparators.
- Homes have become up to 58% less affordable over the last decade.

Health Behaviours & Outcomes

- There are high and increasing proportions of overweight or obese adults.
- There are increasing numbers of overweight or obese children in early years schooling.
- Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease.
- More people in this area die from cancer, heart disease and liver disease than expected.
- More people are being diagnosed with dementia.
- Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing.
Health and Wellbeing Board Strategies

Our Health and Wellbeing Boards are important partners and their agreed priorities are aligned with this strategy.

**Essex HWBB Priorities**

- Improving mental health and wellbeing
- Addressing obesity, improving diet and increasing physical activity
- Influencing conditions and behaviours linked to health inequalities
- Enabling and supporting people with long term conditions and learning disabilities

**Southend HWBB Priorities**

- Increasing physical activity
- Increasing aspiration and opportunity
- Increasing personal responsibility and participation

**Thurrock HWBB Priorities**

- Opportunity for all
- Healthier environment
- Better emotional health and wellbeing
- Quality care, around the person
- Healthier for longer
Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system.

This means:

Healthy Start – helping every child to have the best start in life
// supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
// supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide.

Healthy Places – creating environments that support healthy lives.
// creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – which spring from participation
// making sure everyone can participate in community life, empowering people to improve their own and their communities’ health and wellbeing, and to tackle loneliness and social isolation.

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
// helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home
// from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

Delivering Our Vision

The health and wellbeing of people in some of our areas is much poorer and on average people die younger there than in other areas. As a Partnership our overriding aim is to change this.

We have set four ambitions to help us achieve this aim:

1. Creating Opportunities
   For our communities to thrive we need good education, opportunities for employment, decent housing and a vibrant local economy. Our Partnership represents some of the largest employers and purchasers of goods and services locally, so we have an important role to play. By working together, we can harness these opportunities for the benefit of local residents.

2. Supporting Health and Wellbeing
   By working in different ways and in closer partnership with our communities we can do more to prevent the things that cause poor health and mental illness. Up to 40% of ill health can be avoided so by getting a grip on issues sooner we can stop them becoming bigger problems in the future.

3. Bringing Care Closer to Home
   Joining up our different health, care and voluntary sector services means we can bring services closer people’s homes – whether that is through support on-line, or by bringing health and care services into the community, such as some hospital outpatient appointments, tests like X-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

4. Improving and Transforming Our Services
   We want to make sure our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can. Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage and avoid more serious illness.
Executive Summary

The way we live and the lifestyles we lead have changed a great deal over the years.

Our population is growing, new technology is being developed and research into the things that can affect our wellbeing is providing new answers.

We are living longer, but not all of those extra years are spent in good health and some of our communities experience significantly poorer health than others. Our health and care staff are also under a great deal of pressure, coping with increased demand for our services.

All of this means the support and help we sometimes need to lead a happy and healthy life must change and adapt too.

We want our residents to have a good quality of life, from education and employment opportunities, to making better choices about being active and what they eat.

We are changing the way we work together as organisations to harness the power our communities and residents have to take more control of their lives and wellbeing.

Part 1 of our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

Starting with you, your family and social networks, the first section of our plan describes how we will make it easier to find out about ways to prevent you from becoming unwell and where you can get support to make the changes you need to improve your health.

If you have a long term condition such as diabetes or breathing problems, you will be able to work together with a range of health and care professionals to explore the support you need to manage your health and prevent more serious illness developing.

To do this we are setting-up teams comprising different health and care professionals to provide joined up care. These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector, working together in Primary Care Networks.

Supporting Primary Care Networks will be four “Place”, partnerships covering South East Essex, Thurrock, Basildon and Brentwood and Mid Essex. These will bring together groups of Primary Care Networks, with local council teams, community and mental health service providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

In Part 2, we explain how we will deliver the commitments set out in the national NHS Long Term Plan (LTP) for improving care for major health conditions (www.longtermplan.nhs.uk)

We set out the actions we’re taking to improve care for conditions such as cancer, mental health conditions, cardiovascular disease, diabetes and for people at key points in their lives, for example having a baby or at the end of life. These include:

**Prevention** – see section 9
- our work on prevention for major health conditions including cancer, diabetes, and cardiovascular disease
- work on reducing childhood obesity through the adoption of the Daily Mile across our schools
- increasing physical activity in adults, linking with Sport England and Active Essex

**Cancer** – see section 14
- introducing a new test to help detect and diagnose bowel cancer earlier, so we can treat people quicker and improve their health outcomes
- setting up a Rapid Diagnostic Centre for patients with non-specific symptoms which could indicate cancer
- becoming a pilot area for the National Targeted Lung Health Check to support earlier diagnosis of lung cancer

**Mental Health** – see section 15
- creating safe places for people to walk-in such as community cafés, where they can find emotional support when they feel their anxieties or other mental health problems are escalating
- setting up mental health support teams in schools to provide therapy and support to children and younger people
- improving how we support people with a personality disorder at an early stage, so that they can manage their condition and are less likely to need to go to hospital

**Cardiovascular disease** – see section 19
- focusing on atrial fibrillation (irregular and often abnormally fast heart beat) to improve earlier detection and treatment to prevent stroke
- reviewing existing patients to ensure their medication is appropriate
- improving access to specialist care at the Essex wide Cardiothoracic Centre, with more patients requiring an angiography being seen within 72 hours.
Part 1: Our Strategy

1. Foreword and Introduction

The Mid and South Essex Health and Care Partnership (the Partnership) comprises the key NHS and Local Authority organisations covering the mid and south Essex area. Our ultimate aim is to reduce the inequalities that our residents face.

Through working in partnership over recent years, we have made good progress - for example:

**In primary care:**

// We are investing in primary care to address the significant challenges faced relating to demand for services, the availability of professionals to support patients and updating our buildings and infrastructure. Additional monies will be invested in primary care over five years to enhance the primary care workforce with new roles and enable patients to access a wider range of services locally. Patients will have full digital access to primary care through on-line consultations, appointment booking and prescription ordering.

// We have established 28 Primary Care Networks (PCNs), which are groups of general practices working together across populations of 30-50,000 patients. These networks form the basis for local collaboration and integration of services. Clinical Directors for each network have been appointed.

**In our community & mental health services**

// We have a pan-Essex Mental Health and Wellbeing Strategy, which puts mental health at the heart of all policy and services in Greater Essex, outlining work with our communities to build resilience and emotional well-being, and ensuring that anyone with a mental health need can access the right service at the right time. We have strong plans in place to improve urgent and crisis mental health services.

// Our emotional health and wellbeing service for children and young people is well established and using innovative ways of delivering services, including mental health teams working across schools.

// Our community physical and mental health teams are working closely with primary care and voluntary sector organisations to collaborate and join services around the needs of the local population.

// Our community teams are working in an integrated way to support keeping people at home, and ensuring timely, safe discharge from hospital.

// There is already significant integration between health and social care services at place level and we will develop this further over time.
In our hospitals:

// Our consolidated clinical strategy across the three acute hospitals is reducing unwarranted variation in access and service quality, improving our specialist services and addressing significant workforce challenges.

// Our plans for improving services have been approved by the Secretary of State for Health and Social Care and we have commenced a programme of service redesign to improve services for our patients.

// We secured £118m capital funding to support improvements to our estates and infrastructure across the hospitals to enable these changes to take place.

// Work with our Cancer Alliance has seen significant investment in transforming our cancer services and supporting early detection – with a pilot Lung Health Check programme in Thurrock.

// We have also been selected as a Rapid Diagnostic Centre pilot, bringing faster diagnosis and treatment of cancers for our residents.

In clinical & professional leadership

// We have strong clinical engagement and leadership in developing our plans and ensuring the quality and safety of services.

// Clinical leaders have been identified for all of our transformation programmes.

// Our clinical leaders have opportunities for development through quality improvement and leadership fellowships.

// Our Primary Care Network Clinical Directors are benefitting from specific development targeted to their new roles as system leaders.

In engagement with our residents:

// We have strong engagement with our communities through all of our organisations and ensure that insight gathered through engagement is used to full effect

// We work closely with our Healthwatch organisations.

// We link closely with community groups and voluntary sector organisations at local level. Our CCGs have strong patient participation forums to bring the local voice to primary care development.

In supporting our workforce:

// We have built strong foundations for ensuring effective recruitment and retention across our health and care services, including the development of new roles, a preceptorship programme for newly qualified nurses, and opportunities for staff development.

// Our local medical school at Anglia Ruskin University will support our ambitions to grow a local medical workforce.

// We have implemented a range of innovative solutions to meet our workforce challenges – this includes the introduction of trainee nurse associates, physician assistants, and apprentices.

In using our estate effectively

// We have developed a system-wide estates strategy that ensures we are working together to make best use of our buildings and infrastructure, and ensures that we are planning for housing growth in a strategic way and utilising available development funding to support our communities.

In digital transformation

// Our digital plans include the development of an Integrated Shared Care Record, so that all health and care professionals working with residents will be able to see their records. This will support more coordinated care and enable our health and care professionals to do their jobs better.

In research & Innovation:

// Our strong work on innovation has enabled us to develop and support our staff to introduce new techniques, products and services that benefit our residents.

// We have agreed a way of working with industry partners to ensure our residents can benefit from cutting edge technologies and innovations.

// We have excellent links with our academic partners, including UCL Partners and the Eastern Academic Health Science Network, bringing new ideas and innovations to improve services for our residents.

While we have had many successes, we know that there is much more to do. Traditionally, we have provided services in relative isolation, focussed on specific organisations and resulting in fragmentation and a variable experience for our population. We have also not always fully considered the impact of the wider determinants of health (such as housing, education, employment), and how by working together, we can impact on these issues in a positive way.

The challenge, and therefore the opportunity, is to support individuals and communities to proactively use their strengths and assets. By working together, we can plan for our workforce, enhance our digital capabilities and take advantage of opportunities for research and innovation, using the wealth of data we collect to maximum effect, and ensure that we are making best use of our resources, delivering efficient and effective services.

We believe that coming together as an integrated care system will enable us to deliver for our residents.
2. What have our communities told us?

There are 17 organisations in our Partnership, which together link with and represent a vast range of organisations and networks.

Each of those organisations engage regularly with local residents or citizens, including those who use local health and care services in a variety of different ways and we are committed to ensuring those voices are reflected in the programmes of work we undertake together.

Since the start of our Partnership, we have undertaken a wide ranging programme of engagement as well as a recent full-scale public consultation. As a collective, we engage regularly with thousands of people across the local area, so it is important to note we are not starting our engagement with residents from scratch and we have a wealth of expertise via local place engagement networks, patient reference groups; and community forums which has helped us to maximise our existing engagement mechanisms without duplication of effort and cost.

The bespoke engagement around the NHS Long Term Plan, provided for us through our local Healthwatch organisations, gave the opportunity to continue conversations on the future of health and care in our area and is to be welcomed alongside the willingness of the community to seek greater understanding and become more informed. The report from this engagement is provided at Appendix 2.

What we have heard

We’ve heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan over a number of months. Here is a summary of what we have heard and how we are responding.

We should do more to support people to stay healthy and well, and prevent people from getting ill.

Our approach to prevention will have a focus on children and young people, together with support for parents and carers, and on building active and involved communities.

We have committed to addressing the wider determinants of health, such as housing, education and income through our Partnership, recognising it takes everyone to join forces and tackle inequalities if we are going to make a real difference.

People don’t want to have to repeatedly tell their story to different health and care professionals.

Our plan describes how we will better coordinate the different professionals and services supporting individuals, working with them to shape their care, in locally-based teams to deliver personalised care. We are also developing a shared care record which will enable all professionals to access to vital information when they need it, to improve how we join up the care we provide.

We aren’t making the most of the opportunities that new technology offers to improve people’s care.

From the success we have already seen in projects across mid and south Essex we know that investing in technology will help to put people in control of their health and care, while also providing the opportunity to reduce the pressure on our services. We are committed to focusing on digital transformation across health and social care to benefit both our residents and staff.

Recruiting more people to work in health and care, and supporting our workforce must be a priority.

Our plans mean nothing if we do not have a highly skilled workforce, working in dedicated teams to deliver high quality, person-centred care. Our plans set out how we will recruit new people to work in the health and care sector, as well as do much more to retain and develop our existing NHS and social care workforce through the development of new roles and career development.

People have difficulty in being able to get an appointment at their GP surgery.

We have and are continuing to invest in primary and community care so that different health and care professionals work together in teams based around groups of GP practices. This will make gaining access to care and support easier for our residents and presents a real opportunity to make sure our residents get the care they need, delivered by the most appropriate professional; at the time they need it.

Improving mental health care needs to be a priority area.

We want people of all ages to be able to get the help and support they need quickly and easily, so that mental health needs are identified and treated early. We are increasing our focus on prevention and wellbeing, as well as providing enhanced support for people in crisis and providing effective inpatient care.

We should work more closely with local community groups and voluntary organisations.

Our plan is centred on linking everybody in our communities together to help keep people healthy, well and active, to support people when they are ill and care for people when they need help.

It’s important we consider travel and transport to and from health services and activities which keep people healthy and well.

We recognise transport can be a barrier to people accessing the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities, to make more support available closer to where people live. And if they need to travel for very specialist care, support is in place for those who need it.
Next steps

The Partnership is committed to do all it can to make sure people’s voices remain at the heart of our development and we will continue to build on the excellent work Healthwatch partners and engagement colleagues have done to date.

We are developing at citizens’ panel – called Virtual Views, to support us to research and understand the views of a demographically representative sample of our population.

We will also continue to draw on insight, both quantitative and qualitative, gathered within our Partnership member organisations.

Given their multi-agency membership, the Health and Wellbeing Boards across Essex, Southend and Thurrock, both upper tier, and at district level, continue to provide an effective public forum for discussions on local plans and wider challenges.

We have already begun a series of conversations with our community, voluntary sector and service user groups with the aim of co-producing a refreshed engagement framework. This will be an important foundation to deliver the ambition outlined in this strategy to become a fully integrated care system by April 2021.

3. Delivering Our Vision – Our Ambitions

3.1 Ensuring Equality: Addressing Inequality & Reducing Unwarranted Variation

Reducing inequalities is a complex challenge and we are committed to working with our partners to address this. We aim to do this by:

3.2 Creating Opportunities: Education, Employment, Housing & Growth

Tackling wider determinates – a system of anchors

As key employers and commissioners of services, partnership organisations are well placed to impact on local economic opportunities and to focus on addressing inequalities. Major areas of opportunity include employment and recruitment practice, local procurement targeted at small and medium sized business, and work with schools and other education providers to encourage educational attainment and aspiration.

Employment and Recruitment

Basildon Hospital is leading work in this area and is seen as a national lead with a focus on understanding the local job market. The hospital is also working with Essex County Council to support people with learning difficulties to enter the workplace.

Thurrock Council have worked with NELFT to develop a new shared vision of an integrated front line health and care worker, with a defined career pathway. These posts are being recruited to and have proved very popular in offering a new career choice where carer jobs were seen as unpopular. Essex County Council is starting work on how to explicitly recruit from more deprived areas, recognising that there are barriers to accessing work that will need to be addressed.

Working with schools

As large employing organisations with significant workforce challenges, partners are recognising the importance of working with our schools to address aspiration and employment issues, particularly in more deprived areas. The Essex Children’s Partnership Board, including head teachers, has endorsed this approach. With support from a public health grant, Basildon Hospital is embarking on an outreach programme to local schools to help improve interest and recruitment to NHS roles.
Procurement
Partners are committed to supporting the local economy and commissioning services locally where possible. Essex County Council perform well compared to other counties with over two thirds of commissioned spend occurring within Essex, and one third with small and medium sized enterprises. As a system we will consider how best we can work within existing procurement regulations to support the local economy and will also consider how to ensure local social value is in contracts, including, for example, the number care leavers or people with physical and learning difficulties employed.

South Essex 2050
The councils of Basildon, Brentwood, Castle Point, Rochford, Southend-on-Sea, Thurrock and Essex County are working together to develop a long-term growth ambition to underpin strategic priorities across the region. The ‘South Essex 2050 Ambition’ aims to ensure that the local authorities retain control of South Essex as a place, putting them in a strong position to shape and influence wider plans and strategies from government and other investment priorities.

In January 2018 the local authorities formed the Association of South Essex Local Authorities (ASELA) to ensure implementation of the ambition. The association will focus on the strategic opportunities for the south Essex economic corridor to influence and secure the strategic infrastructure that will help our communities to flourish and realise their full economic and social potential. The aims of the association are to:

// Develop a strategy to open up spaces for housing, business and leisure development;
// Transform transport connectivity;
// Support industrial opportunity;
// Shape local labour and skill markets;
// Create fully digitally-enabled places;
// Secure a sustainable energy supply;
// Influence and secure funding for necessary strategic infrastructure; and
// Enhance health and social care through co-ordinated planning.

Case Study:
Enabling Carers to Care – Essex County Council
Under the Care Act, local authorities have a statutory duty to offer carers assessments and to provide appropriate information, advice and guidance on other forms of support available to promote wellbeing.

Care givers contribute to enabling and empowering their loved ones to stay healthy and live meaningful lives. In Essex, it is estimated over 145,000 people provide care to their loved ones at an estimated value of £822,300,544 per annum.

The commissioning approach for care givers is fragmented across the system. Our research and engagement has identified areas for improvement where we can make a genuine impact on carers’ lives and the lives of those they care for. To support this, we designed a strategic framework to underpin how, as organisations and systems, we can support and improve the lives of all care givers, structured around the five A’s:

// Becoming a care giver – ‘adopting’ the role of a care giver
// Identifying as a care giver – ‘accepting’ life as a care giver
// Living well – ‘adopting’ to life as a care giver
// Responding to change - remaining ‘alert’ to the changing demands of being a care giver
// Life after caring – ‘adjusting’ to life after being a care giver

Our plan for the coming months we will see us work with partners to design and implement a Care Giver’s Charter to establish commitment across communities to better support people in a care-giving role and implement a cultural change programme to support individual resilience.

We will work with newly formed Primary Care Networks to re-design the community offer for care givers and help develop networks of support around them, including supporting the increased take up of care technology, and developing a digital tool to support carer networks.
3.3 Health & Wellbeing: Healthy Lives & Healthy Behaviours

Through partners working together, we aim to support individuals to live healthy lives through:

/// Providing information and support for people to self-care including through on-line and digital options.
/// Focusing on prevention of ill-health by:
/// Providing good housing through the Local Plan of each local authority, with a particular focus on the quality of housing
/// Improving diet and increasing physical activity by building on the “Livewell” and “Active Essex” initiatives, and targeted investment from Sport England.
/// Weight management services supported by a range of community-led delivery partners.
/// Ensuring good air quality
/// Offering smoking cessation services and smoke free environments
/// Working to improve alcohol treatment services across our three hospitals, ensuring links to wider mental health and community drug and alcohol support services.
/// Identifying and supporting individuals at risk of developing ill health, for example through the National Diabetes Prevention Programme.
/// Providing people with long-term conditions access to talking therapies to prevent the onset of anxiety and depression as a result of their condition,
/// Using social prescribing to provide help to people who have “social” needs, for example, through provision of information and guidance on housing or welfare issues.
/// Signposting people to local support mechanisms in their communities that help to address issues of social isolation and loneliness.

3.4 Moving more care closer to home

We are committed to bringing as many services as possible closer to people’s homes – whether that is through digital channels, where residents can access support on-line or through designated apps, or by bringing a range of physical, mental health and social care services into the community.

It is our intention that the vast majority of services will be delivered locally – including lifestyle support services, outpatient appointments, some diagnostic tests and long-term condition support. We will also ensure swift and safe return to home for our residents after a period of hospitalisation.

Part two of this document describes, for some major health conditions, how we will be bringing care closer to home, through our primary care networks and places.

3.5 Transform & Improve Health and Care Services

While the standard of care offered through our health and care services is generally good, we know that we need to make improvements. We have established programmes to improve and transform:

/// Primary and community care
/// Cancer services
/// Mental health services
/// Cardiovascular disease
/// Elective care
/// Care for older people
/// Respiratory services
/// Maternity services
/// Care for people with learning disability and autism

Part two of this document provides further detail on each of these areas.
4. How will we know if we’ve made a difference?

4.1 Our Outcomes Framework

Our Directors of Public Health have developed a Partnership-wide outcomes framework (see Appendix 3) to help us to track our progress in the key areas where we believe, by working together in partnership, we can make a difference.

Linked to our five ambitions described above, table 1 illustrates a selection of indicators that we will use to monitor our progress. Over the coming months, we will work to develop stretching ambitions over the 5 year period of this strategy for each of the indicators given below.

Table 1: Outcomes framework

<table>
<thead>
<tr>
<th>Reducing Inequalities</th>
<th>Inequality will reduce and our residents will enjoy longer, healthier lives.</th>
<th>// Slope Index of Inequality &lt;br&gt; // Healthy Life Expectancy measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating Opportunity</td>
<td>Our children achieve good development and educational attainment. &lt;br&gt; Employment will rise. &lt;br&gt; Homelessness will reduce and we will have good housing stock.</td>
<td>// School Readiness &lt;br&gt; // Percentage of people in employment &lt;br&gt; // Educational attainment &lt;br&gt; // Statutory homelessness &lt;br&gt; // Number of non-decent dwellings &lt;br&gt; // Air quality</td>
</tr>
<tr>
<td>Health &amp; Wellbeing</td>
<td>Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.</td>
<td>// % of adults classified as overweight or obese. &lt;br&gt; // Reception and year 6 prevalence of overweight children &lt;br&gt; // % of adults physically active &lt;br&gt; // Smoking prevalence &lt;br&gt; // Admissions for alcohol related conditions &lt;br&gt; // QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol. &lt;br&gt; // % of people self-caring after reablement &lt;br&gt; // Patient Activation Measures</td>
</tr>
</tbody>
</table>

Moving care closer to home

Our residents report good access to and experience of primary and community services.

<table>
<thead>
<tr>
<th>How will we know we’ve made a difference?</th>
<th>What metrics will we use to track progress?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Inequalities</td>
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</tr>
</tbody>
</table>

Transforming our services

Our residents have consistent, timely access to safe, high quality health and care services.

<table>
<thead>
<tr>
<th>How will we know we’ve made a difference?</th>
<th>What metrics will we use to track progress?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Inequalities</td>
<td>Inequality will reduce and our residents will enjoy longer, healthier lives.</td>
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<tr>
<td>Health &amp; Wellbeing</td>
<td>Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.</td>
</tr>
</tbody>
</table>

Our residents have consistent, timely access to safe, high quality health and care services. The outcomes from our services are improved.
5. Addressing the Wider Determinants of Health

It is well known that socio-economic factors and behavioural aspects have a significant impact on individual health and well-being; the provision of clinical care provides a relatively small impact as illustrated below.

To ensure sustainability of our health and care system in the future, far more emphasis must be placed on the wider determinants of health. The vast majority of interactions with residents take place locally - and this is where we can have most impact on supporting health and wellbeing. The focus of this strategy is on those local plans that are owned by local people and local partnerships, aligned to the relevant Health and Wellbeing Board. The concept of subsidiarity (to deal with issues at the closest level) is key to the success of this strategy.

While partners operate at a number of different levels, we have sought to ensure that there is no hierarchy attached to these levels.

5.1 What will be different?

We are changing the model of care in mid and south Essex, from one which is reactive and heavily reliant on acute hospital services, to one which is focused on empowering people to stay well and look after themselves, ensuring local access to care and support when required.

**Current System**
- Reactive care, focused on treating illness and an over-reliance on hospital services
- Emphasis on organisations and professionals
- Services are fragmented – mental and physical health are seen as separate
- Variable quality of services
- Variable access to services

**New System**
- Personalised and anticipatory care, with a focus on preventing ill health and supporting wellbeing
- Emphasis on empowering people to look after themselves and offering seamless health and care services when required
- Integrated care means that holistic needs are supported
- Remove unwarranted variation and improve standards
- People can access advice and support quickly and as close to home as possible

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status
5.2 Our design principles

In line with this shift in care model, we have started to develop a new collaborative operating model to describe our approach. The design principles of this operating model can be summarised as:

<table>
<thead>
<tr>
<th>Design Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will co-design with insights and intelligence, putting residents at the centre</td>
<td>We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement, driven by a feedback culture. We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity. We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.</td>
</tr>
<tr>
<td>We will connect people together, delivering integrated care in the community</td>
<td>Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. We will ensure different organisations work together, meaning people get the right care more quickly and easily.</td>
</tr>
<tr>
<td>We will support people to stay well through prevention, self-care and independence thus building resilient communities</td>
<td>We will shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.</td>
</tr>
<tr>
<td>We will adopt digital and technology by default</td>
<td>Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions. Other channels will remain available but used only when most appropriate. Staff and residents are supported to adopt to new ways of working and champion innovation.</td>
</tr>
<tr>
<td>We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce</td>
<td>Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset. Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services. We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.</td>
</tr>
<tr>
<td>We will deliver services as close to home as possible</td>
<td>Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs, including online.</td>
</tr>
</tbody>
</table>

5.3 Defining our Future Operating Model

Our operating model is based around the following anchor points:

5.3.1 You

Our model of delivery starts with the individual, their family, friends and social networks. We want to support people to live healthy lives, to make good decisions and to look after themselves.

We will ensure that as individuals and communities people have the right information and support to stay as well as possible for as long as possible. This information and support will be developed in partnership with individuals and communities so that it meets their needs, and it will take advantage of the growing number of channels available to people to consume information in a format and at a time that suits them. We acknowledge that a “one size fits all” approach to care and support will not work across 1.2m people.

When individuals are unwell, or are living with a long-term condition, we are committed to adopting the key principles of the personalisation agenda to support them to be part of their care planning, and where appropriate to tailor the support that they receive to meet their individual needs.
5.3.2 Your Neighbourhood

People are embedded in their local community and this is where good support for health and care is most impactful. Evidence suggests that "natural communities" comprise around 30-50,000 residents and, across mid and south Essex, we are using this footprint as a means of ensuring that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents to provide better access and more streamlined services. Practices will work together to deliver some specialist services closer to home, and also provide services such as home visiting, extended hours access, and same-day appointments. With a focus on prevention and personal empowerment, PCNs will over time become the key operational delivery units for local and national transformation programmes, for example health screening and vaccinations, personalisation and ensuring people age well. PCNs are newly established and these deliverables will emerge over time.

Through PCNs we will deliver the "triple integration" of primary and specialist care, physical and mental health services, and health with social care, consistent with what doctors report is needed. We will move to a GP-led system of care that focuses on improving population health and wellbeing, and supporting the sustainability of primary care and supporting services. The PCNs are developing their plans to open up new methods of accessing care and support, and expanding the workforce to incorporate new roles that will support people in different ways. These new roles in primary care include social prescribers, who can signpost individuals to different means of advice and support, and pharmacists working alongside GPs to manage medicines reviews and provide advice to patients.

5.3.3 Your Place

For mid and South Essex, "place based" systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

In mid and south Essex we have defined four Places:

// Thurrock
// Basildon & Brentwood
// Mid-Essex (comprising three district council areas – Maldon, Brentwood and Chelmsford)
// South East Essex (comprising Southend, Castle Point, and Rochford).

Over time we expect that the four places become Integrated Care Partnerships – an alliance of local authority, NHS, community and voluntary sector organisations coming together to build and support resilient communities.

Each of our Places have defined local plans for and with local communities – these plans are described later in this strategy.

5.3.4 Our System

Some services and activities are best undertaken at system level (across the 1.2m population of mid and south Essex). We are working together on plans focusing on:

// The provision of acute hospital and acute mental health services
// Planning and development for our workforce
// System-wide estates and capital planning
// System-wide digital transformation
// Data and analytics to support population health
// Clinical leadership
// Opportunities for research and innovation

We are committed as a partnership to meet the ambition set out in the NHS Long-Term Plan to become an integrated care system by 2021. This means that we will put our partnership working on a more formal footing, enabling better collaboration to help us to support the health and wellbeing of our population.

Part two of this document describes the work we will undertake to achieve this designation.
5.3.5 Our Operating Model

All of the elements above are represented in our operating model:
6. Place – Based Plans

Our “place based” systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

The following sections provide detailed information on our four places.

**Basildon & Brentwood**

**Predicted population growth**

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2020</th>
<th>2041</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>13.34%</td>
<td>16.08%</td>
</tr>
<tr>
<td>15-24</td>
<td>16.48%</td>
<td>19.30%</td>
</tr>
<tr>
<td>30-64</td>
<td>46.03%</td>
<td>49.81%</td>
</tr>
<tr>
<td>65-89</td>
<td>17.30%</td>
<td>23.83%</td>
</tr>
<tr>
<td>90+</td>
<td>0.97%</td>
<td>2.12%</td>
</tr>
<tr>
<td>Total</td>
<td>269.4</td>
<td>312.2</td>
</tr>
</tbody>
</table>

**Mid Essex**

**Predicted population growth**

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2020</th>
<th>2041</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>25.72%</td>
<td>25.45%</td>
</tr>
<tr>
<td>15-24</td>
<td>22.94%</td>
<td>24.72%</td>
</tr>
<tr>
<td>30-64</td>
<td>47.67%</td>
<td>47.41%</td>
</tr>
<tr>
<td>65-89</td>
<td>28.66%</td>
<td>40.91%</td>
</tr>
<tr>
<td>90+</td>
<td>1.52%</td>
<td>4.01%</td>
</tr>
<tr>
<td>Total</td>
<td>394.4</td>
<td>437.8</td>
</tr>
</tbody>
</table>

**Thurrock**

**Predicted population growth**

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2020</th>
<th>2041</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>14.29%</td>
<td>15.14%</td>
</tr>
<tr>
<td>15-24</td>
<td>11.28%</td>
<td>14.03%</td>
</tr>
<tr>
<td>30-64</td>
<td>30.59%</td>
<td>34.26%</td>
</tr>
<tr>
<td>65-89</td>
<td>8.87%</td>
<td>13.40%</td>
</tr>
<tr>
<td>90+</td>
<td>0.37%</td>
<td>0.85%</td>
</tr>
<tr>
<td>Total</td>
<td>176.2</td>
<td>209.3</td>
</tr>
</tbody>
</table>

**South East Essex**

**Predicted population growth**

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2020</th>
<th>2041</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>23.31%</td>
<td>23.90%</td>
</tr>
<tr>
<td>15-24</td>
<td>21.12%</td>
<td>23.42%</td>
</tr>
<tr>
<td>30-64</td>
<td>61.02%</td>
<td>62.40%</td>
</tr>
<tr>
<td>65-89</td>
<td>28.43%</td>
<td>38.90%</td>
</tr>
<tr>
<td>90+</td>
<td>1.52%</td>
<td>3.60%</td>
</tr>
<tr>
<td>Total</td>
<td>364.8</td>
<td>410.1</td>
</tr>
</tbody>
</table>

**Partnerships:**

- Mid Essex CCG
- Essex County Council
- Chelmsford City Council
- Braintree & Witham District Councils
- Maldon District Council
- Provide CIC
- Mid Essex Hospital
- Farleigh Hospice
- Community Voluntary Sector
- Anglia Ruskin University
- Essex Partnership University NHSFT

**Priorities:**

1. Ensure every child can have a good start in life
2. Wider primary care network development, including a focus on prevention and population health
3. Attracting staff to want to work and live in mid Essex
6.1 Thurrock

Better Care Together Thurrock sets out our plans for delivering a fundamental change in how health and care services are delivered in Thurrock, recognising the importance of addressing the wider determinants of health and wellbeing. Our statutory Health and Wellbeing Strategy, overseen by Thurrock Health and Wellbeing Board, considers and stimulates action on those wider determinants.

Our vision
The Health and Wellbeing Board’s vision is to ‘add years to life and add life to years’. The Thurrock Health & Wellbeing Board strategy focuses on five key goals, each with a number of aligned objectives.

1. Creating opportunity for all, including objectives on educational, progress, employment and training and prosperity

2. A healthier, safer and accessible environment, including objectives on outdoor spaces, good homes, air quality and connected communities

3. Better emotional health and wellbeing including objectives on supporting parents, reducing social isolation and supporting children and young people’s mental health

4. Quality care, centred around the person, including objectives on the creation of four integrated medical centres (IMCs) in communities across Thurrock, improving GP services and supporting people to take control of their own healthcare

5. Healthier for longer including objectives on reducing obesity, increasing early identification of long term conditions, supporting smoking cessation and improving prevention and treatment for cancer

Our Population:
As of 2019, the Borough of Thurrock is home to an estimated 172,500 people. By 2041 this population is projected to grow to over 209,000 residents, an increase of approximately 21%.

Thurrock is a culturally and linguistically diverse borough. An estimated 25% of the population are ‘non-white British’, with this figure rising to around 30% amongst school-aged children. The population speaks over 70 distinct languages.

Thurrock has a relatively young population, with an average age of 36.9 years (lower than both the East of England average (41.6 years) and the England figure (39.9 years). This is directly comparable to the age profile seen in most London boroughs. The average age in Thurrock has been increasing over recent years however and this trend is expected to continue over the next 20 years, leading in time to a fundamentally different population structure - by 2041 Thurrock is projected to see a more evenly distributed age profile, with an increased proportion of residents in the 65+ and 90+ age groups in particular. This will mean an additional 14,000 residents aged 65+ years and 1,300 aged 90+ years respectively.

Thurrock’s overall level of deprivation is lower than the national average, however some Thurrock neighbourhoods (predominantly in the southern and western parts of the borough) are within the most deprived 20% nationally. These areas also experience the highest levels of worklessness and benefit claimant rates.

Health outcomes within Thurrock vary by geography with a life expectancy gap between the best and worst performing wards of 9.7 years for males and 10.2 years for females.

In recent years healthy life expectancy has fallen from 65.7 years (males) and 64.5 years (females), to 62.6 years and 61 years respectively. This suggests that whilst individuals in Thurrock are living longer, they are doing so whilst experiencing more chronic, long term conditions, such as cancer, cardiovascular disease (CVD), diabetes and respiratory disorders.

Our Challenges
Thurrock experiences a number of challenges, these include:

- Staff recruitment and retention, particularly when competing with inner London allowances.
- Travel and access to services – the area comprises urban, rural and industrial areas.
- Regeneration – costs are consistent with London boroughs but land values are lower than in neighbouring authorities.

Our Partnership
The Thurrock Integrated Care Alliance, jointly chaired by Mandy Ansell, Accountable Officer for Thurrock CCG and Roger Harris, Director of Adults, Housing and Health for Thurrock Council, oversees the local plan for health and care.

The Alliance is the result of strong historical collaboration between organisations. The Alliance comprises the following partners:

- Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
- North East London NHS Foundation Trust (NELFT)
- Thurrock CCG
- Essex Partnership University NHS Foundation Trust (EPUT)
- Thurrock Council
- Community & Voluntary Sector partners
- Primary Care Network Leads

“The local authority recognises it is essential to work with the NHS to deliver services that are more joined up, more community based and reflect local community needs and aspirations. Place is important because all the evidence suggests that transformational change and genuine community engagement happens at a local level. That is why we are passionate about supporting our local agenda without forcing people into a ‘one size fits all’ arrangement, across unrecognisable bureaucratic boundaries”

Roger Harris, Corporate Director Adults, Housing and Health, Thurrock Council
The Thurrock Health and Wellbeing Board oversees the programme and is closely aligned with its delivery.

Thurrock has four primary care networks:
- Tilbury & Chadwell
- Corringham
- Grays
- Purfleet

Partnership working in Thurrock has been driven by a comprehensive Case for Change, which proposed using one locality (Tilbury & Chadwell) as an innovation site. This is acting as the ‘route map’, setting the direction of travel for the locality and enabling the alliance to test and learn how best to enable residents to stay well and independent. Shifting the system towards early intervention and prevention was a significant part of the work.

**Our Priorities – Better Care Together Thurrock**

**Our Vision**

To provide better outcomes for individuals that are closer to home, holistic and that create efficiencies (by shifting resources to deliver a better impact) within the health and care system

**Our Aims**

The alliance has five key aims:

1. Reduce the number of unplanned hospital and residential admissions
2. Reduce the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reduce the number of delayed transfers of care
4. Keep people as independent as possible for as long as possible, and reduce/preserve entry into care and support services
5. Move more services out of hospital/acute care into the community

To deliver this a programme of transformation has been taking place across Thurrock that radically changes how services are accessed and delivered for residents. This programme has five main priorities:

**Priority 1: To transform community and primary care services; this includes:**

1. Improved access to primary care and an enhanced range of services available
2. Streamlining how primary care and community services work together in local teams
3. Greater emphasis on prevention and early treatment and support

**Priority 2: To develop strong and resilient communities, this includes:**

1. Improved access to health and care solutions within the community, with a focus on prevention and early intervention
2. Personalised care that focuses on ‘what’s strong’ rather than ‘what’s wrong’
3. Care solutions that incorporate a greater use of technology and of community assets

The approach looks at what is available within the community, how technology can help, and what friends and family can do before looking at a service option. A number of initiatives have been introduced to test and develop the approach, including:

**Community-Led Support** – One team has been introduced in Tilbury and Chadwell to give local people immediate access to social work and enable social workers to support and advise people at the earliest opportunity. The team has focused on reducing bureaucracy so that it can spend a greater amount of time face-to-face, and uses a strength-based assessment approach.

**Wellbeing Teams** – two Wellbeing Teams have been introduced in Tilbury and Chadwell. The teams focus on helping people to achieve what matters to them. The Wellbeing Teams will be working alongside enhanced primary care teams and will play a proactive role in helping others in the community to remain independent.

**Local Area Coordinators (LACs)** – Running successfully since 2013, there are 14 LACs in place to support people who are on the cusp of a crisis and work alongside them to enable them to articulate and achieve what a good life looks like to them. The approach increases individual resilience and reduces the need for formal service solutions.

**Priority 3: To transform how residents with Long Term Conditions are managed in the community, this includes:**

1. Earlier identification of long term conditions (LTC)
2. Emphasis on self-care and assistive technology
3. Redesign of pathways of care to support people with LTCs

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**Case Study:**

**Extended Primary Care Teams**

In Tilbury and Grays the following professionals are working as an extended primary care team across all practices in the primary care network: paramedic, practice based pharmacist, physician associate, physiotherapists, advanced nurse practitioners and social prescribers. A process is underway to recruit mental health practitioners to join this enhanced team.

In addition existing health and social care services, community and voluntary services and assets, also work together to build a seamless service for residents.
To support this priority we have implemented thirteen long term condition projects to improve outcomes, including:

- Increasing the uptake of NHS Health Checks, targeting high risk cardiovascular disease patients
- Increasing detection, diagnosis and treatment of hypertension and atrial fibrillation to prevent emergency admissions and strokes
- Improving diabetes and pre-diabetes detection
- Increasing depression and anxiety screening and treatment for patients with LTCs
- Improving smoking cessation services
- Improving uptake of flu vaccinations amongst high risk patient groups
- Improved support for patients with respiratory conditions

Priority 4: To reconfigure the out of hospital estate

Over the coming three years, we will open an integrated medical centre (IMC) in each of our four localities. In addition to improving the provision of primary care services, following public consultation in 2018, the outpatient and diagnostic services currently delivered from Orsett Hospital will be redistributed to these local centres, enabling Orsett Hospital to close.

The IMCs will provide a range of services traditionally delivered from a hospital setting, including cardiology, haematology, and dermatology, ear, nose and throat, pain management, respiratory services and rheumatology. Thurrock has established a Peoples’ Panel to support the transformation work required to re-provide services currently delivered in Orsett Hospital to the four new IMCs.

“Thurrock has always seen the value of working in partnership to develop solutions that meet the needs of our community. We are very lucky to be co-terminus with our Council and we work closely across many streams of work, sharing information and developing our system for the benefits of Thurrock residents.”

Mandy Ansell, Accountable Officer, Thurrock CCG Officer

Engaging with our Community

Thurrock has a strong history of engaging with its community. The CCG has engaged on the changes to health and care in Thurrock through consultation, local engagement and through working closely with our Healthwatch. The initial conversations around doing things differently were taken out to the public in April – September 2016 through For Thurrock in Thurrock, the council further consulted in the summer 2017 with the 21st Century Health and Care consultation. The CCG has a number of avenues to gain information. This includes our patient group, the Commissioning Reference Group and through visiting local community hubs and support groups including the Thurrock Over Fifties Forum, stroke group and diabetes groups.

As our alliance develops further, there will be further opportunities for our residents to engage with our plans.

6.2 Mid-Essex

Our Population:

With a population of circa 392k, Mid Essex is the largest place in the mid and south Essex system. Estimated population increases to 2039 suggest there will be a 10.8% increase; in line with England averages.

Within mid Essex there are three district authority areas: Braintree, Chelmsford and Maldon, which have distinct population profiles. The Maldon population profile is significantly different to the other districts especially in the 20-40 year age categories.

The future increases in the 75-year plus categories across all districts is significant, while the population for under 75s on the whole reduces. This is likely to have a significant impact on our ability to support the more elderly population.

All local authorities in mid and south Essex have seen an increase in average Indices of Multiple Deprivation (IMD) scores, indicating increasing levels of deprivation between 2010 to 2015. The largest increases in deprivation were seen in Basildon and Chelmsford, although on the whole, the deprivation across mid Essex is lower than most other areas in Mid and South Essex.

Our key health challenges in mid-Essex relate to poor management of diabetes, a growing level of poor mental health, particularly for young men, and a growing homelessness problem.

Our Partnership

The Mid-Essex Live Well Partnership brings together partners enabling them to work together to understand the local social determinants of health and working with our wider population to implement changes. The Partnership is chaired by the CCG Director of Clinical Transformation, and is a collaboration between organisations working to support the population in mid-Essex. The Partnership comprises the following:

- Mid Essex CCG
- Essex County Council (Adult social care, Education, Children)
- Chelmsford City Council
- Braintree & Witham District Council
- Maldon District Council
- Provide CIC
- Mid Essex Hospitals
- Farleigh Hospice
- Chelmsford CVS
- Maldon CVS
- Community 360 (Braintree CVS area)
- Anglia Ruskin University
- Essex Partnership University NHS Foundation Trust (EPUT)
- Clinical Directors for each of the Primary Care Networks
Over time it is possible that further links will be made with statutory authorities and other key providers.

At partnership level, we interact with Broomfield Hospital, our community and mental health service providers primary care, and our local hospice to oversee integration and ensure consistent pathways of care. We can look at pooling or sourcing funding and joining up resources to support local service sustainability. The partnership links closely with the Essex County Council Health and Wellbeing Board.

We recognise, however, that for many areas of concern we can have most impact by working at the local level. To this end, we also work closely with our district authority partners on issues such as housing and leisure, as well as with voluntary sector partners to deliver support at the local level.

Across Mid Essex there are nine primary care networks. These are very much at an early stage of development. We have clear plans in place to support their development.

Over time, the CCG expects to align staff with partners at district authority and primary care network level to maximise the benefits that local partnership working can bring. District Health and Wellbeing Groups will oversee the implementation of the local Live Well agenda. At this very local level, we also work to engage with our communities.

Workforce/Education

Doing more to attract staff to want to work and live in Mid Essex. This will include being more proactive with schools to highlight the career opportunities within the public sector.

These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health & Wellbeing Strategy. Over the coming months the Partnership will agree some outcome measures to track the success of these priority programmes.

Engaging with our Community

There is strong community engagement through individual organisations within the Partnership. Over the coming months, the Partnership will develop its plans on continuing community engagement.

Our Priorities

The vision for the Mid Essex Live Well Partnership is “Creating Opportunities to Live Well”.

By working together, we will jointly own issues and seek to act in a proactive way to support our residents. The Partnership has decided that its initial priorities will be focused in three areas:

Start Well

Working together to ensure every child can have a good start in life and the education to ensure they can live well.

Wider Primary Care Network Development

Development of the PCNs with support from system partners to align services so that there is greater sustainability across both health and care services. This will also focus on the preventative and population health agenda to mitigate demand on public services.

“Our place based plans in Mid Essex provide us with the opportunity to work with our local stakeholders around our common goal of ensuring that everyone in Mid Essex can live well. The real excitement is that our plans will be built around our local population and maximise the use of our local community assets alongside our health and care services”

Caroline Rossell, Accountable Officer, Mid Essex CCG
6.3 Basildon & Brentwood

Our Population:
Basildon and Brentwood is coterminous with the boroughs of Basildon (population 185,000) and Brentwood (population 78,000) and has a GP-registered population of 279,000. There are 35 GP practices working across six primary care networks. The area has a mixed demography with some very affluent wards, and some of the more deprived wards in the country, pockets of high density housing to low density rural communities.

Pitsea and Laindon are more deprived areas with a significant regeneration planned which can support health and care integration. It is anticipated that by 2037, the overall population will have grown by 18%, with those aged over 65 years growing by 61%. The working age population (<45 years), will shrink whilst there will be a sizeable increase in the younger age group (0-14 years). The birth rate has remained fairly constant in recent years, although risk in maternal health must be addressed to reduce perinatal mortality and teenage pregnancies.

Brentwood is relatively more affluent whilst Basildon has very large disadvantaged communities. There is at least a seven year difference in life expectancy across the boroughs. There is a pronounced level of premature mortality, with cancer (134 per 100,000) and circulatory diseases (60 per 100,000) being the greatest burden. The inequality in health is highlighted by the difference in mortality rate in cancer between Pitsea North West in Basildon (140 per 100,000) and Tipp Cross in Brentwood (64 per 100,000).

While there has been progress in some quality measures, compared to the CCG’s peer group (ONS Cluster of similar CCGs), the performance against metrics such as potential years of life lost from causes amenable to healthcare, health-related quality of life for people with long term conditions and those with long term mental health conditions are amongst the lowest recorded. Basildon has a significant proportion of excess deaths in winter especially in the older age group. The CCG has the highest proportion of people living with a common mental health condition compared to its peers.

It is estimated that 10% of local residents are acting as unpaid carers and many will experience changing health and housing needs. Around 6% of older people live alone in Essex and it is now estimated that 60% of them could develop dementia and therefore be more likely to enter residential/nursing care.

Our Partnership
Partners working across local health and care come together in the Basildon and Brentwood Alliance Forum. The Alliance Forum is chaired by Dr Boye Tayo, chair of Basildon & Brentwood CCG, and oversees planning and delivery of local health and care transformation. The Alliance is a collaboration between organisations working to support the population in Basildon & Brentwood and comprising the following partners:

- Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
- North East London NHS Foundation Trust (NELFT)
- Essex Partnership University NHS Foundation Trust (EPUT)
- Primary Care Networks Clinical Directors (x6)
- Essex County Council
- Brentwood Borough Council
- Basildon Borough Council
- Basildon and Brentwood CCG
- Voluntary Sector organisations (via the CVS)

Basildon and Brentwood has six Primary Care Networks (PCNs) around the neighbourhoods of Billericay, Brentwood, Central Basildon, East Basildon, West Basildon and Wickford. The PCNs were formed this year to bring together general practices to form a strong foundation for the local integration of community based teams with primary care.

Basildon and Brentwood CCG is an active participant in three Health and Wellbeing Boards – Essex County Council, Basildon and Brentwood. The work of the Alliance aligns closely with the priorities of these three Health and Wellbeing Boards.

Our Priorities
The Basildon and Brentwood Alliance have agreed the following priorities:

- Support local people to improve their health and wellbeing and stay independent for longer
- Reduce health and wellbeing inequalities for people of all ages
- Integrate health and care services
- Deliver safe and sustainable services
- Progress towards becoming an Integrated Care Partnership.

By working together around four initial priority areas we will strengthen our local partnerships and build a culture of integrated working that delivers improved outcomes of our population.
The Mid and South Essex Health and Care Partnership: Our 5 Year Strategy & Delivery Plan

**Aligned Teams**
Improve integration of health and social care services around PCN footprints.

**Dementia**
Improve diagnosis and subsequent support for patients with dementia.

**Intermediate Care**
Review patient flows across health and social care and develop pathways to support optimal independence.

**Reducing inactivity**
Reduce levels of inactivity across Basildon as part of a Sports England pilot.

**OUTCOMES**
- Reduce emergency medical readmissions.
- Reduce emergency admissions due to falls.
- Reduce % of physically inactive adults.

These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health and Wellbeing Strategy.

Implementation of the Aligned Team model will transform the way services are integrated to better support the populations they serve. The Aligned Teams will operate on a Primary Care Network footprint and cover community health, mental health, primary care, social care and third sector provision with in-reach from secondary care services where appropriate. This model requires significant cultural change in the way services are delivered in order to risk stratify the population, proactively care plan and support patients and carers to better manage their own health and wellbeing.

The integration of services at a neighbourhood level incorporates a model for social prescribing that has been implemented across the Basildon and Brentwood footprint which has helped to provide signposting and support to patients on how to access alternative services.

Dementia has been recognised as a priority where each partner within the Alliance has a role to play in improving the initial diagnosis for patients with dementia and then the subsequent care and support provided to enable individuals to remain as physically and emotionally healthy as possible.

Partners within the Alliance have commissioned an external review of Intermediate Care Services. The aim is to understand where our intermediate care offer can give people better outcomes and help more people stay at home. A case review and patient flow review is underway to establish the difference between one ‘ideal’ pathway for patients and the current provision. Through the Alliance partners will work together to redesign and integrate services so that care provided is seamless and people receive effective short term care in the community leading to the most independent long term outcome.

Essex is one of 12 pilot areas selected by Sport England with Basildon being targeted as an area with a high level of physical inactivity and higher levels of poverty and social immobility. Reducing inactivity will be a whole system approach focused on an asset based community development approach which is working with communities to harness their strengths, capacity and knowledge.

**Outcomes:**
By working together, we want to make a difference to the way in which services are planned, purchased and delivered. We have defined a small number of indicators to help illustrate that our new ways of working are having impact, these are:

- A reduction in non-elective readmissions for patients aged 75+ for medical reasons
- A reduction in falls-related admissions
- A reduction in the rates of physical inactivity

Whilst the initial priorities are focused around our elderly population, the Alliance Forum will be considering the needs of all age groups including children and young people.

**Our 5-Year Plan**
Over the next five years the Alliance Forum will transition into an Integrated Care Partnership that will support the delivery of the ambitions set out in this strategy. In the first years the focus will be on delivering the agreed priorities outlined above. It is recognised that a significant change in culture is required to deliver the transformation programme and that will not happen overnight.

The next step change will be as we mature as an Integrated Care Partnership and move towards the development of an outcomes framework that measures how we are performing and improving the health and wellbeing of our population. The Alliance Forum will adopt a Population Health Management approach using health and social care data to have a greater understanding of people’s needs to target interventions and deliver care to achieve maximum impact.

Towards the later years the Integrated Care Partnership will establish a comprehensive model of personalised care that supports people of all ages and their carers to manage their physical and mental health and wellbeing. This will build upon community resilience and the asset based development approach that has been adopted in the earlier years.
The Integrated Care Partnership will work with the ICS to ensure that the investment in system-wide estate and digital technologies will enable more care to be brought into the community and integrated with the established teams. The workforce expansion and development to support the new models of care will accelerate throughout the five-year period.

**How we will deliver this**

The Alliance Forum will have clear oversight of the delivery of our agreed priorities through a shared work plan, with each scheme being led by the most appropriate organisation. The focus will be on the integration of health and social care services to support a shift away from reactive to pro-active care. Combined with the development of the asset-based management approach that build individuals and community resilience, the transformation in culture will start to impact.

The Alliance recognises that the traditional approaches to contracting and commissioning and individual organisational accountability will not deliver the change required. Over time the Alliance will adopt a collective approach that is outcome driven for both operational staff and senior leaders.

The Alliance Forum supports ‘doing things once’ where it makes sense to do so. This would include the development of a service operating model that would define standards and outcomes. Nonetheless, there are likely to be some specific nuances in the delivery of the service offer as a result of taking a targeted Population Health Management approach to reducing inequalities in certain wards within the population of Basildon and Brentwood.

**Engaging with our Community**

The priorities and approach the Alliance is seeking to take is driven by significant engagement with communities and stakeholders undertaken by the CCG, Essex County Council, Basildon Council and Brentwood Council. There are very active patient participation groups, residents groups and service user groups in existence and the Alliance will ensure these are part of the design and implementation of service change locally.

**Our Work with the System**

The organisations represented within Basildon and Brentwood Alliance Forum work at a system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation.
6.4 South East Essex

Our Population:

South East Essex (SEE) comprises three main areas – Southend, Castle Point and Rochford with a combined population of c370,000.

The SEE local system is under intense pressure as a result of a multitude of issues including but not limited to a growing population, reduced funding for adult social care, a plateauing of funding for the NHS, an increase in individuals experiencing problems with their mental health, multiple long-term conditions, social circumstances (e.g. housing, employment etc) and an increase and variable ask of public services. These are challenges that are faced all across the country and, in South East Essex, the circumstances are no different.

Moving forward SEE will see a growth in population of 6%, or 20,000 people, over the next 10 years (2018-2027); this coupled with funding pressures and lifestyle choices, will under the current model of care and support, lead to an exponential and unmanageable demand for public services.

SEE as an area is one that contains a collection of smaller communities, each with their own specific care needs based upon the demographic of the population.

It also has a complex and varied health profile as summarised within Public Health England’s Local Authority Health Profiles 2018.

<table>
<thead>
<tr>
<th>Health in summary</th>
<th>Southend-on-Sea</th>
<th>Rochford</th>
<th>Castle Point</th>
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<tbody>
<tr>
<td>The health of people in Southend-on-Sea is varied with the England average. About 19% (6,300) of children live in low income families. Life expectancy for both men and women is lower than the England average.</td>
<td>The health of people in Rochford is generally better than the England average. Rochford is one of the 20% least deprived district/unitary authorities in England, however about 10% (1,300) of children live in low income families. Life expectancy for both men and women is higher than the England average.</td>
<td>The health of people in Castle Point is varied with the England average. About 15% (2,100) of children live in low income families. Life expectancy for both men and women is similar to the England average.</td>
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<table>
<thead>
<tr>
<th>Health inequalities</th>
<th>Southend-on-Sea</th>
<th>Rochford</th>
<th>Castle Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas.</td>
<td>Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived areas.</td>
<td>Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas.</td>
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</tbody>
</table>

SEE, like many other areas, is a complex landscape of health and social care commissioners, providers and third sector organisations. SEE is rich in community assets which currently work, some through partnership, some through silos, in support of communities and individuals. The area is diverse on many fronts: poverty, affluence, ethnicity and age but is rich in terms of its physical assets. The challenge for SEE is to ensure that these are used to support the health and wellbeing of our residents. The SEE area also forms part of the Mid and South Essex Health & Care Partnership planning footprint.

The complex nature of SEE aligned with increasing demand for services, unaligned workforce cultures, reducing community resilience and decreasing resource means that we have to deliver support, preventative interventions and integrated services on a population needs basis.

Our Partnership

The local health and care work is overseen by the South East Essex Partnership Group, chaired in rotation by a senior executive from either Southend on Sea Borough Council, Essex County Council or either of the two CCGs. The Partnership Group is a collaboration between organisations working to support the population in SEE and comprising the following partners:

- Southend CCG
- Castle Point & Rochford CCG
- Southend Borough Council
- Essex County Council
- Castle Point Borough Council
- Rochford District Council
- Essex Partnership University Hospitals NHS Foundation Trust (EPUT)
- Southend University Hospital NHS Foundation Trust (SUHFT)
- Southend Association of Voluntary Services (SAVS)
- Castle Point Association of Voluntary Services (CAVS)
- North East London NHS Foundation Trust (NELFT)

The area is covered by nine primary care networks (PCNs), which have formed this year with the aim of building on the strong foundations built informally between locally working to support the population in SEE and comprising the following partners:

- Southend CCG
- Castle Point & Rochford CCG
- Southend Borough Council
- Essex County Council
- Castle Point Borough Council
- Rochford District Council
- Essex Partnership University Hospitals NHS Foundation Trust (EPUT)
- Southend University Hospital NHS Foundation Trust (SUHFT)
- Southend Association of Voluntary Services (SAVS)
- Castle Point Association of Voluntary Services (CAVS)
- North East London NHS Foundation Trust (NELFT)

“The development of a long-term plan for mid & south Essex represents a significant opportunity for the south east Essex system.

With the plan focused on prevention, health inequalities and local people managing their health, there is a clear link with the strength and community based approach we are collectively delivering in south east Essex.

We are very excited for the future and keen to explore the benefits from the close working relationships we have invested and built over the course of the past few years. The engagement across south east Essex to develop the ‘Living Well in Thriving Communities’ strategy was substantial and we are now beginning to see the benefits of this work.”

Simon Leftley, Deputy Chief Executive (People), Southend-on-Sea Borough Council and Chair of the South East Essex Group Partnership.
integrated teams and primary care providers. The PCNs in SEE represent a significant opportunity to further integrate local teams with primary care, to respond to the local needs of our populations and build upon the community assets within our localities.

There is a direct line between both the Southend Health and Wellbeing Board, the Essex Health and Wellbeing Board and the partnership group. The group is mandated on behalf of both Boards to develop, evolve and implement the agreed locality strategy.

The implementation of the locality strategy operates through an approach of partnership working, integration and collaboration. The arrangements that are evolving are built on this principle and it is clear that it will require organisations and interests, to be represented in multiple forums. The group has the task of oversight and ensuring that the key challenges to implementation of the locality strategy are addressed. Co-design and co-production are principles that run throughout and the group supports each individual organisation represented to report separately into governance channels.

Our Priorities
There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the residents within an area. The desire includes the mobilisation of all the assets at our disposal (within local authorities, health and third Sector) which can be used to engage communities and empower a supportive functionality and ensure public services are designed to support this approach.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how the support individuals require can be delivered against this backdrop that is person centred, outcome focused, integrated and that provides the best possible outcomes for the individual.

Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third

"Health and care partners across south east Essex are collaborating across organisational boundaries to unlock the potential within the community and better understand how local residents can be supported to keep safe, well and happy in their own homes.

The development of our local Primary Care Networks offer a positive foundation for strengthening and re-designing community services to meet local needs. We want to proactively support people at risk of deteriorating ill health, focus on what individuals can do and support them to achieve their goals while supporting local staff to work in partnership with shared information to provide joined up care."

Dr Sunil Gupta, Chair, Castle Point & Rochford Clinical Commissioning Group

and statutory sectors. By focusing on the deficits, rather than the assets, top-down approaches can sometimes be criticised for undervaluing the importance of local knowledge and assets and, as a result, the differentiation between local and systemic/national issues becomes misunderstood. This can be problematic, particularly when thinking about improving health and wellbeing, as it can cause us to think that the wider perspective is all that matters and prevent us from understanding local needs. Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight.

By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved. Through the above approach and by strengthening our local partnership the following priorities have been agreed;

// Strengthened GP services. The provision of primary care services is diverse and varied. With the evolvement of the PCNs and locality working our plan is to invest in and improve GP services so that outcomes are improved for residents and patients. Patients, in the first instance will be encouraged to take responsibility for themselves and access GP services only when needed. GPs will work in partnership with partners to ensure access to front line services will be dictated by need rather than availability. An outcome for patients will be that they are able to access the right care at the right place at the right time.

// Appropriate access to secondary care. We will invest in the community, in primary care, in social care so that our residents will only need access to secondary care services when it is absolutely necessary.

// All age mental health is an increasing issue for the SEE population. We will invest in mental health services, build partnerships across organisation so that patients who have a need for mental health interventions receive the best possible outcomes.

// Supporting self-care & prevention through Population Health Management. By understanding further the needs of our local population, integration and local working can be tailored. Through sharing data and working in partnership we can further understand the impact of the wider social determinants (eg poor housing, income, diet, environment etc) on an individuals’ health and wellbeing. The impact of living close to or having better access to parks or open spaces can be better understood. This understanding (as examples) will influence who and what we invest our limited resources in.
Our 5-Year Plan

It is collectively agreed that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of a locality approach. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an outcomes framework may be structured.

For this to be successful all parties need to agree the key outcomes the system wishes to achieve, and commission and provide services that ultimately contribute to the delivery of these.

The SEE plan to deliver our agreed strategy is across two levels:

Firstly, we will work at a locality level supporting the development of locality teams. We will support the development of a culture built through partnerships and relationships. Integrated working will be actively encouraged, safe spaces will be created through which operational staff will be able to try different initiatives, learn and evolve. The community and community assets are at the centre of this plan as is a strength based approach. The initiatives developed will be in partnership with our communities, they will directly respond to a need and will place the person at the centre. Operational relationships across the entire system will be challenged; the wider determinants of health and wellbeing will be a major consideration. Most importantly, the learning from each initiative will be understood and used to evolve the next steps.

Examples within this first level that have already been delivered are: the development of a community group to address social isolation and loneliness (West Central Locality); regular multi-disciplinary team working (all localities); the development of the ‘hub’ concept (East Central and East Localities); assistive technology and care homes (West Central Locality); dementia navigators (all localities).

Future examples include the development of a community based asset around the new St Luke’s Primary Care Centre (East Central Locality).

Secondly, our senior leaders will be challenged to work in partnership at both an individual and organisational level. This will be achieved through the development of outcomes, a plan to further pool budgets, work in true partnership with providers and strengthen relationships with the community and voluntary sector. Our leaders will listen to communities, residents, patients and operational staff. Outcomes will be ’made real’ for our leaders so that they can understand the impact of their collective decision making. However, a risk has been identified with the merging of the CCG and the engagement of senior leaders within the SEE system.

How we will deliver this

The model of care designed for SEE is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided access to solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner; and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

Whilst the ‘Living Well in Thriving Communities’ model has a focus on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to:

It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of collaboration shall be adhered to across SEE to address the challenges and deliver the model as described in this document.
Previous attempts to redesign the system have failed in part as a result of what is sometimes referred to as the ‘fortress mentality’ – in order to overcome this the partners will be open and honest in the interactions with each other and the populations which they serve.

Underpinning both of these is a need to be compassionate and supportive – not only towards the populations that they serve, but also to individual organisations’ positions. The system has a greater chance of overcoming challenges together by accepting them as system challenges, as opposed to separate organisational ones.

We will ensure that where it makes sense to ‘do things once’ the system will support this. The expectation is that strategic direction will be defined once across the system ensuring that there is a single approach to: (a) defining the model and ensuring consistency in model development where this makes sense; (b) where gaps in interventions or functions are identified within localities and where this gap exists across multiple localities a single approach will be strived for; (c) standard operating procedures for functions such as MDTs or social prescribing; (d) agreeing locality population health and wellbeing outcomes; and (e) developing and delivering an approach for the definition, extraction and analysis of information needed to support locality development.

It is acknowledged that whilst we can simplify need and challenges across the wider footprint each locality will have its own specific nuances based upon the local population. These include:

- Health behaviours such as tobacco use, diet and exercise and alcohol and drug use
- Physical environment such as air and water quality, housing and transport
- Social and economic factors such as education standards, employment levels and income
- Access to and quality of clinical care

Collectively, whilst these contribute to the length and quality of life of an individual they also contribute to an individuals’ ability and appetite to engage with their own health and wellbeing and take responsibility for their own independence.

Engaging with our Community

The development of Locality based models of care, which focus on prevention, personal empowerment, community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on:

- The principles of co-design and co-production - involving, collaborating and devolving – and evolution from current approaches to engagement, and
- A whole system approach, across locality, communications and engagement to offer a place based offer for the locality and where appropriate and specific locality focus to meet separate needs and requirements.
- Working in partnership with voluntary sector and communities to build upon what is already strong within localities.
- Working with residents on a good life model, helping people to stay strong, preventing the need for a service in their lives.

It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system.

Our Work with the System

The organisations represented within SEE work at system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation. We need to keep building and working on a shared purpose ensuring that behaviours and values are consistent across the system.
7. Our Current Challenges

Organisations within the Mid and South Essex Health and Care Partnership are facing significant pressures, both in terms of rising demand for services, shortages in staff and financial challenges.

Workforce

Securing a sufficiently skilled workforce is a challenge for all partners in our system. In the NHS, vacancy rates are high, and this is creating pressures both in relation to service provision and finance (the locum /agency staff rate of 14% is higher than the average across the East of England). We are in close proximity to London, and trained, experienced staff are often attracted to work there; this is exacerbating our workforce pressures.

In social care, there are significant workforce challenges, particularly within the domiciliary care market, where there is a high turnover of staff and a number of provider failures. Attracting nursing staff and managers to work in care homes is also very challenging. It is often difficult to attract younger workers into the care market when they can obtain similar or higher salaries in the private sector.

See section 28 and Appendix 4 for further detail.

Performance & outcomes

We face significant challenges in performance against NHS Constitutional Standards, in particular, demand for urgent and emergency care which impacts significantly on waiting times for cancer and elective care,

It is of concern to us that our cancer outcomes are not where we would want them to be and this will be a major area of focus for us in the coming months.

In general our performance against mental health standards – including access to talking therapies, early intervention for first episode psychosis and children and young people’s mental health – are in line with constitutional standards requirements, but we know that we have further to go to improve services for residents experiencing mental health conditions.

Part two of this document describes our work to improve performance and outcomes in more detail.

Demand

Demand for our services is rising – our primary care strategy (June 2018) identified that as a combination of increasing demand and a lack of primary care capacity we are approximately 20,000 GP appointments short per week. As well as impacting patients who may not be able to access the support they need, this lack of capacity undoubtedly places additional demand on other services within the system, as a significant proportion of patients looking for a GP appointment will attend A&E. We estimate that if we do nothing to address capacity issues in primary care, the gap could grow to 60,000 appointments per week, with the attendant impact on patients, carers and services. Our work through Primary Care Networks and developing our place-based plans are geared towards addressing these challenges.

Local authorities

The scale of the challenge facing social care is creating an uncertain service and financial environment within local authorities. Demographic pressures, growing public concern and a system at ‘tipping point’ contribute to this uncertainty whilst increasing financial pressures solidify the issue.

Council funding for social care is derived from the remaining revenue support grant received from central government, from locally generated incomes such as council tax and business rates, and from user charges. Current national policy is to end the revenue support grant over the next few years and for Local authorities to retain 75% of business rates raised. In addition, with the Government only recently announcing a one year spending review for 2020/21 there remains continued uncertainty with Government funding for social care. This policy presents a risk to local authorities as they may find themselves with revenues that differ significantly from the social care spending needs.

Additional funding has been available via the Better Care Fund, an Improved Better Care Fund grant, winter pressures money and the ability to supplement council tax with a social care precept alongside recent one-off social care grants. However, the difficulties facing social care remain and the Government has yet to provide the full funding and certainty of funding requirements. In addition, the thrust of Government policy for local authority funding is for local authorities to enter an era of financial self-sustainability, which will bring imminent challenges given the demands and cost pressures of social care.

Challenges around the increasing demands of workforce, provider stability, recruitment and retention remain despite proactive work by the local authorities to address concerns.

The task set by national policy is to consolidate and integrate services across health and social care. With no certainty around the future funding for social care local authorities have identified high risk to committing funding over the long term.
NHS Finance

The NHS in mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population. We have agreed a delivery plan to meet allocated system control totals over the next five years. These plans are not without challenge, however, it is only by working together, and making best use of the wealth of data we collect, can we reduce duplication and drive efficiencies in the system. Part 2 of this document and Appendix 5 provides further detail on NHS financial plans.

Addressing challenges together

Through the Better Care Fund (BCF) NHS and local authority partners are working together to address the challenges on each sector:

// Thurrock’s Better Care Fund Plan reflects the vision for and progress made on delivering a redesigned place-based health and care system. The pooled fund now totals £48m of joint health and care funding, with the plan’s schemes designed to shift activity away from the acute sector. This includes a strong focus on prevention and early intervention as well as ensuring, as far as is possible, that the current adult social care market can be stabilised. Governance arrangements for the BCF Plan are through Thurrock’s Integrated Care Partnership and ultimately through the Health and Wellbeing Board.

// The challenges in Southend are significant and demand for services continues to increase. The Southend BCF plan continues the work of integration, community asset building and locality development and builds on all the successes and learning from previous years. There is a strong focus for the Southend BCF on strengthening primary care through the development of Primary Care Networks, investing in the community and alleviating pressures within the acute environment. As noted elsewhere in this strategy, Local Authority finance is uncertain so the challenge for the BCF has been to find balance between sustainability and investment at pace. The Southend BCF plan is further underpinned by the close partnership held with partners across mid and south Essex.

// The Essex BCF plan is worth a total of £154 million in 2019/20 and aligns to the wider integration landscape across Essex. The Essex health and social care landscape is particularly complex, with five CCGs and three Health and Care Partnerships that overlap Essex borders. The BCF supports local delivery of Long Term Plan aspirations and forms the foundations for integrated working. At a pan-Essex level the focus is on prevention; early intervention and enablement, safeguarding, and care market quality and sustainability. Individual CCG locality-based pooled funds channel funding according to local priorities. The Essex Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning and acts as the final point of governance for the Better Care Fund.
Part Two: Our Delivery Plan

8. Delivering on NHS Long Term Plan Commitments - Introduction

This part of the strategy outlines how the Partnership will deliver on the foundational commitments in the NHS Long Term Plan (LTP).

The LTP set out a number of criteria against which plans would need to align.

Our plans are:

- **Clinically-led** – senior clinicians are involved in leading the development of all of our plans – through individual clinical transformations programmes, PCN Clinical Directors, provider and commissioner clinical leads and, at system level, through the Clinical Cabinet. All of our change programmes have clear quality impact assessments and “check and challenge” through the various clinical fora. Further information on our Clinical Cabinet and plans for future clinical leadership arrangements can be found in section 33.

- **Locally-owned** – we have engaged with our communities over a long period of time and this engagement continues through individual statutory organisations, through pathway and programme groups, and via the system-wide Service User Advisory Group. The feedback received from all these sources has helped to shape our plans (see section 2).

- **Realistic workforce planning** – within the current workforce restraints, individual organisations have set realistic workforce plans to enable the safe delivery of current and transformed services. Our workforce plans have been triangulated with finance and activity plans, and we have placed great focus on retaining and developing our existing staff alongside the development of new roles to meet the changing needs of our population. See section 28.

- **Financial balance** – our plans observe the business rule set out in the NHS LTP Implementation Framework. As part of our plans to achieve Integrated Care System designation, we recognise that we have further to go in relation to maturing our financial management across the system and this work is underway.

- **National standards and LTP commitments** – as a system we are committed to delivering the requirements of the LTP – and we set out below how we will do this.

- **A focus on reducing inequality and unwarranted variation** – as a partnership we are committed to reducing health inequalities. Our strategy has described how we will do this through our focus on creating opportunities, supporting healthy lifestyles, bringing care closer to home and transforming our services.

- **Engaging partners** – our plans are a collaboration of partners involved in delivering health and care services in mid and south Essex.

- **Focused on innovation** – we place great emphasis on innovation in our system. Our work on innovation is summarised in section 31.
9. Prevention and addressing health inequalities

Clinical Lead: Mike Gogarty (ECC), Ian Wake (Thurrock), Krishna Ramkhelawon (Southend), Directors for Public Health
Senior Responsible Owners: CCG Accountable Officers

Prevention is about transforming life outcomes, and not simply about stopping bad things from happening. An estimated 40% of all ill health is preventable. By reducing the prevalence of the risk factors, we will reduce the burden of ill health. We know that prevention is best achieved through improving material wealth with a focus on employment and education, addressing social isolation and tackling unhealthy lifestyle choices. We are committed to using evidenced based clinical and non-clinical interventions and planning and infrastructure that influence life outcomes from birth.

Our Commitments
With an ageing and growing population, it is imperative that we find ways to reduce avoidable demand on our statutory services. Prevention requires actions across the Partnership. It cannot be done by any single organisation. The aims of our prevention programmes are to:

// Improve the health and wellbeing of our population
// Support people to be in good health for longer (improving healthy life expectancy)
// Target interventions to improve self-management for people with long-term conditions
// Develop our staff to work in different ways – promoting wellness
// Develop our digital capability to support residents to live well

9.1 Giving children and young people the best start in life

Every child and young person, regardless of the circumstances into which they are born, should have the opportunity to maximise their potential and future life chances.

Our Commitments
We are focussed on ensuring that mid and south Essex is a place where children can flourish and achieve their full potential in life.

We know it makes strong sense to invest in the early years from an economic perspective as the long-term savings that can be generated are considerable.

Current Work & Future Plans

Thurrock
Brighter Futures Thurrock represents an integrated children’s partnership which brings together – Healthy Families, the Prevention and Support Team and Children’s Centres. The ambition for Brighter Futures is to ensure children and families achieve good outcomes through universal provision and when needed through effective early help. This model will be underpinned by a Children’s Prospectus from 2020/21. This high level strategic document will seek to clearly articulate Thurrock’s vision for the health of its young people.

Local evidence points to key challenges for the under 5’s – these include immunisation, obesity, breastfeeding initiation and maintenance, communication and language, outcomes at the two to two and half year child development check within health visiting and early years, oral health and accident and minor illnesses. A wellbeing offer for the 0- fives is being co-produced in Thurrock to address these needs, thereby providing an equitable evidenced offer to residents based on need.

Childhood immunisations trends in Thurrock have experienced a downward trend since 2010, specifically MMR1, MMR2 and PCV. In response the public health team have developed a child immunisations recovery plan, 2019 -21. This was prepared in partnership with NHSE and overseen by the Essex Vaccination Committee. Implementation commenced in June 2019. The plan aims to

// Improve understanding of performance at a smaller area level
// Understand the barriers and opportunities underpinning vaccine uptake.
// Improve access to vaccinations for children
// Ensure proactive messages about childhood vaccination are promoted in line with local social research and national evidence
Essex County Council

ECC has commissioned a partnership of Virgin Health and Barnado’s to deliver a focussed, evidence-based and needs-driven approach to the Best Start in Life. This was informed by ethnographic research into the needs of local young people and families.

The council and partners recognise the central importance of evidence-based parenting support in ensuring school readiness especially within deprived populations and high risk groups and a set of outcome based KPIs have been agreed to ensure progress in this area.

In some areas there are unacceptable levels of child poverty and the system is adopting the Healthier Wealthier Child model from Glasgow using links between midwives and health visitors and local Citizens’ Advice Bureau (CAB) to ensure young families can access all the support, advice and benefits they need.

Southend

Childhood immunisation in Southend is generally improving with the transfer of the Health Visiting service in-house. The council is closely aligned with the A Better Start Southend (ABSS) programme, and is developing a new framework for the commissioning of the 0-19yrs service with a focus on serving the most disadvantaged communities better and to bring about incremental behaviour change through engagement and co-design of support services.

ABSS’s mission is to achieve system change such that by the conclusion of Lottery Funding, local partners have embedded a sustainable system. The aim is to shift the focus away from traditional service commissioning towards greater levels of community and practitioner ownership, recognising the social capital we can build will be key to sustainability of services and the local approach.

9.2 Flu Immunisation

An effective flu immunisation programme will prevent vulnerable people from becoming unwell.

Our Commitments

We commit to working with existing networks to:

// To increase public awareness of the need for the vaccine, its benefits and to dispel myths
// Support primary care networks to offer the vaccine – eg. offering flu clinics outside normal hours, using GP-online to book appointments etc.
// Regularly monitor uptake data, to have a better understanding of practice/group variation etc. in order to give support.

Current Work & Future Plans

Essex

Supports public awareness of winter health through its public facing website that signposts to NHS information on seasonal flu immunisation and other ways to stay healthy. In addition the council is promoting the uptake of seasonal flu immunisation among public facing social care staff.

Southend

The 2019/20 Flu plan for Southend-on-Sea aims to increase the uptake of the vaccination in key vulnerable groups through collaboration across healthcare and public sector organisations in the borough to optimise resources and increase public awareness. The key aspiration of the plan is to achieve 75%+ uptake in adult vaccinations, 48%+ uptake in pre-school children, and 65%+ in school age children. Additionally, key vulnerable groups such as homeless/rough sleepers are being prioritised for service outreach and the LeDeR Programme has identified people with learning disabilities as a key group to prioritise.

A key component of the flu vaccination plan is the vaccination of healthcare staff and of public-facing staff in the local authority and partner organisations. The plan has widened access to the staff vaccination programme to key staff members in, for example, housing services and the voluntary sector.

Thurrock

The overarching strategy of the 2019/20 Thurrock Flu action plan is to work with existing networks including GP surgeries, extended access health hubs, pharmacies and community nursing, to offer the flu vaccination to a wide range of our population, particularly those aged 65+ and our ‘at risk’ population aged 64 years old and under. The work involves collaboration with staff working in care homes, healthcare workers, carers, and those who come into contact with vulnerable groups.
9.3 Cardiovascular Disease (CVD) Prevention

The most recent modelled prevalence of cardiovascular disease published by Public Health England highlighted a gap between the registered prevalence in the area for hypertension, atrial fibrillation and diabetes. These are major risk factors for premature death and disability and yet are relatively simple to address to enhance prevention. However, there is still a substantial variation in rates of early diagnosis and optimal treatment.

High quality primary care is central to improving outcomes in CVD because this is where much prevention, diagnosis and treatment is delivered. Improving primary care management of cardiovascular and cardiovascular-related conditions can prevent both adverse health events and costs. This underpins the need for the development of programmes that can identify patients suffering from long-term conditions at the earliest onset.

Long term conditions disproportionately affect certain groups of people such as, vulnerable individuals, those in the BME groups, areas of high deprivation or those with a disability. One of the factors identified to contributing to the highest level of inequality is due to low capacity in primary care. To tackle this unfairness, public health is looking at bringing screening services closer to the community and contributing to creating more efficient screening and diagnosis pathways in primary care.

Our Commitments

// Bring screening services closer to the community.
// Target groups of vulnerable people to decrease existing inequities.
// Create efficient, evidenced based pathways for screening, referral and diagnosis.
// Educate on and promote high quality management of cardiovascular disease.
// Work collaboratively with the voluntary sector to better understand the needs of the population and create programmes and interventions that are tailored to specific population groups.

Current Work & Future Plans

Thurrock

// NHS Health Checks provide a systematic way of identifying patients either at high risk of, or with undiagnosed cardio-vascular disease and then providing referral to lifestyle modification programmes or where necessary clinical management. NHS Health Checks in Thurrock are provided either by the GP practice or by the Thurrock Healthy Lifestyle Service. There is an ambition to reach a 60% conversion from invites to completed checks. Last year the service achieved 48%. Improvements have been made through new software that enables consistent delivery of the health check and ensures data is transmitted back onto the clinical systems. In 2016 a localised best practice guide was produced to help GP practices deliver the NHS Health Check programme to a high standard.

// The Thurrock the Hypertension Detection project commenced in April 2017, as a 3 year programme to address the high level of under-detection of hypertension. The overarching outcome of the project is to achieve a 10% increase in hypertension register completeness in Thurrock by 31st March 2020 compared to the 31st March 2017 baseline. The series of detection streams being implemented as part of the overall project includes;
// GP waiting area detection (Since Feb. 2018)
// Smoking Cessation clinic detection (Since Jul. 2018)
// Community hub detection (Since Aug. 2018)

The programme has been highly successful, delivering a 6% increase in register size in its first year.

// Diabetes Detection Programme – a series of pilot projects which commenced with a Diabetes Detection in Dentistry is underway. The purpose of Thurrock Diabetes Community Detection is to develop work streams to act on the low case finding rates for diabetes mellitus (type 2), aiming to increase the detection rate of people living with diabetes who are asymptomatic and are at risk of serious health implications if undiagnosed. Additional to early diagnosis, pre-diabetic range is also being considered, with high risk patients being referred into the National Diabetes Programme for healthy lifestyle education. It is intended that the projects will also increase the number of people receiving appropriate care and treatment to prevent disease onset.

// CVU Upskilling - Public health have developed and implemented a number of work streams focused on the improvement in detection and management of patients with long term conditions. These work streams also carry with them a significant financial investment. To ensure the effectiveness of the initiatives and achievement of outcomes it is acknowledged there is a need to upskill the practices and clinicians who will be delivering the required activity. A focused training programme incorporating up to date guidelines and evidence-base, aimed specifically to address the needs of front line primary care was procured. The CVU Upskilling programme encompasses six Modules of training, with the aim of supporting primary care services to achieve the stated outcomes of ensuring appropriate practice based investigations and diagnosis, ongoing CVU management and onwards referrals. The first round of training was completed in March 2019 with resoundingly positive feedback. The second cohort of clinicians commenced in October 2019.
Stretched QOF – this contract with primary care commenced in July 2018 to incentivise GP practices to achieve above the maximum Quality and Outcomes Framework threshold for selected CVD, mental health and respiratory indicators. In doing so, this seeks to provide interventions to an increased number of patients eligible, improving the management of long term conditions in primary care leading to the following outcomes:

- Reduction of non-elective hospital activity from patients with long term conditions.
- Reduction in the number of patients having a major health event that results in a new or increased need of adult social care packages (e.g. stroke).
- Improvement in the health and wellbeing of patients with a long term condition (LTC).

In 2018/19 the programme delivered a significant increase in performance across 18 of the 19 QOF indicators selected, with performance in CVD indicators in Thurrock now significantly better than the England mean. In 2019, the contract was updated to reflect the new QOF indicators and clinical threshold targets as indicated in the Long Term Plan.

**Essex**

**Health Checks:** Essex County Council remain one of the top performing county councils for health checks and have an ambition to increase uptake in the most deprived groups such that 25% of checks are within the most deprived quintile. Additionally, the Council continues to commission senior health checks, recognising the higher absolute risk and lower numbers needed to treat in the 75 to 84 age group.

**Hypertension:** Essex completed a hypertension detection and management project in 2018. Our consideration of published evidence and local data suggest further specific initiatives in this area in Essex are not currently a priority although we would still expect primary care to identify and manage people with high blood pressure and wider cardiac risk in line with national guidelines.

**Diabetes prevention:** Essex are keen to work with primary care colleagues to ensure people who may be at risk of diabetes are referred for lifestyle advice including weight loss. Local review of literature and a desire to simplify systems suggests a model simply based on weight is best to identify the most people at risk of type 2 diabetes and there is ample capacity in lifestyle and weight loss support services to support referrals.

**Atrial fibrillation:** Essex have run several initiatives over recent years to work with practices to ensure people with AF receive optimal stroke prevention management. There is however further scope for improvement in this area and therefore the AF work highlighted in section 21 is welcomed.

**Southend**

Southend-on-Sea met its targets for provision of NHS Adult Health Checks in 2018/19 and has sought to build on this for 2019/20, working with the new PCNs to better target people in areas of higher deprivation and provide more flexible access out of hours service through community hubs. In addition, a plan has been developed for provision of a dedicated service to increase access to physical health checks for people with significant mental illness.

A local incentivised scheme for PCNs has been developed to support prevention interventions across the life course. This provides an extended QOF for a set of prevention areas to be prioritised according to key areas of PCN need from childhood through to older age populations. This extended QOF service includes work to reduce risk factors for CVD through identification and optimised management of atrial fibrillation (AF) and hypertension. This will be in place from January 2020.

Additionally, surgery pods are in place in a number of GP practices in Southend with a plan agreed to roll this out across all practices. These pods are also in place in care homes across the borough. There is scope to enhance these pods to enable further identification of AF through additional software.
9.4 Tobacco Control

The proportion of current smokers among residents aged over 18 has mostly decreased across mid and south Essex since 2011. Helping people to stop smoking remains a key way to prevent avoidable early ill health.

Our Commitments:
All partners are committed to working together to take a more proactive approach around smoking cessation for staff, patients and visitors. We will achieve this by preventing people from starting to smoke, supporting more people to quit and tackling health inequalities by targeting key groups. Specific points of action will be:

// To ensure smoke free environments within our own institutions and focus more on identifying smokers and supporting them to quit.
// Using the Anchor Institution programme to support the smoke free agenda, particularly through work with hospitals as major employers.
// Through our Places we will target interventions in particular areas of high smoking prevalence.
// Through our maternity services transformation work, ensuring additional support is available for pregnant women to quit smoking, both in order to reduce health inequalities and the adverse impacts on the health and development of foetuses and infants.

Current provision & future plans
Community smoking cessation services exist across our three local authority areas. These services offer lifestyle advice and support for stopping smoking:

Southend
Has launched a new Harm Reduction Strategy which will tackle the issues intertwined with gambling, tobacco control and smoking and drug and alcohol misuse. This will drive the smoke-free work across a number of partnerships. The council is actively working with local vaping shops to support smokers to quit tobacco smoking, as well as moving to appoint a dedicated public health midwife to better support pregnant smokers. The Smoke-free School Gates campaign is working with primary schoolchildren to encourage their grown-ups to stop smoking at the school gates.

Thurrock
Public health officers have been working with EPUT, BTUH and secondary care datasets to support the implementation of smoke free sites set out in the Tobacco Control Plan for England (2017-2022) and the NHS Long Term Plan’s Ottawa/CURE model in acute settings. This includes brief advice, screening and referral to community smoking cessation services but also smoking cessation support for inpatients.

Collaborative working with Trading Standards is restricting the supply of ‘pocket-money-priced’ illicit and counterfeit tobacco. Test purchases and tobacco detection dogs are just two of the enforcement measures implemented. Since 2017, the council’s Trading Standards Team has conducted numerous covert operations across the borough, seizing tens of thousands of counterfeit and smuggled cigarettes and numerous kilos of hand rolling tobacco. The Council has taken enforcement and legal action against all itinerant traders.

Essex
Alongside more traditional interventions, piloted the use of vape vendors in supporting complete switch from tobacco to ecigs. This followed recognition that many people chose to try and substitute tobacco with vaping rather than approach traditional smoking support services. The approach has been recognised by Public Health England and shared as good practice. Trading Standards, part of the Public Health team in Essex, have too made considerable inroads into tackling illicit tobacco.
9.5 Alcohol Use

Alcohol is a significant cause of harm across mid and south Essex, resulting in high numbers of hospital admissions, ambulance call outs and GP attendances.

Through the narrow measure of alcohol related hospital admissions per 100,000 population (which includes only those admissions where alcohol is directly attributable), Basildon had the highest rate of all local authorities across mid and south Essex and the largest increase over the previous five years. This contrasts with Southend-on-Sea which had the second largest rate for 2017 but was the only local authority to show a decline (-47) in hospital admission rates since 2012/13.

Based on population estimates, the number of alcohol-related hospital admissions is likely to increase, with Basildon and Thurrock forecast to have the largest percentage increase over the next five-20 years.

Our Commitments:

// We will take a more proactive approach to alcohol management including identification of individuals with alcohol dependency, and support for people to reduce/abstain to prevent ill-health.

// All organisations will take action to minimise the impact of alcohol on the most vulnerable including the children of dependent and harmful drinkers.

// All local authorities seek to increase the number of dependent drinkers receiving treatment.

// Specific actions will target areas with high prevalence of alcohol related harm through place-based plans.

Current provision and future plans:

// Across the system we have some excellent community alcohol support services including preventative and treatment services being provided across community, primary and secondary care, but the service offer is not consistent and funding arrangements require review. Better alignment across the partnership footprint between service providers could ensure we manage differential access and share learning and good practice.

// The LTP highlighted alcohol treatment teams (ACTs) as being an effective approach to preventing alcohol-related harm. Currently the local authority Public Health teams fund two roles in each hospital – an Alcohol Liaison (nurse) Service and an A&E Liaison Service. Discussions are ongoing about how to enhance the hospital-based services, focused on linking with mental health workers and improving links to community drug and alcohol services and having more liaison support workers covering longer hours, including events and weekends.

// The charity Open Road provide weekend support in the city centre in Chelmsford to keep those affected by alcohol safe and away from A&E services, this model is being reviewed across the footprint. Southend has started this review, following the decommissioning of a similar service in 2017-18.
9.6 Obesity

Children

Being overweight is partly responsible for more than a third of all long term health conditions.

If the proportion of overweight or obese children remains the same, due to projected population increases, the total number is likely to increase across the footprint. It is forecast that Southend, Thurrock and Basildon will consistently have the highest count of overweight or obese children in reception.
Adults

The proportion of overweight or obese adults was the highest in the Basildon district; however, the proportion in all but three local authorities was higher than across England.

It is forecast that Basildon, Southend and Thurrock will consistently have the three highest counts of overweight or obese adults and the largest percentage increase in count from 2019 to 2024 and 2039.

Basildon and Thurrock had the lowest proportion of adults that were physically active, lower than the Essex and England average. Basildon also had the lowest proportion of adults meeting the recommended "five a day" fruit and vegetable target, lower than the Essex and England average.

Our Commitments

// We recognise that active and health lifestyles contribute to improve physical and mental health. We commit to supporting our residents to make the best choices about their diet and physical activity levels.

// Our local authorities have committed to a "health in all policies" approach.

// We will ensure access to commissioned weight management services across the footprint for both adults and children, in accordance with NICE guidance.

// Increase uptake of the Diabetes Prevention Programme and target groups that are at higher risk.

// Work together on whole system approaches to encourage healthy lifestyles and weight management.

// Use the Anchor Institution approach to create healthier working environments, particularly active travel, physical activity opportunities and reduced access to high sugar food and drinks.

Current Provision & Future Plans

Currently it is estimated that 22% of the population of Essex is classified as inactive.

Southend

A new wellbeing service was commissioned in 2019 in Southend. The main remit is to enable community-led Tier 1 service development, building on some existing initiatives and more collaboration with other existing "Tier 2" providers locally. The services work with the PCNs to develop a wider offer for the Exercise Referral Programme, which currently only offers gym-based sessions. PCNs would like a mix of community-led initiatives as well as dedicated low to moderate impact activities – such as yoga, Pilates, TaiChi, swimming, etc. Southend plans to launch this new service in 2020.

The council is reviewing their offer for Strength and Balance exercise programmes, expanding from fall prevention to healthy ageing.

Southend Council is also promoting the Daily Mile in schools and will shortly add this to the menu of interventions as part of the Enhanced Healthy School programme.

The dedicated investment through A Better Start Southend programme is enabling more alignment between physical wellbeing activities and the diet and nutrition component in looking at obesity.

The Southend Physical Activity Implementation strategy is entering its final year, and most of the key actions are already in place or in development including tackling obesity through planning and development and adopting Sport England’s "10 Principles of Active Design".

Essex

The limited range and impact of traditionally commissioned tier 2 services led to a service redesign, led by the tier 2 provider, to transform the service to be one of community-led peer support weight loss groups. These have delivered a 30% increase in activity in the first year at half the cost, with weight loss levels in individuals comparable with the National Diabetes Prevention Programme. This work has led Essex to rethink how best to prevent diabetes locally, including an approach to optimising referral of anyone who is overweight into the service.

A second approach, highlighted as best practice in the NHS Green paper, is a whole system approach to childhood obesity developed on the evidence based EPODE model, piloted in a local authority. The schools benefitting from the whole system interventions showed weight loss over the pilot while control areas saw a gain. The model will be rolled out subject to continued gains in the upcoming NCMP results.
Essex has been awarded a £10.68m National Lottery grant from Sport England to increase physical activity and tackle the inequalities that prevent nearly 400,000 people from enjoying the benefits of an active lifestyle. The programme has seen 20 action research projects across the county and involves almost 1500 stakeholders and community groups. The plans include:

// Getting local people involved, who want to create activities in their areas
// Creating active parks, coastal paths and new walking and cycling routes
// Easy access to small grants and support for community projects
// Investing in successful voluntary groups and charities to scale up their activities
// Training people in voluntary as well as paid roles, creating thousands of new volunteers, leaders and coaches
// Brightening up buildings, streets and parks to make them attractive places to be active
// World class measurement and evaluation which will be shared UK-wide

**Thurrock**

**Whole Systems Obesity Strategy**

In 2017/18, 69% of the adult population were overweight and obese in Thurrock. This prevalence is statistically significantly greater compared to England (62%) and is the highest in the East of England. Prevalence of childhood obesity in Thurrock at reception and year six are 10.7% and 25.3% respectively (2017/18). The year six prevalence is also statistically significantly greater than England’s prevalence.

In 2019/20, a Whole Systems Obesity Strategy has been developed as the strategic driver for preventing and reducing obesity in Thurrock. There are five goals within the strategy:

// Enabling settings, schools and services to contribute to children and young people achieving a healthy weight
// Increasing positive community influences
// Improving the food environment and making healthier choices easier
// Improving the built environment and getting the physically inactive active
// Improving the identification and management of obesity

**Thurrock Exercise on Referral (EOR)**

EOR is a prescribed exercise programme offering specific programmes for people with long term conditions including obesity, COPD, Parkinson’s, low level mental health, diabetes, back pain, cardiovascular conditions (e.g. high blood pressure), stroke and cancer. The programme is 12 weeks long and includes twice weekly sessions. Impulse Leisure is the provider of the service and it is offered at the three leisure centre sites across Thurrock. The programme has physical, mental and social benefits. Being in the group provides a social opportunity useful for sharing ideas and tips around self-management.
9.7 Air quality

Air pollution contributes to a number of conditions, including lung cancer, heart disease, stroke and lung diseases, such as asthma and is a significant contributor to health inequalities.

Our Commitments

/// Work in partnership to encourage and support staff to use travel modes such as cycling, public transport or walking. Some organisations already offer incentives and subsidies for using public transport (eg, the acute hospitals offer discounts on bus travel) and we will seek to map what is on offer and share good practice.

/// Support and encourage service users to use sustainable travel methods.

/// Reduce business mileage through increased use of video- and tele-conferencing, Webex and other on-line means.

/// Use of low emission vehicles for business wherever possible. Southend boasts the only electric car-club scheme in this area for use by council employees and other local residents/businesses.

Future Plans

Southend

Will be looking to explore opportunities in the creation of Park & Ride schemes that could better serve the airport and encourage the use of the excellent train service to access its beaches.

Southend recognises the need to invest in new technology to help better measure peaks of poor air quality and is looking to pilot an Internet of Things project with the support of Public Health England. Southend will also be exploring policy options to help alleviate high air pollution in its Green City policy development.

Essex

Through its Essex Design guide, Essex County Council is setting the expectation that the substantial new development that is taking place in Essex supports active transport and access to the natural environment.

Essex Air, a collaboration of all upper and lower tier local authorities in Greater Essex, is developing its public facing website to improve the information to the public to provide clear information on air quality in their local area.

9.8 Anti-microbial resistance

The NHS Long Term Plan sets out an ambition to drive progress in implementing the Government’s five-year national action plan, Tackling Antimicrobial Resistance, to reduce overall antibiotic use and drug-resistant infections.

Our Commitments

/// To achieve the measures of success within our remit as set out in the Tackling Antimicrobial Resistance 2019-2024; the UK’s five-year national action plan

/// To optimise system wide use of antimicrobials

/// To establish a:

1. single system-wide antimicrobial stewardship committee
2. system wide antimicrobial stewardship strategy
3. surveillance system for data review and analysis
4. system to promote the antibiotic guardian pledge

/// Provide system wide leadership to providers on the delivery of national Commissioning for Quality and Innovation (CQUIN) indicators.

Current Work & Future Plans

/// There is a newly appointed senior responsible officer for AMR, who will provide system leadership to ensure the delivery of the 5-year national action plan.

/// Focus to date includes;

/// Establishment of system- wide governance structure with a single overarching Antimicrobial Stewardship Committee to provide system leadership for preventing and reducing rates of healthcare associated infections (HCAI) and the AMR agenda.

/// Provision of system wide leadership to:

1. Reduce total antibiotic consumption by 1% from the 2018 baseline by the end of Q4 2019/20
2. Deliver the two NHS Improvement Commissioning for Quality and Innovation (CQUIN) indicators:

   /// Improving the management of lower urinary tract infections in older people
   /// Improving appropriate use of antibiotic surgical prophylaxis in elective colorectal surgery
Our work plan for the coming two years is to:

- Establish a single Primary care antimicrobial prescribing formulary across mid and south Essex
- Establish a single secondary care antimicrobial prescribing formulary across mid and south Essex hospitals
- Standardise the implementation of the national PHE target antibiotic campaign on an ongoing basis
- Monitor antimicrobial prescribing data and local antibiotic key performance indicators (KPs) eg. Prescribing of broad spectrum antibiotics, to address areas of improvement by educating and training all prescribers on appropriate use of antibiotics by promoting use of the target antibiotic toolkits

9.9 Public Mental Health

Essex County Council

It is recognised that, regardless how much the system invests in mental health services, it will be impossible for funded services to identify and intervene with all people who may be at risk of mental health issues. One of the solutions includes developing local social media Facebook groups to enable people to be able to identify and the address the issues that are important to them within their own communities. The system will support them with training and with small microgrants.

The system is growing in coverage with Facebook groups being identified and supported by an independent social media expert. Work to date includes widespread community based mental health first aid training, online suicide training and domestic abuse training as well as action around social isolation, weight loss support and physical activity.

A second key route to communities in many parts of Essex is via the parish councils. A dedicated public health practitioner post has been employed by the Association of Local Councils and charged with engaging parishes in the work described above.

The system is also working with employers to ensure a strong workplace health approach. The Joint Health & Wellbeing Strategy for Essex has specific targets on helping people with mental health issues to be employed and retained in the workplace.

Essex has seen a rise in suicides and specific action has been initiated to tackle this including widespread roll-out of training to communities, with particular focus on those who may be in contact with those at higher risk. This has led to work through local districts with barbers, taxi drivers and pubs who are most likely to see people who may be less likely to recognise their own risk. There is also work with debt agencies, housing and Job Centres to ensure those at risk through debt and lack of employment can best be identified. This is being supported by a social media campaign “It’s never too late, Mate”.

Loneliness is a key challenge and the system is developing a series of local and system-wide approaches to tackle this. This has included the launch of the United in Kind social movement and the development of a systematic approach to identify and tackle loneliness across Essex. This requires active (but very limited) intervention through primary care and is built around a care navigator model embedded in a large local community organisation. The new opportunity open to PCNs through social prescribers will be aligned with existing related systems to ensure the optimal gain to local people from these new roles.

In addition to issues around access to work and the impact of this on health and life expectancy, people with mental health issues often suffer poor lifestyle choices. Improved physical activity will both help address mental health issues and improve wider health outcomes. As a national Sport England LDP pilot one area of specific focus is improving physical activity in people with mental health issues using a whole system approach.

The system is also working with employers to ensure a strong workplace health approach. Working Well provides targeted and tailored interventions within the workplace to support employers to improve and maintain the mental and physical health of their employees. The programme offers a broad range of approaches including Mental Health First Aid training, smoking cessation, stress awareness training, as well as increased physical activity.

This is now also supported by the Working Well Accreditation programme, and a monthly newsletter is provided to organisations which gathers feedback on mental health first aid interventions carried out by the Mental Health First Aiders. This programme is currently working with 165 businesses county-wide and has partnered with the Chambers of Commerce and the Federation of Small Businesses to increase reach.

Southend

The Southend 2050 vision places health and wellbeing at the heart of planning across all areas of local authority business, and recognises the benefits of a “health in all policies” approach to addressing the wider determinants of mental health. The vision and strategy seeks to develop systems and a planned environment within the borough that enables residents and communities to optimise their life opportunities and resilience and improve their wellbeing.

Priority areas of work for promoting wellbeing and preventing mental ill health are the development of a multi-partner social prescribing system across the borough, development of population health management approaches to identify optimal use of mental health resources, and a new system for increasing access to physical health checks for people with significant mental illness. The Public Health team manage and deliver/commission a significant programme of interventions and systems for children and young people to build personal resilience and support them in times of emotional wellbeing need, both inside and outside school. The A Better Start Southend programme supports parents in areas of high deprivation with developing healthy relationships with their young children, recognising the importance of this for the rest of the life course.

The council is also reviewing its offer to local businesses in regards to mental health and wellbeing as part of a refresh of the Public Health Responsibility Deal, with a focus on micro-businesses which make up 86% of all local enterprises.
Thurrock

Adults and Older People

// Thurrock is involved in a number of initiatives around improving the mental health and wellbeing of its population and preventing onward service use. Thurrock’s overall commitment to this approach can be seen in the recent signing of the Prevention Concordat for Better Mental Health, which was submitted in July 2019 by Thurrock’s Health and Wellbeing Board – demonstrating the extent of partnership agreement towards this aim. Some examples of specific work programmes currently underway or planned to commence include:

// Mapping where residents with poor mental health are currently being seen by non-specialist services, in order to roll out improved opportunities for case finding/early identification and better pathways to support options such as the Recovery College

// The housing service have recently employed a mental health practitioner to improve staff skills around identifying and supporting those with mental ill-health, and to increase awareness of wider support options available

// We are supporting national initiatives, such as promoting Every Mind Matters, but have also invested in Mental Health First Aiders across the borough. We plan to evaluate the success of this in 2020.

// We will complete a worklessness and health Joint Strategic Needs Assessment which will include recommendations on ensuring the mental health needs of those in employment are met, and also that those with poor mental health who are out of employment can be supported.

// Several organisations are screening their patients for likely anxiety or depression, with an onward referral pathway to the local IAPT service if required. This is underway in a handful of GP practices for diabetes patients in the first phase, and will be further rolled out to more practices during 2019/20. It is also being undertaken in the Healthy Lifestyles Service and the community diabetes team.

// Thurrock is also undertaking a number of initiatives which will aim to reduce inequalities in those groups identified to have poorer mental health. The Public Health team undertook Joint Strategic Needs Assessments for Adult Common Mental Health Disorders and for Children’s Mental Health and Wellbeing in 2017. Both documents profiled key groups at high risk of poorer mental health. Public Health intelligence has informed the way data is being collected for several clinical services – such as EIP, IAPT and Recovery College, as the services are now monitoring more information on different population groups. This is monitored as part of monthly contract review meetings – particularly for BAME and older people’s referrals.

// As part of the work to transform the mental health of those with serious mental illness, Thurrock is developing a new model of care at locality level – piloting in Tilbury. Fundamental to this is the mapping of all services and organisations which might support those with poor mental health – even if that is not their primary remit; understanding current demand, capacity and service interfaces. This will aim to improve the future offer of support and ensure services that support employment, housing, social care and other wider determinants of health are aligned appropriately with clinical treatment models – recognising that aspects such as homelessness and unemployment are key drivers of poor mental health.

// To improve the mental health of those with physical LTCs, Thurrock is rolling out a new programme of serious mental illness Physical Health Checks for 2019/20, with the ambition for 60% to have had this by March 2020. The other programme of work for those with LTCs relates to depression screening – completion of the PHQ9 and GAD7 screening tool is being trialled in a handful of GP practices for Diabetes patients, and will be further rolled out to more practices during 2019/20 and evaluated for impact. Depression screening will also shortly begin in the Council’s Sheltered Housing tenancy reviews - this will aim to improve identification and referrals from older people. If successful, this approach will be further rolled out to more front line staff.

Thurrock’s Mental Health Transformation Board agreed the need to have an Outcomes Framework for Mental Health, which focussed on system-wide outcomes rather than service-specific targets and will incorporate information around inequalities.
10. Giving People Control – Personalised Care

Underpinning all of our work is the commitment to give our residents control of their lives and, if health and care services are required, to ensure these are personalised and support the principles of the comprehensive model for personalisation. We acknowledge that the move to a system built on principles of proactive and personal care requires a shift in the cultural mind-set of all those that play a part. Personalisation will not be seen as a "nice to do", but as a fundamental element of our new operational model, irrespective of the age or need of the individual. As a system we will ensure that the flexibility in service provision is available for those groups of patients who may need adjustments to the universal offer, groups like people with a mental health need, children and those approaching the end of their life.

All transformation will be measured against the nationally defined comprehensive model for personalisation, from the simplest level of personalised care – choice - through to the ability to implement personal budgets where these are appropriate to meet the needs of individuals not met through universal service offerings. Achieving this requires a level of cultural change across the system that has not been previously delivered.

Through a programme of organisational and cultural change over the next four years, we commit to supporting:

// the public to understand the personalisation agenda
// providers of health and care to become flexible in service provision, enabling shared decision-making at all points in a patient journey, and promoting the self-care agenda through enabling both individual and community resilience
// commissioners of services to ensure that services are contracted in a way that enables the delivery of the personalisation agenda, including a movement to commissioning for outcomes that matter to the individual, and does not discourage local innovation amongst providers to flex services to better meet the needs of residents.

Our commitments

In order to ensure we embed personalised care across the Partnership, we will:

// By April 2020 create a Partnership-wide Personalised Care Pledge; underpinning a cultural transformation programme across all key partners
// Ensure the six components of personalisation become "business as usual" for all partners within the system, underpinning both the approach to commissioning and provision and the messages shared with the local population
// Identify personalisation champions within the system
// Develop the infrastructure across the system to ensure personal health budgets are available for those individuals that would benefit from them

Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Target Populations</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Specialist Integrated Personal Commissioning, including proactive case finding, and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.</td>
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<tr>
<td>Universal Shared Decision Making, Enabling choice (e.g. on maternity, elective and end of life care). Social prescribing and link worker roles. Community-based support.</td>
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<tr>
<td>Targeted Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.</td>
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</table>

People move as their health and well-being changes

Supported people to build knowledge, skills and confidence and to live well with their health conditions.

Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

People with complex needs 5%

People with long term physical and mental health conditions 30%

Whole population 100%
Personal Health Budgets and Integrated Personal Budgets

The CCGs are active in ensuring the roll out of Personal Health Budgets (PHBs) across their areas. This includes Personal Wheelchair Budgets, Continuing Healthcare (CHC) and Children’s Continuing Care on a ‘right to have’ basis. Whilst we accept the PHB target the local view is that PHBs should be utilised, not to hit a specific target, but to improve patient outcomes where an individual’s needs are either uniquely different, or not being met through the universal service offer to the whole population.

In accordance with NHS England’s PHB work programme, the CCGs have developed clear activity improvement trajectories to meet the national target of 200,000 by 2023/24. The development of a system-wide pledge for personalised care will facilitate standardisation of good practice across the region.

11. Transforming “Out of Hospital” care

Clinical Lead: Dr Jose Garcia, Chair, Southend CCG & Chair of the Primary Care Programme Board
Senior Responsible Owner: Caroline Rassell, Accountable Officer, Mid Essex CCG and Lead Accountable Officer for Out of Hospital Care

We developed our single Primary Care Strategy in June 2018, focusing on ensuring general practice is sustainable and able to fulfil its role as a foundation for future models of care. The strategy recognised that the ‘full population’ registered list of general practice makes them an essential partner in any move to population health and population health management.

The Primary Care Strategy focused on creating capacity and managing demand through both individual practice support and transformation, as well as collaboration both between practices and between practices and the wider system through our neighbourhoods. This direction of travel was later supported through the NHS Long-Term Plan and nationally negotiated GP Contract Reforms, the latter delivering a contractual vehicle, the Network DES/Primary Care Network Contract, that is being used to accelerate local plans.

Developments in primary care, including the maturity of primary care networks, are overseen by the Primary Care Programme Board:

- MSE Partnership
- CCG Governing Bodies
- CCG Joint Committee
- Primary Care Programme Board

Coordinates and drives delivery of the strategy and workstreams

Primary Care Executive/working Group

- Digital
- Estates/Capital
- OD and Leadership Development - PCN
- Workforce
- GPIT

Oversees/coordinates of progress/implementation
11.1 Primary Care Networks

Primary care networks (PCNs) will form the vehicle for delivering collaborative working amongst front-line staff. Through PCNs we will deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care. We will move to a GP-led model of care focused on improving population health and wellbeing, and supporting provider sustainability. PCNs will be the foundation stone on which local places will thrive and the key provider vehicle for delivering local services.

We see PCNs as more than just a collaboration amongst practices. At their core they will support collaboration amongst those who positively impact on their population’s health and wellbeing. This includes other significant incumbent providers of health and care, education providers, major employers, the third sector and community groups. PCNs are seen as a vehicle to bring together the wider network of primary care providers - community pharmacists, optometrists and dentists.

PCNs are led by clinical directors who will provide leadership for networks’ strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. We will nurture and support the clinical directors to ensure they are able to fulfil the requirements placed upon them.

With 28 primary care networks it is accepted that they will vary in terms of stability and maturity in the short to medium term. They are however seen as fundamental building blocks in the success of the local health and care system, being the core out of hospital ‘delivery units’.

The National Ageing Well agenda, with a focus on anticipatory care and enhanced health in care homes, as well as urgent community response, will only deliver the ambitions where PCNs take a leading role in the care of older people in the community – irrespective of where they live. We envisage, as a minimum the national allocation - £878k in 2019/20.

A comprehensive development plan for each PCN will be in place by the end of 2023/24. As a system we are committed to all PCNs achieving level three maturity by 2023/24.

Meeting the Funding Guarantee

We commit to meet the local requirements of the real terms increase in funding that covers primary care, community health and continuing health care (CHC) spend by 2023/24.

11.2 PCN Service Developments

We will work with PCNs to ensure they are able to fully deliver services to their population in line with the requirements included within the seven nationally negotiated service specifications.

<table>
<thead>
<tr>
<th>Service Specifications</th>
<th>From 2020/21:</th>
<th>From 2020/21 onwards:</th>
<th>From 2021/22 onwards:</th>
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Improving anticipatory care

As part of the Ageing Well programme, anticipatory care will support the move from a reactive, hospital-centric, health and care offer to one of prevention, empowerment and community and personal resilience. The principles of anticipatory care underpin the future models and focus on maintaining wellbeing. This will be underpinned by our Population Health Management work stream.

The expectations of the national service specification are due to be implemented across community providers and general practice from April 2020. The system commits to ensuring the work to date continues, and the national requirements are considered the minimum offer for our population.

We have developed a risk stratification tool to assist PCNs in identifying and managing high risk and rising risk patients in a structured way and this will be rolled out to all PCNs in the coming months to enable a proactive and targeted approach to supporting patients.

Anticipatory care will also encompass supporting maximum coverage of screening opportunities – including supporting early cancer diagnosis –, annual health checks for those who would benefit from it, and ensuring that there is sufficient support for carers, on whom the system relies so much.

Personalised Care

With improvements in anticipatory care, patient identification and holistic care planning driven by a more diverse workforce, PCNs will provide greater emphasis upon personalisation and a move to service delivery in line with the Comprehensive Model for Personalised Care.

Enhanced Health in Care Homes

As part of the Ageing Well programme, the CCGs have been working to improve the offer to residents of care homes. With over 8,000 care home beds a significant proportion of our most vulnerable residents live within a care home setting.

We have prioritised work to implement the Enhanced Health in Care Homes (EHiCH) Framework. This is delivered through a partnership approach to coordinate the implementation and delivery of a single plan across mid and south Essex. The expectation is to increase the support to care homes through the EHiCH model by 2022/23, implementing all elements of the framework across the full footprint.

Good progress has already been made across the seven domains within the EHiCH Framework. Local and system level priorities have been identified, with plans being developed to reach full achievement by 2022/23.

Structured Medicines Review and Optimisation

Across the system practices and PCNs have already appointed clinical pharmacists to their primary care teams. The roles and functions of these vary across the patch, but a key commonality is their focus on medicines review.

PCNs will work to ensure that structured medication reviews are provided as a minimum to the defined set of patients as clarified in the specification. The system acknowledges that the introduction of this service coincides with the cessation of Medicines Use Reviews under the Community Pharmacy Contract.

Crisis Response

Across the footprint community-based crisis response has been a key pillar of the evolving models of care, and is seen as an essential component of any future model at place level, providing a safety net for when the proactive and anticipatory models breakdown and ensuring that solutions are not reliant on acute attendance and admission.

Across the footprint we already commission:

- 100% population coverage for access to community crisis response within 2 hours as part of the commissioned community offer
- 100% coverage of the population for reablement care within two days of referral

Supporting people to stay at home – Admission Avoidance

We know that our ambulance service is stretched and that people who call for an ambulance who are not suffering a life-threatening condition can experience a significant wait for a response. We also know that, for older patients, waiting a long period of time for an ambulance and then being conveyed to hospital often results in admission. Our community providers are working closely with East of England Ambulance Services Trust to support people who have called an ambulance, where the call has been allocated a category two, three or four response. Where clinically appropriate, community teams are able to intervene and visit these residents to assess their needs and provide any immediate care and support. This scheme is aimed at preventing an ambulance conveyance to hospital. The evaluation of the scheme will be published by the end of 2020; early indications are that the scheme has been successful in supporting people to stay at home and has supported closer collaboration between our community providers and the ambulance trust.
11.3 Digitally Enabled Primary Care

**Governance**

A primary care specific digital transformation working group has been set up to deliver the digital commitments outlined in the NHS Operational Planning and Contracting Guidance 2019/20, GMS contract for 2019/20 and GMS contract framework.

This group provides a centralised strategic approach to delivering digital transformation in primary care that is clinically-led and locally owned i.e. by PCNs, GP practices and patients.

This Primary Care Digital Working Group links closely with the Partnership Digital Board to ensure alignment of all digital programmes (see section 29).

As described in the Primary Care Strategy we know that the use of digital and other technologies will be a key enabler for our future model of care. These have the potential to help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale.

We have identified a number of potential solutions which, taken together, could help practices reduce their workload and close the gap between demand and capacity.

One of the key design principles of our future operating model is to adopt a "digital first" approach. We know that the use of digital and other technologies have the potential to support patients and help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale.

The primary care digital working group will ensure delivery of all national “must do’s” that are primary care specific commitments, as well as identify other local priorities.

11.4 Mid and South Essex - Primary Care Workforce

To drive transformational change in the primary care workforce, a system-wide primary care workforce team has been established along with a dedicated primary care training hub.

There have been a number of developments which support the aspirations set out in the Interim NHS People Plan. Examples include:

- A focus on general practice nursing as a priority and developing new models of working collaboratively with stakeholders locally and nationally towards integrated care.
- We have increased the wider workforce by almost 12% including the employment of 13 emergency care practitioners, a move designed to reduce the pressure on the GP workforce.
- Information booklets for practices have been developed for new roles including the emergency care practitioner.

As we support the development of PCNs and the full uptake of the additional roles reimbursement scheme we expect to see significant increases in the numbers and types of staff working within primary care.

Whilst PCN’s will develop the staffing model that best meets the needs of the local population, assuming PCNs grow the workforce in line with the national assumptions around role types and staff numbers it can be assumed that almost 500 additional posts will be created within primary care as part of the PCN workforce.

**WTE - per 50,000 PCN**

<table>
<thead>
<tr>
<th>Role</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
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<tbody>
<tr>
<td>Clinical Pharmacist</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Link Worker</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
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|                    | 52      | 156     | 234     | 364     | 494     |
Volunteers

The valuable contribution that volunteers make in health and social care sectors is well known. The Kings Fund report, ‘Volunteering in General Practice’ (2018) identifies specific ways in which volunteers can engage and support general practice. There are over 300 volunteering NHS role-types within our footprint and we have well established volunteering programmes across our provider trusts and partner organisations.

A Digitally-Enabled Workforce

Whilst focus rightly remains on ensuring sufficient numbers of staff are in post, and existing vacancy rates are improved, future models will require a workforce that has enhanced non-clinical competencies, particularly in relation to their use of technology.

We will support, empower and train the workforce to embrace digital tools and innovation as enablers to support them to manage and conduct their roles more efficiently, and with higher level of quality. We will improve the digital capabilities of everyone in the primary care workforce and support positive behaviour change to recognise the potential that digital transformation can bring.

12. Improving our Hospital Services

Clinical Lead: Dr Celia Skinner, Group Medical Director, Mid & South Essex University Hospitals Group
Senior Responsible Owner: Clare Panniker, CEO Mid & South Essex University Hospitals Group

Following a public consultation Your Care in the Best Place, and detailed review of plans by the East of England Clinical Senate, the CCG Joint Committee approved all recommendations relating to the reconfiguration of hospital services in June 2018.

The changes were aimed at improving access to, and quality of, specialist hospital services, and dealing with the significant workforce challenges in the acute sector. The changes were based on five principles:

1. The majority of hospital care remains local (outpatient appointments, diagnostics, day case surgery and maternity), and each hospital will continue to have a 24 hour A&E department that receives ambulances.
2. Certain more specialist inpatient services to be concentrated in one place.
3. Access to specialist emergency services, such as stroke care, will be via the local (or nearest) A&E, where patients will be treated and, if needed, transferred to a specialist team, which may be in a different hospital.
4. Elective and emergency care should, where possible, be separated.
5. Some hospital services should be provided closer to home.

The proposals were referred to the Secretary of State for review by the Health Overview and Scrutiny Committees of Southend and Thurrock Councils. Following review by the Independent Reconfiguration Panel, the Secretary of State has advised that the agreed changes can go ahead. Over the coming three years, these plans will be implemented as follows:
Clinical Reconfiguration Programme

<table>
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<th>2019/20</th>
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- **Vascular Emergency**
- **Emergency**
- **Hip and Knee (ASA 1,2)**
- **Spine**
- **Interventional Radiology**
- **Cardiology (Broomfield only)**
- **Cardiology (Southend)**
- **Ophthalmology (Braintree)**
- **Hands, Wrists, Ankles**
- **General Surgery**
- **Respiratory**
- **Stroke**
- **Renal**

These changes are supported by the £118m capital award, secured in 2017. This capital funding will support the following schemes:

- New endoscopy suite
- Emergency care expansion
- Critical care expansion
- Onsite helipad
- New renal ward
- New theatres

- Critical Care expansion
- Emergency care expansion
- 2 new inpatient wards

- Purpose built (2 ward) elective surgical care block
- Emergency care expansion
- New theatres
- Creation of new paediatric assessment unit
- New endoscopy suite
- 4th LINAC bunker
- Refurbished ophthalmology unit

Hospital merger

The three acute hospitals in mid and south Essex will merge in April 2020, reflecting significant work over the past three years to consolidate the clinical and corporate strategies, create a single executive team and Chief Executive. The key principles of the three hospitals working together are given below:

- **Working together as one team means we can do better**
  - Specialist centres of care leading to faster specialist access, diagnosis and treatment to improve patient outcomes and to attract clinical staff.
  - Standardised model and approach to care based on best practice - reducing variation through the use of protocols, again leading to better care and outcomes for patients.
  - Standardised model and approach to corporate services based on best practice and using modern technology, better service to the front line and reduced costs.

- **In turn, these things are enabled by a number of other activities**
  - Merger - single systems, policies, procedures - clarity of management decision making.
  - Infrastructure improvements - particularly in IT, informatics and estates.
  - Capacity and capability building - organisational development, strategy unit, change management, communications and engagement.
13. Reducing pressure on emergency hospital services

Clinical Lead: Dr Eddie Lamuren, Group Clinical Director (Emergency Care), Mid & South Essex University Hospitals Group
Senior Responsible Owner: Hospital Site Managing Directors, Mid & South Essex University Hospitals Group

We have three established sub-systems for urgent and emergency care (south east, south west and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services.

The urgent care system is under significant pressure and this impacts on our responsiveness to deliver elective and cancer services. All partners are working hard to address urgent care pressures.

How will urgent care services be delivered in future?

You

Individuals with an urgent care need can access a range of support including on-line (www.nhs.uk), and through NHS 111, where they can obtain advice, check symptoms and figure out the best course of action.

NHS 111 will provide advice, support and the ability to book appointments with the right professional.

Patients will be able to access on-line advice and consultations with the GP practice.

Neighbourhood

PCNs will be able to offer extended hours appointments in the evenings and at weekends. They may also offer extended home visiting for patients who need it.

PCNs will use risk stratification tools to proactively identify patients who may be at risk of deterioration or ill health, and intervene early so that they can get the proactive care and support they require, reducing the need for an urgent response.

Community providers and the ambulance service will work together to avoid, wherever possible conveyance to hospital for patients who could be seen within their homes by community teams.

13.1 Integrated Urgent Care Service

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services.

As part of the national pharmacy contract reforms, from October 2019 NHS 111 will be able to refer minor illness and urgent medical supplies to community pharmacy. The Community Pharmacy Consultation Service provides the opportunity for community pharmacy to play a bigger role and to become an integral part of the NHS urgent care system.

13.2 Same Day Emergency Services

All three hospitals offer a same day emergency service for 12 hours/day, 7 days/week. These services provide fast access for patients to diagnostics and treatment and reduce admissions to hospital.

13.3 Older People’s Service

Our three hospitals have worked to develop assessment and treatment units specifically to meet the needs of older people. At Broomfield, the operating hours of the Frailty Ambulatory Service is 08.00-20.00 Mon-Fri. A move towards a 7 day service will be reviewed in April 2020. The community admission avoidance service operates 7 days per week.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00 (a total of 40 hours per week). An extension to the operating hours is being overseen by the Frailty Steering Group. A business case is being developed in support of additional staff to facilitate achieving the 70 hours target by December 2019.
13.4 Discharge Processes

Due to good partnership working between local authority and NHS partners, our Delayed Transfer of Care (DTOC) rate across the three acute hospitals (1.4%) falls well below the target of 3.7%. We expect to maintain this low rate moving forward.

Across Essex, we are working to better understand our reablement and rehabilitation processes and improve on these for our residents. This work has taken an embedded approach to work with discharge teams, patients, families and carers to understand the realities of the discharge process and its outcome. The work is on-going, however, interim findings suggest that if the system could make optimum use of intermediate care and on-going decision-making, there is a significant opportunity to reduce the use of residential placement and for people to be cared for at home (along with their individual wishes).

With the ideal use of intermediate care and ongoing decision making, there is a significant opportunity for people to be at home instead of in a residential placement.

Comparison of Actual and Ideal Long-term Settings

14. Improving our cancer services

Clinical Lead: Dr Donald McGeachy
Senior Responsible Owners:
Michael Cotling, Director of Cancer Services, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team

With almost 7000 new cases of cancer confirmed across mid and south Essex in 2017, our cancer services are under significant pressure. Our screening rates for breast, bowel and cervical cancer are below the required standards which impacts on our early detection and survival rates.

Performance against the 62 day waiting time standard has been challenging for the system. Significant work has been undertaken by the Cancer Alliance and the acute hospitals to improve the situation. We now expect to be compliant with this standard by March 2020.

We recognise that, as well as improving on waiting times for diagnosis and treatment within the hospital setting, the whole system has a responsibility to prioritise prevention, screening early diagnosis and treatment. We are shifting focus to our places, with the intention of improving access, early diagnosis and outcomes for our population – this work will be underpinned by the incorporation of faster translation of innovation and research into practice.

We know that cancer incidence increases with deprivation. Our place-based plans provide a real opportunity to focus on reducing health inequalities and prevention activities, and also to significantly enhance the uptake of screening programmes locally to improve on early diagnosis and treatment. We are also ensuring that:

// Primary care networks will support practices in using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.

// Our Macmillan GPs work with PCNs to identify and target variation in screening and referrals to promote early diagnosis

We have been successful in our bid to have a Rapid Diagnostic Centre, which is planned to commence in January 2020, as follows:

// Cohort 1: A&E referrals across all three hospitals
// Cohort 2 & 3: Upper and lower gastrointestinal referrals
// Cohort 4: Tele-dermatology (piloted by three Primary Care Networks initially)

Thurrock CCG has been selected to participate in the National Targeted Lung Health Checks programme. This is due to go-live in early 2020. While focussed on the population of Thurrock, we will rapidly take the learning from this programme and seek to embed the improvements across the Partnership.
How will cancer services be delivered in future?

You

Individuals will be supported to maintain healthy lifestyles, with support to reduce the risk factors that can lead to cancer.

Neighbourhood

PCNs will be focused on prevention and ensuring we meet standards for screening programmes for breast, cervical and bowel cancers.

By working together, practices will be able to offer faster access to appointments ensuring fast onward referral, where required, for tests and treatments.

Patients diagnosed with cancer will receive personalised support throughout their treatment and afterwards.

Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, on welfare advice and support groups.

Place

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Our places will be focussed on measuring success against activities aimed at improving our cancer offer, for example, monitoring screening uptake, using data to target additional support and interventions where required.

Places will also be focussed on joining up health and care services, reducing fragmentation that patients and their families might encounter.

System

At system level, we will work together to:

// Reduce unwarranted variation in access, quality and outcomes.
// Undertake workforce planning and development to support cancer services
// Coordinate communications and engagement, eg through public health messages
// Coordinate research & innovation opportunities to improve cancer care for our patients
// Identify appropriate digital solutions that will help patients manage their condition

We have established clinical leadership and a cancer board to oversee the improvement and transformation plans we have in train, working closely with the Cancer Alliance. An overview of the governance and work programmes is as follows:

Mid and South Essex Governance - Cancer Transformation Programme

- East of England Cancer Alliance Advisory Board (South)
- Mid & South Essex Cancer Locality Group
- Mid & South Essex Cancer Delivery Group
- Implementation of National Optimal Lung Cancer Pathway
- Implementation of National Optimal Prostate Pathway
- Implementation of National Optimal Colorectal Pathway
- Implementation of National Optimal OG Pathway
- Implementation Rapid Diagnostic Centre
- Implementation FIT in Primary Care
- Implementation of Personalised Best Supportive Care

Our Commitments

We commit to deliver the two national ambitions for cancer to improve the outcomes for our population.

// Survival Rate: Ambition 70% of cancer patients will survive five years or more

The LTP survival ambition aims to place England among the best countries in Europe for cancer survival. The East of England Cancer Alliance five-year survival rate is currently 53.5%, the Partnership’s ambition reflects the national plan of achieving 70% survival at 5 years. We are actively pursuing opportunities to improve breast, cervical and bowel screening processes as a means to achieve this ambition as earlier detection improves survival rates.

We have successfully rolled out FIT to our practice population and this will expand to incorporate the national FIT screening programme.

We will also ensure the continued roll out of cancer care reviews and holistic needs assessments for relevant pathways. This enables people with cancer to have a regular review and a personalised care plan ensuring that they are able to access advice and support, or reach back into services without of delay should they identify a concern. We have undertaken this work in partnership with Primary Care, building on the Quality Outcomes Framework to ensure that there is a planned review to support the patient and their wider network following a cancer diagnosis.
Early stage diagnosis: Ambition to diagnose 75% of cancers at an early stage.

Across England, 53.7% of cancers are diagnosed at stage 1 or 2. Across the East of England Cancer Alliance, 54.6% are diagnosed, with the highest CCG early diagnosis rate at just over 60%. However, currently only three cancers have early diagnosis rates above 75% (breast, melanoma, uterine), with some remaining below 30%.

We will be focusing on the skin pathway (as part of the Rapid Diagnostic Centre work) to incorporate, at primary care network level, the use of Tele-dermatology (based on the Anglian Health Science Network experience). This will improve screening, access and early diagnosis ensuring patients access the right pathway, first time while also releasing capacity within this significantly challenged specialty.

We are working to deliver the national optimal pathways in order to standardise delivery across the system ensuring equity for the population. Interdependency with networked sites (London and East of England) is essential and this is being mapped within each pathway to ensure that delays and flow is understood and risks mitigated.

Our cancer programme is underpinned by a number of key enablers these include:

Cancer Alliance Transformation monies – these monies have supported a number of key programmes and the recruitment of staff to facilitate care and pathway improvements (e.g. the cancer care navigator role).

Patient Leadership – from the Cancer Board through to individual pathways, patient representation is paramount. Our patients have supported and driven the focus and direction of our work.

The Thurrock patient group is actively progressing experience and engagement to improve reach and awareness of cancer programmes within the local population, this work will be evaluated, and rolled out across the Partnership.

Workforce:

Workforce is a key challenge for cancer – through work commissioned by HEE and the Cancer Alliance, the three hospitals have undertaken strategic workforce planning. The key findings of the work were that:

- There is currently a workforce gap, with specific concern in oncology, cancer nurse specialists and chemotherapy.
- Incident of cancer is likely to grow by 25% over the next decade and will impact on the workforce,
- There are opportunities to leverage the scale of the hospital reconfiguration and merger to mitigate some future pressures

The current priorities for workforce transformation are:

- Clinical nurse specialists – the scope of CNS roles across the group differs and there is an opportunity to standardise and, in so doing, support CNS to work at the top of their competence, thus increasing capacity in the workforce
- Oncology and chemotherapy staff require specific focus – services currently rely heavily on locum and agency staff. The hospitals will focus on retention and staff development in the knowledge that there is currently a national shortage in both roles.

Transparency of system metrics and reporting – we are working with the Cancer Alliance to develop and test a new dashboard enabling the system to understand performance and other measures that reflect the progression of the Cancer Plan, this is supported by sharing of information and data including Right Care/GIRFT. We will develop and roll out a dashboard for the four National Optimal Pathways (breast, lung, urology, and colorectal).

Our cancer transformation plan can be found at Appendix 6
15. Improving our mental health services

Clinical Lead: Dr Milind Karale, Medical Director, EPUT
Senior Responsible Owner: Mark Tebbs, Director of Mental Health Commissioning, Mid & South Essex CCGs

Our vision for mental health is to:
// Integrate social care, mental health and physical health – parity of esteem and care closer to home.
// Promote good mental health and preventing poor mental health – early intervention and prevention.

It is clear that in order to deliver on this vision, partners need to work together, focusing on the wider determinants of health to enable the best possible outcomes for our residents. The mental health transformation programme is an extensive undertaking with significant interdependencies and interfaces involving CCGs, local authorities, Essex Police, the ambulance trust, mental health providers, acute hospitals, Healthwatch and many community and voluntary sector partners.

A joined up collaborative approach and governance framework has been agreed to enable us to expedite projects at pace and facilitate decision making both as a collective, and through individual governing bodies.

The NHS has made significant additional funding available for mental health services, and has committed that funding will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

Our key transformation programmes are:
// 24-7 community mental health emergency response and crisis care – assessment and home treatment;
// Transforming the model of care for dementia;
// Transforming the model of care for personality disorders;
// Integrated primary and community care mental health.

The full transformation plan can be found at Appendix 7.

Current Provision

Our Mental Health Partnership Board has overseen the development of a ‘Costed Delivery Plan’ to help us to understand how we could best use the additional investment to efficiently and effectively deliver on the LTP commitments.

The work highlights a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place.
Through our focus on the wider determinants of health, our primary care networks and place-based plans, we want to ensure the system rebalances in favour of prevention, early intervention, resilience and recovery.

**Key issues for mid and south Essex**

- One in five people suffer from a mental health condition, many with depression/anxiety;
- While depression rates are high, not all patients are diagnosed in primary care and rates of diagnosis vary widely across GP practices and CCGs;
- The system currently spends £253m on mental health and related services in primary care and social care;
- Secondary care mental health services represent £103m of overall spend with approximately 17% directed at inpatient mental health support;
- In 2018/19 we spent c. 12% less per head than national median, though this could be reflective of the relatively lower mental health prevalence in the area;
- Mental health services are delivered by approximately 2,200 staff across different care settings, with 30% delivering inpatient care;
- We have proportionately fewer adult consultant psychiatrists and registered nurses as a proportion of inpatient beds;
- Inpatients are likely to spend longer in hospital than national benchmarks;
- More patients are likely to be readmitted as an emergency, while patients receive fewer community contacts than the national average.

**Our Commitments**

15.1 Urgent and Emergency Care (UEC) Mental Health

People facing a mental health crisis should have access to care seven days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. To deliver responsive options and maximise patient experience and outcomes we are implementing a comprehensive Urgent and Emergency Care Mental Health transformation programme.

Liaison Mental Health

BTUH and SUHFT received UEC wave 1 transformation funding in 2017 to pump prime and accelerate existing plans and expand existing mental health liaison services so that they operate at the ‘Core 24’ standard. The service commenced mobilisation in April 2017 and formally launched in July 2018. The service which is delivered by a multi-disciplinary team comprising of medical staff, nurses, psychologists and support workers, aims to see patients in A&E within one hour and to discharge patients from the A&E department to the clinically appropriate pathway within four hours. It provides an assessment, diagnosis, treatment and risk management model.

MEHT has just been successful at the UEC wave 2 transformation bid to enhance the current service. The ambition is the ‘Core 24’ service will commence mobilisation in December and be fully operational by April 2020.

Investment has been committed as part of MHIS for sustainability of all 3 services.

**Adult and Older Adult Crisis**

The current CRHT service offer only covers 12 hours a day, seven days and does not support access for self-referrals. Access is purely through health professionals and the home treatment function operates only to 8pm.

To deliver the national mandate and provide a fit for purpose, 24-7 responsive and high standard service, a business case has been developed for additional investment to resource a new service model to meet the needs of people in a mental health crisis by providing a responsive 24-7 community crisis service via NHS 111, offering access via self-referral and promoting intensive home treatment to minimise the need for inpatient services.

We were also successful in receiving national transformation funds to establish three crisis cafes that will be located in the following areas:

- Thurrock – covering Thurrock, Basildon and Brentwood.
- Southend – covering Southend, Castlepoint and Rochford
- Chelmsford – covering Chelmsford, Braintree and Maldon.

The cafes will be operated by the voluntary sector and will provide more suitable alternatives to A&E for many people in a mental health crisis who do not have medical needs. The service specification of the new Mental Health Emergency Response and Crisis Care service is being co-produced with all stakeholders, ensuring users, carers and families play a key role in shaping the model of delivery. The ambition is the new service will be fully operational by April 2020.

**Acute Care (including Out of Area Placements (OAPs))**

EPUT has undertaken a comprehensive exercise to repatriate patients placed out of area in the last year. Work continues to minimise need for OAPs and eliminating adult OAPs:

- Assessment Unit opened in the north serving Mid Essex reducing need for OAPs
- The Assessment Unit has been funded from the reduction in Out of Area Placements
- On trajectory to deliver against set system level plans
15.2 Community Serious Mental Illness services for Adults and Older Adults

Implementing the Five Year Forward View for Mental Health describes the ambition that by 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver responsive access to evidence-based interventions, integrate with primary care, social care and other local services and contribute towards continued efficiency within the mental health system.

Early Intervention in Psychosis (EIP)

We have 3 EIP teams serving mid Essex, south west Essex and south east Essex. They have all received the 2018-19 national NCAP spotlight audit rating at level 2 (Needs Improvement). The ambition was for all teams to meet level 3 compliance by 2019-20. Action plans are being developed to ensure compliance in the next audit which has now commenced with reports published by summer 2020.

In summary the highlights indicate a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place. Our five-year mental health plan will endeavour to demonstrate how the system rebalances in favour of prevention, early intervention, resilience and recovery through implementation of the MHFVF and NHS LTP requirements to 2023-24. A robust engagement plan has been developed to run over Q4 2019/20 to ensure the implementation work plan is informed by locality detail.

Individual placement services (IPS)

Rates of employment are lower for people with mental health problems than for any other group of health conditions. IPS is an evidence-based approach to providing employment support for people experiencing serious mental health problems, shown to be twice as effective as vocational rehabilitation, and associated with reduced utilisation of other services, including use of inpatient admissions. IPS is based on eight principles, with increased fidelity to these principles correlated to better outcomes for service users.

We have three IPS services covering Essex, Southend and Thurrock. All services have received transformation funding in the last two years and are on trajectory to deliver the yearly defined targets. The Essex service is classed as a national Centre of Excellence and Southend will be seeking re-accreditation in 2019-20. Thurrock is the youngest service with an ambition to be accredited as a Centre of Excellence by 2022-23.

Serious Mental Illness – Physical Health Checks

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15-20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Every CCG has put in place a plan to ensure people on SMI registers not known to secondary care mental health receive robust physical health checks and follow on interventions. The plans are centred on:

- Validating registers to enable clarity on performance against trajectories.
- Promotion campaigns through coproduction and outreach activities
- Public health programmes e.g. ‘Every Contact Counts’
- Primary care training sessions
- Monitoring and contract arrangements

There is a system wide steering group in place to facilitate interface with EPUT, standardise processes between secondary and primary care and share good practice.

We currently average 25-30% of people with SMI accessing physical health checks and our ambition is to meet 60% by end Q4 2019/20. The validation of registers alone is likely to give an improved status. All CCGs have committed funds through Locally Enhanced Services initiatives to ensure both the validation is completed and checks are undertaken. We are working to embed SMI-PHCs as a function of the integrated primary and community mental health teams.

Integrated Primary and Community Care Mental Health

Work is in progress through co-production in all CCGs to define and implement an integrated primary and community care mental health offer for the PCNs. This will provide additional mental health workforce integrated in primary care to deliver a wrap-around mental health service that supports primary care to respond to mental health needs at the earliest presentation, manage need in the least restrictive environment and provide a seamless interface with crisis response and secondary care mental health. The ambition is for the 28 PCNs to have a mental health service offer by 2023-24.
15.3 Community CMI for Adults and Older Adults

IAPT

Nine out of ten adults with mental health problems are supported in primary care. IAPT services across mid and south Essex are commissioned on CCG footprints. The ambition is that all services will continue to deliver against the access, recovery and waiting time’s targets. To achieve these the focus is on building workforce capacity through training. Health Education England will fund places and 60% salary support over the next two years whilst CCGs meet the remaining 40%; CCGs will pick up the total responsibility from 2021-22.

Thurrock has embedded therapists in primary care and fully commissioned a bespoke IAPT/long-term condition pathway. The other areas are at different stages of fully operationalising these two requirements. The expectation is that CCGs will be largely compliant in 2020-21. All services are working closely with PCNs to maximise case finding to ensure unmet demand is identified and supported e.g. through social prescribing to access services.

15.4 Perinatal

Integrated model

Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS; the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage, ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care.

High level implementation plans which describe the anticipated phases the have been approved through Mental Health and LMS Governance structures. Firstly, we have committed to using a co-production approach to underpin and inform future investment and design. This will be completed in collaboration with the Maternity Voices Partnership and patient representative groups through commissioning a series of events reflecting both the localities and three acute maternity interfaces. The engagement events will form part of a wider needs analysis to understand demographic variations and features, current referrals and access to specialist services. The access target of 4.5% is being achieved; however there are current variations across localities to address to ensure equity and reduce any resulting health inequalities. Workforce will be considered as part of the Workforce Action Board and LMS Group and include a training needs analysis.

The access target of 10% by 2023/24 will be delivered with further investment to the specialist service expanding and remodeling to align with maternity and locality systems. The phasing of performance against the access targets will be achieved through the development of key areas including:

- Enhancing the evidenced based psychological offer whilst strengthening the multidisciplinary approach of the specialist team.
- Expanding the model from the current pre conception advice offer working closely with primary care networks.
- Extending the service offer for women to 24 months and including assessment/ signposting for partners.
- Developing maternity outreach clinics, through coproduction; these are anticipated to be delivered in pilot sites and rolled out across the system as a test and learn approach. The area would be interested in becoming a pilot site for targeted maternity outreach clinics.

A wider system audit will evaluate key touch points across services including Maternity, IAPT, Health Visiting, Children’s Prevention and Support Services and GPs. The aim is to understand unwarranted variation to enable development of a system wide action plan to deliver quality and effective care for women, partners and their families. Key partners will include the voluntary sector to understand the offer across localities and explore opportunities such as prevention of social isolation and peer/support networks for partners.

15.5 Dementia

We know that the population is growing but also ageing rapidly with projection that people aged 75-84 will increase by 28% over the next five years. As of September 2019 the system was achieving a dementia diagnosis rate of 66.2% (range 59.6% Mid – 71.9% SE) against the 67% target.

A transformation programme is currently being implemented to invest more in a community based Dementia model with a focus on early diagnosis. The programme will comprise:

- A community model that is optimally provided with system partners in primary care, to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings.
- A dementia in-patient model for those with the most complex needs whose care and treatment cannot be safely provided within the community. In-patient stays for assessment and treatment will be planned, purposeful and time limited with the outcomes of the admission agreed with patients and carers at the point of admission.

The model has been collaboratively developed with EPUT clinical leads and frontline staff, carers by experience, CCGs, local authority commissioning colleagues and third sector partners. Model testing has been undertaken in each CCG as opportunities have arisen. A full test of the model has been undertaken in south east Essex, arising from a requirement to reconfigure dementia inpatient beds in order to provide preparation for winter pressures.
A small augmentation to the South Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in a significant reduction in admission to dementia beds. The reduction in admission to inpatient dementia beds has been sustained and provides evidence for the effectiveness of the model. This has enabled reaching and maintaining diagnosis rates above 70%.

The plan is for the model to be rolled out fully across the system with any efficiencies realised through a reduction in inpatient use being re-invested into the community services.

15.6 Suicide Reduction & Bereavement
Suicide is rising, after many years of decline. We have identified reducing suicide and self-harm as one of three key priorities for mental health. Suicide is a significant inequality issue. People in the lowest socioeconomic group and living in the most deprived areas are ten times more at risk of suicide than those living in the most affluent group living in the most affluent areas. Suicide is the leading cause of death in males between the age of five and 49.

Suicide Reduction
Southend, Essex and Thurrock have a suicide prevention strategy overseen by a steering board comprised of local authority and NHS senior responsible officers; the board will be listening to the voice of people with lived experience of a death by suicide and linking into organisations such as the Samaritans and SOBS to further enable this.

Organisations across Essex have invested in both suicide awareness and Mental Health First Aid training establishing nominated first aiders. EPUT has a suicide reduction strategy in place.

We are not in receipt of current waves of transformation funding from the Suicide Reduction Programme or suicide bereavement support. (See also section 9).

Bereavement
Under the Southend, Essex & Thurrock Suicide Prevention Plan an established bereavement working group is mapping the availability of national and local resources to establish a single point of local online presence. The group is also designing a pathway for responding to suspected and confirmed death by suicide including establishing the point of entry (ongoing discussions with Essex Police and the Essex Coroner).

15.7 Mental health data
Commissioners and providers ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. This is undertaken as part of contract monitoring and it means:

// All providers being compliant with MHSDS v4 Information Standards Notice (ISN) from 1 April 2019; EPUT is compliant with MHSDS V4 and have been successfully submitting since May 2019.
// All providers submitting interventions to the MHSDS using SNOMED CT codes. Action plan is currently being implemented in line with Trust CQUIN to ensure SNOMED codes are implemented within EPUT from Q3 2019/20

15.8 Digital Mental Health

// EPUT has a robust, published IM&T Strategy through to 2022.
// Digital maturity - the second digital maturity assessment placed EPUT between the second and third quartiles, plans in place to improve
// EPUT already offers a range of self-management apps, digital consultations and digitally-enabled models of therapy
// Digital clinical decision making tools
// EPUT’s IM&T Strategy includes full interoperability to national standards (FIHR and Snomed) supported by the Tiani Health Information Exchange (HIE).
// EPUT’s IM&T Strategy is fully funded for all planned projects and therefore additional financial resource is not required at this point.

IAPT providers
All IAPT providers (including EPUT) are compliant with the new data quality requirements and monitoring is via the Information Assurance Framework and contract arrangements.

15.9 Mental Health Investment
The system commits to the mental health investment standard. Further detail can be found in Appendix 5.
16. Children and Young People’s Mental Health

To deliver the LTP requirements for Children and Young People (CYP), partners are working closely with West Essex CCG, the lead commissioners for CYP mental health services. The work being undertaken is summarised below:

0-25 Pathway
// Transforming our CYPMHS to move to a 0-25 years’ service offer, this will be achieved by:
// Increasing access age range for 18-25yrs into our service
// Increasing wider CYPMHS delivering within the CCG’s offer provision to 18-25yrs
// Delivering more lower level mental health intervention to CYP 0-25yrs
// Working with Adult commissioners/providers and NHS England to count the 18-25yrs cohort towards the access target.

Eating Disorders
// Utilise the CYP Eating Disorder (ED) funding investment to support ensuring full staffing to the specialist CYPED service
// Work with the voluntary and community sector to deliver an early intervention service offer around CYPED to support; awareness, self-referral, professional awareness and signposting

Comprehensive 0-25 support offer
// Transforming our CYPMHS to move to a 0-25 years’ service offer, this will be achieved by:
// Increasing access age range for 18-25yrs into our CAMHS service
// Increasing wider CYPMH Service offer to deliver provision to 18-25yrs; achieved by service redesign and roll-out/ embedding of current pilots
// Working collaboratively to ensure we offer an ‘every age’ service offer to 0-25years population in need of mental health support, this will be achieved by:
// Children’s and Adults mental health commissioners aligning service offers and agreeing that the 18-25years cohort have choice of access based on need.
// Working with providers to ensure alignment and patient choice of access is available and delivered on clinical and patient suitability

Mental Health Support Teams (MHSTs)
We will train and roll out MHSTs in the current phases, and will apply for further funding as this comes available. We are working towards the national and regional targets to deliver MHSTs across the region by 2023/24.
// Ensure MHSTs activity is submitted to MHSDS and counted towards the access target, this will be achieved by:
// Ensuring the delivery providers have access and can submit data to MHSDS

24/7 Crisis Provision
We already have in place a 24/7 crisis provision for CYP for crisis assessment and brief response. The service is currently mobilising a wider service offer to include intensive support and home treatment functions. This will be fully mobilised by April 2020.

We plan to evaluate the new model in 2021 and ensure continuation of a 24/7 crisis provision for CYP which offers crisis assessment, brief response, intensive support, home treatment functions and better alignment with A&E, acute hospitals, Tier 4- admissions and admission prevention

Local Transformation Plan
The Southend, Essex & Thurrock Local Transformation Plan is in year five (2019/20) was refreshed and published by 31st October 2019. The LTP will be refreshed for its final year in 2020/21 with sustainability aligned to the NHS LTP.

CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people’s services and health and justice, from 2022/23

Southend, Essex & Thurrock will work towards aligning CYPMH plans by 2022/23 by joining CYP work stream plans and moving towards a CYP system wide strategy.

Children’s mental health has been a key transformation plan for Thurrock’s Health and Wellbeing Board. Following recommendations from the Children and Young People’s Mental Health JSNA product developed by the Public Health Team in 2018 which focused on prevention by exploring risk and protective factors, Thurrock has just recently implemented a School Mental Wellbeing Service (SWS). This is a partnership approach between Thurrock Council, Thurrock CCG and local schools and academies with a main focus to strengthen and improve the emotional wellbeing and mental health of school aged children and young people, as well as supporting families and school staff. The programme represents a £1M investment in the mental health of our children and young people. The service is a universal offer with an ambition to provide a whole school approach to emotional and mental health needs of children and young people in school and enabling mentally healthy school environment.
17. New Models of Care in Mental Health – Provider Collaboratives

In line with the NHS Long Term Plan, mental health providers are collaborating to deliver new models of secondary care. The anticipated benefits for patients include:

// Care closer to home
// More consistent and high quality care through standardising our approaches
// Greater influence from patients on the design of care at both service and individual level
// More ‘joined up’ care with close working between NHS providers and private sector partners

The following trusts have formed an aspiring East of England Collaborative:

// Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
// Central and North West London NHS Foundation Trust (CNWL)
// East London NHS Foundation Trust (ELFT)
// Essex Partnership University NHS Foundation Trust (EPUT)
// Hertfordshire Partnership NHS University Foundation Trust (HPFT)
// Norfolk and Suffolk NHS Foundation Trust (NSFT)

In early 2019, NHSE invited applications from trusts to form new care model collaboratives in respect of the following services:

// Low and medium secure mental health services including those for patients with a learning disability
// Specialised eating disorder services
// Child and adolescent mental health services

The designated lead providers are EPUT for low and medium secure services, HPFT for CAMH and CPT for Eating Disorders.

Community Forensic Services

The collaborative agreed that EPUT as lead provider of low and medium secure services would submit an Essex-focused bid to set up community forensic services on a pilot basis during 2019/20 and 2020/21. Negotiations continue between EPUT and NHSE in this respect.

18. Improving our planned care services

Clinical Lead: Pathway specific clinical leads in place
Senior Responsible Owners: Jane Farrell, Managing Director, Broomfield Hospital
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Current Provision & Future Plans

We are taking steps to address long waits for treatment, but have significant capacity constraints as a result of the demand for urgent care services. One of the key principles of our hospital reconfiguration programme was to separate, where safe and possible, the provision of planned care from emergency care so as to protect planned care capacity, particularly over times when the system experiences more pressure than usual on the emergency care pathway, eg winter, bank holidays, etc.

An Elective Care Programme Board has been established (July 2019) to oversee the redesign of system-wide pathways to support delivery of planned care standards (as identified through use of Right Care and Model Hospital data).

Our Commitments

// We will reduce the number of 52 week waits to zero by focussing on the longest waiting patients waiting over 40 weeks.
// We will implement the national tools and functions aimed at supporting planned care, including advice and guidance, apps for appointments, capacity alerts and triaging at point of referral to reduce demand for elective services.
// We are considering the use of new models of care including first contact practitioners and non-acute models of care, self-management, etc.
// We will redesign our outpatient services to ease pressure on planned care pathways and ensure we are using the most appropriate ways of managing elective care demand.
// We are focussing on an initial set of pathways to conduct detailed, system-wide demand and capacity assessments; these are ophthalmology, dermatology, neurology, urology, orthopaedics and gastroenterology. Collectively, these pathways account for over half the waiting list across the three hospitals. We will have national assistance from the Intensive Support Team on this demand and capacity work.

The system recognises that this programme cannot solely be focussed on hospital provision and a whole pathway approach is required to ensure that models established are fully utilised across mid and south Essex by all sectors.
Backlog Clearance
Waiting lists have grown over recent years and we have a large number of patients waiting over 18 weeks for treatment. The trusts and CCGs are discussing how best to achieve the commitments in the LTP within the context of the currently available capacity and the financial challenges faced by the system.

Long Waits
We are committed to reducing the number of patients waiting over 52 weeks for treatment to zero by April 2020. We have clear plans in place to ensure this.

Currently Mid Essex Hospital is not reporting on elective care data, the hospital expects to return to reporting in April 2020.

First Contact Practitioners
Nationally, over 30 million working days are lost due to musculoskeletal (MSK) conditions every year, and they account for 30% of GP consultations in England. NHSE have identified the First Contact Practitioner (FCP) service as a High Impact Intervention for elective care transformation. CCGs in south east Essex were identified as a pilot site and in September 2018 the CCGs commissioned a FCP pilot, which aimed to introduce physiotherapists into Primary Care to address the MSK workload in general practice. This was based on the learning from National best practice, and focussed on embedding clinicians from within the main local provider, in this case Southend Hospital.

Since January 2019 there have been 2.5WTE FCPs working within one of the PCNs. The scheme had been very successful, with 96% of appointments being filled; only 1% DNA rate; and nearly 80% of all appointments being discharged with no onward referral (to either GP or hospital). This success enabled the south east CCGs to commission a second test site in another PCN, which is due to mobilise in December 2019.

Thurrock is also piloting direct access to MSK FCPs. As of April 2020, Thurrock will have one FCP operating within each of its four PCNs. The model will see full MSK assessment, triage and physiotherapy services provided across 7 sites in Thurrock, offering extended access appointments 7 days per week, including evenings and weekends. The service will include direct access to diagnostics, including ultrasound and MRI as well as scan-guided procedures. Through this work, we expect to deliver faster access to MSK and physiotherapy services for patients and a reduction in the use of hospital services. This brings care closer to home for patients in Thurrock as part of its overall place-based strategy.

The impact and learning from all 3 of the pilot sites with be measured, analysed and shared across the Health and Care Partnership to inform future commissioning decisions.

Evidence Based Interventions
There is a single policy for most evidence based interventions which reflects national guidance and provides equity for our patient population. The policy also supports the management of demand through patients not being listed for those procedures with little clinical evidence for them to be undertaken. There is a consistent full individual funding request process in place. This is overseen by the CCG Joint Committee.

How will planned care services be delivered in future?

You
Individuals will maintain healthy lifestyles, with support, where required, to reduce key risk factors that lead to ill health and the need for planned treatment.

Neighbourhood
By diversifying the workforce within PCNs, people will get swifter access to the right health or care professional to get help with a developing condition - this might be a physiotherapist, a pharmacist, and specialist nurse or a GP.

When thinking about treatment options, patients will receive personalised support to enable shared decision-making.

Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, community groups, exercise classes, and support groups.

Place
Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Similarly, rehabilitation and reablement services will be available to support patients to return to full health after having had an operation or treatment.

Patients that require bed-based rehabilitation and support will usually be able to receive this at place-level, and support to get them home will be provided by discharge teams, social care and health care practitioners working together.

System
At system level, we will work together to:

// Reduce unwarranted variation in access, quality and outcomes for our elective care services.

// Identify appropriate digital solutions that will help patients manage their condition.

// Make best use of our estates and infrastructure to deliver care closer to home.
19. Improving our cardiovascular services

Clinical Lead: Dr Rebecca Morgan, GP Lead
Senior Responsible Owner: Karen Wesson, Director of Commissioning, Mid & South Essex CCGs, Acute Commissioning Team

Section 9 above on prevention highlights the work we are doing in partnership to prevent cardiovascular disease across our three local authority areas.

As a partnership we have agreed to take atrial fibrillation (AF) as a focus area to support the cardiovascular disease (CVD) programme of work, following successful work in Thurrock. In May 2019 the CCGs agreed a programme to:

- Review patients currently on AF medication to ensure that they are medicated appropriately,
- Review patients on the AF GP practice register that are not currently medicated, and
- Case find new patients.

To progress this work, the system has secured support from our Academic Health Science Network partner, UCLPartners, to provide programme management support using the experience they have gained from similar projects across London. We have also appointed a GP lead for this work, funded through the GP Retention Intensive Support Site.

The UCLP programme manager and clinical lead are working closely with commissioning leads, primary care teams, medicines management, locality pharmacists, GPs and public health to improve the detection and protection of AF patients across mid and south Essex.

Locally, our places, working with local authorities will be implementing wider prevention programmes according to local need.

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20. Improving our cardiac services

Clinical Lead: Dr Stuart Harris, Group Clinical Director, Cardiovascular, Mid & South Essex University Hospitals Group
Senior Responsible Owners: Tom Abell, Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Our STEMI and NSTEMI pathways operate within a networked model with the Essex Cardiothoracic Centre (CTC) in Basildon. Opportunities to improve these pathways have been identified and were subject to East of England Clinical Senate scrutiny, public consultation and Secretary of State approval.

Our revised pathways will accelerate access to the CTC for NSTEMI patients to increase the proportion of patients who undergo angiography within the 72 hour target and reduce duplication in diagnostics between receiving hospital and the CTC, thereby reducing length of stay by two to three days for these patients.

This new pathway is scheduled for implementation during 2020. In advance of this a pilot of the new pathway will be undertaken with a seven day cardiology service being implemented at Basildon Hospital and NSTEMI patients being accelerated to Basildon from Broomfield Hospital. An evaluation of this service will be undertaken during February and March 2020 to inform the implementation of the system wide model.
21. Improving our stroke services

Clinical Lead: Dr Indi Gupta, Group Clinical Director, Specialist Medicine, Mid & South Essex University Hospitals Group
Senior Responsible Owners: Tom Abell, Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

We have a comprehensive stroke work programme that is developing a standardised stroke pathway - from prevention to rehabilitation care - for the population of mid and south Essex, informed by NHS Right Care and other nationally recognised models. The work covers the following key components:

21.1 Prevention
As above, AF is a particular focus for the system as are the activities described in the prevention section, above.

21.2 The acute stroke pathway
The future acute stroke care pathway has been agreed through the 'Your Care in the Best Place' proposals which were subject to East of England Clinical Senate scrutiny, approved by the CCGs in July 2018, and by the Secretary of State in June 2019 following referral by Southend-on-Sea Council.

The future acute stroke pathway will see all three hospitals continuing to receive suspected strokes with optimised scanning and initial treatment (thrombolysis) with confirmed strokes then being transferred to a new acute stroke unit at Basildon Hospital for up to 72 hours for intensive care and support following which patients will be stepped down to either an Acute Stroke Unit at their local hospital, or home supported by early supported discharge services. The full model is planned to be in place by 2022. In line with the consultation the trusts have commissioned UCL to undertake an evaluation of the new model of care.

21.3 Acute/community pathway
The five CCGs commission early supported discharge (ESD) via their local community providers and each provide services in a different way. At present, none of the services are commissioned to the National Clinical Guidelines for Stroke standards. The CCGs are currently undertaking a gap analysis to understand the future commissioning model for ESD with a view to offering a standardised service offer for the population. This has included criteria for bedded and non-bedded ESD services, multidisciplinary input, staffing, non-clinical and clinical follow-ups and six monthly reviews. A new pathway is currently being developed and will be reviewed by the Clinical Cabinet before a full business case is developed.

21.4 Rehabilitation
Across the seven CCGs in Essex, a neuro-rehab navigator role has been introduced. This has facilitated improved patient flow and reduced delays in acute inpatient beds. In addition, a procurement process has been undertaken for a provider of Level 2B inpatient and outreach neuro-rehabilitation. This will go through relevant governance processes in Q3 2019/20 with a view to commence mobilisation January 2020.
**22. Improving diabetes care**

**Clinical Lead:** Dr Sammi Ozturk, GP lead  
**Senior Responsible Owner:** Tricia D’Orsi, Chief Nurse, Castle Point & Rochford and Southend CCGs

We are committed to improving the quality and consistency of services to deliver best outcomes for people living with diabetes or at risk of developing the condition. Building upon existing best practice there is significant potential to improve services in both traditional and innovate ways and contribute to national targets in the following areas:

- Prevention and Early Identification
- Structured Education
- 8 care processes and treatment targets
- Diabetes foot pathway

**Our Commitments**

We are committed to achieving an improvement in outcomes for people at risk of developing, or living with diabetes. Our commitments include:

- Prevention of the onset of type 2 diabetes
- Promotion of awareness and earlier detection of type 1 and type 2
- Reduction of the occurrence of diabetes related complications
- Reduction of the impact of diabetes among hard to reach groups
- Using evidence, research and data to strengthen our approach to prevention and care
- Improvement of health care education

**Current Provision & Future Plans**

From 2017/18 data, the number of patients diagnosed with diabetes across the five CCGs is as follows:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Number of Registered Diabetes Patients</th>
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**2017/18 Data**

**Table:** The table above shows the number of registered diabetes patients across different CCGs along with the population prevalence percentage. The data indicates the number of patients diagnosed with diabetes and the prevalence among the population aged 17 and above.

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**Table:** The table above shows the number of registered diabetes patients across different CCGs along with the population prevalence percentage. The data indicates the number of patients diagnosed with diabetes and the prevalence among the population aged 17 and above.
22.1 Our ambitions:

We are aiming for improvements in care processes for type 1 (from current 25% to 40% to bring us in line with national performance) and for type 2 (from current 35% to 60% to bring us in line with national performance).

We are also aiming for a 50-60% conversion rate (referral to intervention) for the National Diabetes Programme.

In order to achieve these ambitions, we have developed a diabetes framework which will be delivered within a model of care based on four tiers: broader determinants, including prevention; PCN (neighbourhood level); community care via a collaborative service (PCN/place-based) and hospital care. According to their individual needs, a person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future.

The collaborative service will be provided by a comprehensive diabetes skilled multidisciplinary team. Collaborative care by its definition requires all professionals involved in a person’s care to work in partnership, including generalists, specialists, other health professionals and support staff, with the person living with diabetes and his/her family at the centre of their care. The workforce will be upskilled within the collaborative service to provide more specialist care in the community.

Where appropriate we will agree a mid and south Essex approach to elements of the model such as addressing the wider determinants of health. All tiers will be underpinned by a population health management approach with self-care and management being a fundamental component throughout.

As part of our improving diabetes care journey, we need to identify and support current workforce capacity and competency to deliver the future model of care. Implementing a new model of care to support diabetes management will include staff training and development needs.

The skills required to support effective diabetes care include many that are generic to all long term conditions, as well as others that are specific to diabetes.

This will involve:

// acknowledging the philosophy and principles of support for self-management
// identifying accountable leadership
// identifying the population involved (risk stratification)
// identifying the capacity of individuals to engage in the necessary processes and supporting them to do so
// identifying the multidisciplinary teams involved and the roles and responsibilities of each team member in order to ensure that care is personalised and co-ordinated
// using available evidence-based and quality-assured training
// identifying robust metrics, data collection methods, analysis and feedback to drive improvement.
The MID AND SOUTH ESSEX HEALTH AND CARE PARTNERSHIP

Our 5 Year Strategy & Delivery Plan

23. Respiratory disease

Clinical Lead: Various
Senior Responsible Owner: Terry Huff, Accountable Officer, Castle Point & Rochford and Southend CCGs

Redesigning respiratory services is one of our transformation priorities.

Our vision is ultimately to improve the respiratory health and well-being of the population of mid and south Essex from the start to the end of their lives.

Our respiratory plans will initially focus on a defined scope of adult chronic respiratory disease before expanding to include acute and paediatric services.

All CCG’s have already implemented or planned initiatives to improve respiratory services and patient outcomes. Our programme will review and revise these initiatives to create a system-wide offer that meets national standards and LTP commitments, with a focus on ensuring prevention and self-care, ensuring as much care as possible is provided close to home.

Programme objectives:

To create a consistent approach to respiratory care across mid & south Essex.
To increase early and accurate diagnosis of respiratory disease.
To promote better medicine management.
To improve education and support GPs to enable them to manage patients.
To comply with the requirements of the National Spirometry Register using targeted funding as it becomes available.
To promote self-management, including the MyCOPD app, to enable greater patient control of their own care.
To increase the uptake and completion of pulmonary rehabilitation programme, using targeted funding as it becomes available.
To reduce avoidable admissions for community acquired pneumonia.
To reduce hospital outpatient activity.
To deliver high quality integrated care in line with best practice guidelines.

In order to achieve our vision, the respiratory Programme aims to support;

1. Prevention of respiratory ill health

We will increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks of poor respiratory health. We will ensure that the activities of individual services and agencies support this aim.

22.2 Digital Solutions

The MyDiabetes App has a number of embedded functions such as expert written information, structured education, blood glucose level (HbA1c) log and monitoring, programmes of simple activities and diet plans, and access to a pool of clinical specialists for advice and support in understanding Diabetes, the associated risks, and self-management of the condition.

MyDiabetes will be used by newly diagnosed Type 2 diabetes patients and provides a lifetime licence for the patient once registered; therefore the patient has access to the app, dipping in and out of the embedded functions as and when required.

We will undertake a 6 to 12 month pilot (100 licences per CCG area) in addition to the face to face structured education courses currently provided.

22.3 Our Deliverables

<table>
<thead>
<tr>
<th>Key Milestone Deliverables</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Care Partnership five year Diabetes framework finalised and approved</td>
<td>Nov-19</td>
</tr>
<tr>
<td>Review and redesign Health and Care Partnership foot pathways community through to acute</td>
<td>Dec-19</td>
</tr>
<tr>
<td>Governance structure established (in line with existing forums)</td>
<td>Jan-20</td>
</tr>
<tr>
<td>Prevention/self care programmes identified across the wider health system</td>
<td>Feb-20</td>
</tr>
<tr>
<td>Benchmarking (gap analysis) against the framework completed</td>
<td>Feb-20</td>
</tr>
<tr>
<td>System-wide and CCG priority areas agreed and plans developed</td>
<td>May-20</td>
</tr>
<tr>
<td>Framework changes to service pathways implemented</td>
<td>Jun 20 - Mar 22</td>
</tr>
<tr>
<td>MyDiabetes app distributed to 100 Type 2 diabetes patients within each CCG (initial pilot) as part of the existing structured education pathway</td>
<td>May-20</td>
</tr>
<tr>
<td>NDPP referrals increased in line with yearly IP allocation</td>
<td>Aug 20 - Jul 24</td>
</tr>
<tr>
<td>Improvement in variances across practices in care processes and 3TTs</td>
<td>Mar-21</td>
</tr>
<tr>
<td>Diabetes workforce competencies developed based upon national guidelines</td>
<td>Sep-20</td>
</tr>
<tr>
<td>Workforce training needs identified</td>
<td>Mar-21</td>
</tr>
<tr>
<td>Collaborative working across PCN/Place - community and specialist</td>
<td>Apr 22 - Mar 23</td>
</tr>
<tr>
<td>Care model developed and procured (subject to PCN maturity)</td>
<td>Apr 23 - Sep 24</td>
</tr>
<tr>
<td>Care models implemented</td>
<td>Mar-25</td>
</tr>
</tbody>
</table>
2. Earlier detection of respiratory diseases
We will ensure people are aware of the signs and symptoms of respiratory diseases in order to encourage positive health-seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

3. Primary Care and Community based support
We will provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

4. High Quality Hospital Services
We will ensure that pathways and services are in place so that people who need them receive prompt, effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

5. Promoting Self Care and Independence
We will make sure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate, personalised information, support and interventions to help them.

6. Develop the workforce to support quality provision of respiratory care
We will implement an agreed competency framework for healthcare professionals involved in managing respiratory disease and support this with a flexible educational programme that is accessible to all healthcare professionals.

Our Expected Outcomes
Through working together on a system wide approach we expect to:
// Reduce the prevalence of respiratory disease
// Reduce the burden of respiratory disease
// Reduce variation of care across the system for respiratory disease
// Increase the number of patients accurately diagnosed with COPD and Asthma at an earlier stage of disease
// Reduce reliance on secondary care services
// Improve patient quality of life
// Provide proactive care delivered by the right person at the right time

How will respiratory services be delivered in future?

You
Individuals will be supported to prevent the on-set of respiratory disease and self-manage their condition, including education programmes and support with healthier lifestyles. A range of digital tools (eg MyCOPD, asthma), will be available
Individuals with respiratory disease will have personalised care and management plans, and be at the heart of decision-making about their care.

Neighbourhood
Diversifying the workforce within PCNs will mean that patients get access to the right care professional for their needs to obtain education, advice and guidance – this could be from a pharmacist, a specialist nurse, therapist or GP.
PCNs will support practices to undertake proactive case finding and risk stratify patients to ensure that those at high risk receive the right care and support.
Structured medicine reviews and education will be undertaken.
PCNs will adopt consistent management approach for community acquired pneumonia – ensuring swift diagnosis and treatment.
Community teams will be aligned to PCNs, providing pulmonary rehabilitation, community clinics (including oxygen assessment clinics). Psychology services, nebuliser trials, home support and where required, palliative care support & end of life care co-ordination

Place
At place level we will look to provide a respiratory diagnostic / assessment unit/HOT clinics and in-reach into acute services, along with supported early discharge from hospital.
We will offer flu immunisation at Place-level, with a focus on the most vulnerable.
We will bring as much care close to home as possible to prevent patients having to travel wherever we can.
We will offer effective smoking cessation services and ensure that all health and care professionals can offer brief advice on smoking cessation.

System
We will develop a single service specification for respiratory services and simplify points of access for patients.
The shared care record will assist health and care professionals to support people living with respiratory conditions.
We will develop and a workforce competency framework and deliver education programmes to our staff.
24. Redesigning Outpatient Care

Clinical Lead: Specialty-specific leads in place
Senior Responsible Owner: Tom Abell, Deputy Chief Executive, Mid & South Essex University Hospitals Group

Outpatient redesign has been identified as one of our key transformation priorities.

As part of the acute reconfiguration arrangements, we planned a significant reduction (274k fewer) outpatient appointments would need to be delivered in alternative ways to ensure sustainability of all services and while bringing as much care as possible closer to where people live. To deliver this reduction, we will need to work in different ways including taking a ‘digital first’ approach, reducing face-to-face appointments and bringing hospital clinicians into the community to support delivery of this service.

In planning our future estate requirement, we are mindful that we want to move as much care closer to where people live as possible to prevent people having to travel to hospital. Additionally, in planning the future estate as part of the capital business case for hospital reconfiguration and integration plans, we have a need to ‘right size’ our outpatients departments. Our approach to this will use the latest technology and adoption of proven innovations to deliver new ways of working to support personalisation and choice for patients, while improving the capacity and utilisation of our services.

Our outpatient redesign programme has the following key objectives:

- Reduce overall outpatient appointments
- Reduce % of face to face outpatient appointments
- Reduce variance across our three hospitals, optimising our administrative processes
- Optimise Outpatient experience
- Enhance Outpatient data analytics to enable continuous improvement
- Adoption of a ‘digital by default’ approach

As well as taking a pathway approach to improvements (pre-OPD, OPD delivery, Follow-up), we are focussing on three key specialities as part of the NHS England Outpatient Transformation Programme (dermatology and rheumatology across the three hospitals, and urology at Southend Hospital). This work will involve commissioners, newly formed primary care networks and other community providers, also linking closely with our digital transformation and estates programmes.
25. Children & Young People

25.1 Maternity & Neonatal

Clinical Lead: Teresa Kearney, Chief Nurse, Basildon & Brentwood CCG
Senior Responsible Owner: Karen Berry, Senior Maternity Commissioner, Basildon & Brentwood CCG

Positive, healthy pregnancies and births, and good early development have wider societal impacts for our population.

We aim to ensure that children and their families have the best quality of care throughout pregnancy and early life and that parents are given choice and control of their care and support.

The Maternity & Neonatal Long Term Plan commits to include the Better Births programme with Maternity and Neonatal ambitions. The mid and south Essex Local Maternity Service Transformation (LMST) programme has clear governance processes and a robust link is being developed across the system with interdependent programmes. We have established a Local Maternity System Transformation Board comprising representatives from commissioners, hospital providers, community services and patient representatives. A full report on our maternity and neonatal transformation programme can be found at Appendix 8.

Context

Across mid and south Essex, our maternity services deliver approximately 12,305 births/year. The acute hospital merger will provide the opportunity for our Maternity and Neonatal services to become standardised. There are two standalone midwifery units and three co-located midwife-led units.

Each acute hospital unit has a level 2 Neonatal unit. Our intensive care pathways operate as follows:

Southend Hospital / BTUH - The Royal London Hospital

Mid Essex - Cambridge University Trust and are part of the Cambridge Cluster hospitals

A capacity and demand analysis of mid and south Essex (2018) suggested birth rates in Essex were expected to remain steady over the next few years with a small expected increase in Basildon in 2020 and steady thereafter. Given the amount of cross border activity it is not immediately clear where this expected increased activity will have most impact. The information available suggests it is most likely to impact on BTUH and MEHT. Given the small increase in birth rate indicated, the requirement for additional staff does not appear to be significant at this time. However, we are aware there are significant housing developments within the area and the impact of these. Therefore, ongoing monitoring of the impact of this as well as increases in maternity bookings will be required by the Heads of Midwifery to ensure that any increase results in an establishment uplift.

**Saving babies lives care bundle version 2**

Version two of the Saving Babies’ Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and address the issues identified in the SPiRE evaluation. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy,
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth

**Our current work and future plans**

We are committed to delivering against the requirements of the Saving Babies’ Lives Care Bundle. A deep dive performed in 2018 demonstrated the gaps in our compliance and we have clear plans in place to close these gaps (see Appendix 8). We are committed to making significant progress on the “halve it” ambition of halving rates of stillbirth and neonatal death, maternal death and brain injuries during birth by 50% by 2025.

**Stillbirth rate**

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<td>Rate</td>
<td>Baseline 2016</td>
<td>2019/20</td>
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<td>2021/22</td>
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**Neonatal Mortality rate**

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<td>Rate per 1,000 live births and still births</td>
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Improvement Programmes
All three maternity units in our LMS are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme.

Southend Hospital Maternity participated in Wave 2, specifically to improve the early recognition and management of deterioration during labour and early post-partum period. They completed a Quality Improvement piece of work on early identification and treatment of Sepsis.

Basildon Hospital Maternity are in Wave 3 and are undertaking a Quality Improvement initiative focussed on improving the proportion of smoke free pregnancies. This has included Carbon Dioxide monitoring at each point of contact. The LMS financial plan has supported the initiative for smoking cessation.

Mid Essex Hospital Maternity participated in Wave 3, the focus was on improving early the early recognition and management of deterioration during labour and early post-partum period. Their quality improvement project is in the management of post-partum haemorrhage.

The LMS are reporting the use of Magnesium sulphate for women in suspected labour under 27 weeks. They are exception reporting when this is not being done. When unable to transfer women to a tertiary unit prior to 27 weeks.

All three Maternity units are using the perinatal Mortality review tool to review all stillbirths and neonatal deaths. Learning from these is shared via a safety newsletter.

All three units take part in the National Neonatal Audit Programme (NNAP). The 2018 data results are available at Appendix 8.

Term babies admitted to the Neonatal unit are being reviewed locally to enhance learning and ascertain if the admissions could have been avoided, also consideration is given as to whether babies could have been cared for under a transitional care pathway which would reduce the likelihood of them being separated from their mothers. All three sites have an Avoiding Term Admissions to NICU (ATAIN) action plan. In addition to this there are action plans for each unit to introduce a transitional care service.

The LMS has considered the use of placental growth factor testing. This will be kept under review but not instituted at present.

Choice and Personalisation
Better Births state that all women should receive personalised care, centred on the woman, her baby and her family, based around their needs and decisions, where they have genuine choice, informed by unbiased information. The LMS is working to ensure that:

// All women have a personalised care plan by 2021
// All women can make choices about their maternity care, during pregnancy, birth and postnatally
// More women can give birth in midwifery settings (at home and in midwifery units)

MSE Personalised Care and Support Plans are now completed; Maternity choices are available on each of the trust websites. The Maternity Direct App has gone live at BTUH, it will be developed to be available for all women to download and is a platform for health information for those who are able to download the app. The chat and appointment functionality will be available at BTUH, but not currently at Southend or MEHT, until IT integration has been achieved.

At present all Maternity units are using personalised care plans and these are given at booking ensuring the majority of women have a personalised care plan.

Continuity of carer
At present, we are offering 12.9% of women the opportunity to have the same midwife throughout pregnancy, during birth and postnatally, against a requirement of 20%. We will continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2020 we progress towards 35% of women are being placed on a continuity of carer pathway and in March 2021, Most women will receive continuity of carer.

Our work will be targeted towards women from BAME groups and those living in deprived areas, for whom midwife-led continuity of carer is linked to significant improvements in clinical outcomes. By 2024 75% from Black/Black British and Asian/Asian British communities and women from the most deprived areas will receive continuity of carer.

Perinatal mental health
Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS, the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage. Ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care.

See section 15 and Appendix 8.

Maternal Smoking
We are committed to reducing maternal smoking and aim to unify smoking cessation services available to women and their partners across the footprint. Smoking at time of delivery for 18/19.

Workforce
Workforce profiling has included Birth rate + reports from all three sites. This has demonstrated a midwifery workforce deficit of 30 WTE and a deficit of maternity support workers (MSW) of 14.5 WTE. All three Trusts provide maternity workforce statistics and use this information to support future planning of workforce numbers and skill mix. Reporting of workforce information will be aligned across the three Trusts.
Postnatal Care

All three sites are providing personalised care planning which includes postnatal planning in the antenatal period. Two sites have clear pathways for timely referral for women who experience issues with their pelvic health. We recognise that there needs to be greater emphasis on access to emotional and mental health support, and this is included in the perinatal mental review.

Infant feeding

Currently, only Mid-Essex have a tailored feeding strategy and so we will develop a tailored feeding strategy ideally across the system. Breast feeding support has diminished across the LMS and the Maternity Voices Partnership are looking at ideas to improve our service to women.

BTUH and SUHFT have infant feeding midwives with baby friendly accreditation initiative (BFI) whilst MEHT currently have a vacancy for this position and need to reapply for BFI.

How will maternity services be delivered in future?

You

Pregnant women will be supported to maintain healthy lifestyles, with support where required to reduce key risk factors. Eg smoking in pregnancy

Women will be able to access support and advice through the Maternity Direct App.

Neighbourhood

Swifter access to the right health and care professional through primary care networks.

Women will receive personalised support to develop care plans.

Close work with community and voluntary sector organisations will aide women and families in accessing a range of support services pre- and post-natally eg new mum groups, breastfeeding support.

Place

Where safe and possible, a range of outpatient appointments and diagnostic tests will be available closer to home.

Immunisations offered through place-based arrangements.

System

At a system level organisations will work together to further develop digital channels for accessing information, advice and support/

We will continue to develop and improve our maternity services, ensuring full adoption of the Better Births principled across our three maternity units and ensuring continuity of carer in line with LTP commitments.
25.2 Children and young people’s mental and physical health services

Clinical Lead: Dr Sooraj Natarajan

Mid and south Essex has a child population of circa 270k and although there are similarities in the health needs, there are also significant variations linked to demographics and wider health determinants. The joint strategic needs assessments undertaken across the footprint have informed commissioning priorities and will continue to support collaborative working across health and care partners.

Children and Young People Partnerships

Children and Young People (CYP) Partnerships are currently aligned with the individual council and unitary footprints. This includes Essex Children’s Partnership Board, Thurrock Brighter Futures Board and Southend Success for All. These three partnerships will have oversight of presenting health inequalities and local needs; each reports to the relevant Health and Wellbeing Board. The delivery of the Families and Children Act in relation to Special Educational Needs and Disabilities (SEND) remains accountable on the local authority footprints supported by the SEND Partnership Boards. Safeguarding for CYP also has locality accountability; however Southend, Essex and Thurrock work in collaboration to have a consistent approach underpinned by the single Safeguarding and Child Protection Procedure.

Clinical leadership

To support the work across mid and south Essex there is a well-established Paediatric Clinical Engagement Group (PCEG) which brings together universal health and prevention services, children’s acute and community services. The PCEG has strong clinical leadership and is chaired by the CYP GP Lead.

PCEG and the primary care networks will work closely together to support integration across the health and care system for CYP with long term conditions including asthma, epilepsy and diabetes. This will include the ongoing and transfer of care to adult services and integration with education and wider settings who provide care for this group of children.

The PCEG has developed an overarching model to illustrate the integrated approach for children and young people (see below). The model illustrates the importance of taking a whole family holistic approach to prevention and early intervention and the potential benefits to be realised by maximising integration.
26. Learning Disability and Autism

Clinical Lead: Tricia D’Orsi, Chief Nurse, Castle Point and Rochford and Southend CCGs
Senior Responsible Owner: Simon Leftley, Deputy Chief Executive, Southend Borough Council, Chair of Transforming Care Partnership

We will deliver the Long Term Plan commitments to improve services and outcomes for people with learning disabilities, autism or both, through working across the existing Essex Transforming Care Partnership (TCP) that was set up in 2016.

The Essex Transforming Care Partnership consists of Southend CCG, Castle Point & Rochford CCG, Basildon & Brentwood CCG, Thurrock CCG, West Essex CCG, Mid Essex CCG, North-East Essex CCG, Essex County Council, Southend-on-Sea Borough Council and Thurrock Council. The Partnership covers all of the mid and south Essex footprint, but also sits across Hertfordshire and West Essex and Suffolk and North Essex.

Since its conception the Essex TCP has successfully delivered against the national Transforming Care agenda. Key achievements include:

- Reducing admissions to adult learning disability in-patient facilities by over 50%.
- Reducing overall learning disability adult in-patient numbers by 34% and exceeding the targets within the national Transforming Care programme;
- Delivering a transformed local service model in line with “Building the Right Support” - the national service model for learning disability - through a new 7 year contract with Hertfordshire Partnership University NHS Foundation Trust (HFFT)
- The establishment of a Pooled Budget underpinned by a Section 75 agreement across the partners;
- The establishment of an integrated learning disability commissioning function funded by all partners and hosted by Essex County Council.

Since the publication of Valuing People in 2001 it has been clear that the wider determinants of health for people with learning disabilities – housing, employment, and healthy living are influenced best by Local Authorities. Those areas that achieved the greatest successes in reducing health inequalities have had strong partnerships between CCGs and Local Authorities. The Essex TCP has a senior responsible officer in place (Simon Leftley, Deputy Chief Executive, Southend Council) and the commissioning infrastructure to deliver the commitments within the Long Term Plan.

The Essex TCP also sees opportunities of working across all three Health and Care Partnership footprints. The areas that offer the greatest benefit for operating at this larger scale are low volume and high cost niche services where it makes sense to commission collaboratively. For example:

- We are already working with the Suffolk TCP to explore opportunities around co-commissioning assessment and treatment services. Both Essex and Suffolk are looking to remodel their assessment and treatment units and doing this together would deliver improved economies of scale;
- We are working with Hertfordshire, Suffolk and Norfolk to explore how we can commission low volume high cost in-patient beds to achieve the best value and ensure consistent quality standards.

The Essex Transforming Care Partnership has recently extended its terms of reference to address the wider health inequalities that people with learning disabilities and autism experience. In 2019/20 we will publish the first Health Equalities strategy bringing together the learning from Transforming Care, LeDeR, STOMP / STAMP and annual health checks into a coherent programme of work across the partnership.

The partnership has invested in a commissioning structure to deliver Learning Disabilities Mortality Reviews (LeDeR). Through the appointment of two permanent LeDeR reviewers, a LeDeR co-ordinator, a number of interim workers to address the backlog, and our existing reviewers within the local health and social care system, we will ensure reviews are undertaken within six months of the notification of death. The Essex TCP was one of the first areas to produce an annual LeDeR report and has an active steering group to address the identified themes from the reviews.

The Partnership also has steering groups for the Stopping Over Medication of People with a learning disability or autism and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to ensure a consistency and efficiency across all seven CCGs.

Co-production has always been central to the work of the Essex TCP and experts by experience have been involved in shaping all aspects of the programme from co-producing the service model and specification to being full members of the board. Within the new commissioning structure two permanent posts have been created for a person with a learning disability and a family carer and they will have responsibilities for developing systems to monitor the quality of care, support and treatment, and that local services are making reasonable adjustments.

The Partnership has already had considerable success in reducing adult inpatient usage and has plans to exceed its targets for both 19/20 and 20/21. The Partnership has also reduced the length of stay in adult in-patient services and actively uses the 10 point discharge plan to ensure people do not have to stay in hospital any longer than they need to. We will continue to actively monitor the use of seclusion, long term segregation, and restraint through our quality monitoring on in-patient services and through the Care and Treatment Review process to ensure these interventions are minimised and only used where absolutely necessary. We will also ensure that the providers we commission services from (both NHS and Independent Sector) meet the Learning Disability Improvement Standards.

The achievements in reducing adult in-patient services have been delivered through our new service model that went live in November 2018 that includes an enhanced community support service available seven days a week and a community forensic service. The Partnership has utilised capital to deliver housing solutions to discharge some of our long-term inpatients and we have a housing strategy in place to further reduce inpatient numbers.
The new seven year contract which covers the Partnership as a whole consists of the core services described in Building the Right Support, and a Local offer in which CCGs can tailor local services through their place plans to meet the needs of their populations. A key component within the place plans is improving the uptake of physical health checks to meet the target of 75%.

Our Priorities

A real focus of the Partnership over the next eighteen months will be children and young people with learning disabilities and autism. The Accelerator Pilot that was implemented in 2018/19 has illustrated how multi-disciplinary working and a person-centred offer can reduce crisis for children and young people with learning disabilities and their families. The current children’s LD service that operates in north, mid and west Essex is being extended in 2019/20 to cover the Partnership as a whole to embed the learning from Accelerator Pilot. The Partnership will also be extending the model to include children and young people with autism and trial the use of keyworkers with access to flexible support including Personal Health Budgets in preparation for a roll out of the keyworker model in 2020/21. The Partnership with its local authority footprints also provides the best framework for testing the model for taking eye, hearing and dental services to children and young people in residential schools from 2021/22. The Health and Care Partnership is also reviewing its neurodevelopment pathways to ensure that C&YP with autism receive the support they need pre and post diagnosis; so that a diagnostic assessment is not just a Gateway to services but forms part of the overall support offer for this cohort.

The model for Children and Young People will align with the SEND plans for each of the three local authorities. The Partnership is also in the process of retendering for its CAMHS services (also on a TCP footprint) which provides an opportunity to ensure that the social care, education, and mental health offer for children and young people with autism are fully aligned to meet local need and reduce the need for in-patient admissions.

26.1 Special Educational Needs and Disability

The Children and Families Act 2014 requires Local Authorities and CCGs to work together to support the health element of services for children and young people with Special Educational Needs and Disability (SEND), enabling children and young people to have more say over what support and services are offered in the local area and the help they need to prepare for adulthood. Local Authorities publish information about the range of support available in their area for children and young people aged 0 to 25 years with SEND. This information is known as the ‘Local Offer’ and covers education, health and social care support and services.

Children and young people’s needs are met from a range of NHS services, some are universal, such as GPs and health visitors and some are more specialised and may need an assessment or referral from a health or social care professional – these include, but are not limited to, speech and language therapy, community paediatrics, physiotherapy, specialist children’s nursing, continence services, emotional health and wellbeing services, continuing health care assessments and packages of care.

Ofsted and the Care Quality Commission are tasked with inspecting local areas on their effectiveness in fulfilling their duties under the Children and Families Act.

Following recent inspections, our three local authorities have each been given a Written Statement of Action, detailing where improvements must be made to SEND services and the local offer. The CCGs and local authorities are keen to commit to being joint and active members of an improvement board and have further committed to reducing inequalities within joint commissioning arrangements, recognising the need to work to agreed outcomes. Work has already commenced to this effect with commissioners working with officers from the local authorities. The work includes:

// The development of a joint outcomes framework
// Undertaking a gap analysis against best practice for a universal 0-25 service to support early intervention. This is likely to lead to a jointly commissioned service for higher level needs for the specialist service.
// Education Health and Care Plans and inclusion of health and social care - a working group has been established to oversee this

The Improvement Board will feed into the SEND strategic governance group.
27. System financial plans

Clinical Lead: Various (depending on efficiency plan)
Senior Responsible Owner: Chief Finance Officers

27.1 Five-year System Control Totals

Mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population.

Our five year financial planning is predicated on two initial high level aims:

- To achieve the control total set for the system as a whole by the end of the planning period
- To ensure that our financial planning is both credible and an enabler for the delivery of the commitments set out in the NHS Long Term Plan

Further to these initial challenges, we continue to explore further opportunities that will also allow us to:

- Achieve the control totals for each year across the planning period; and
- To achieve the control totals set for each individual NHS organisation

The starting point for planning is the published CCG allocations for the next five years that set out the funding available to deliver the ambitions of the Long Term Plan and ensure quality healthcare is delivered for our population. This funding amounts to £1.64bn in 2019/20, rising to £1.91bn in 2023/24 which equates to annual increases in funding of between 3.5% and 4.2% p.a. Together with social care resources (circa £0.6bn) across our system our population will benefit from £2.5bn spent on care.

Our financial plans show the following position:

### Summary by Organisation (£m)

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</tr>
<tr>
<td>System issued control total</td>
<td>(39.6)</td>
<td>(81.9)</td>
<td>(78.2)</td>
<td>(74.7)</td>
<td>(71.1)</td>
</tr>
<tr>
<td>Surplus / (Deficit) to control total</td>
<td>(26.1)</td>
<td>(6.7)</td>
<td>(1.1)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

This plan is not without its challenges however, particularly around the level of financial efficiencies required (totaling over £300m between the CCGs and provider trust programmes alone by 2023/24 on an anticipated annual allocation of £1.9bn). The key components of this include:

- Demand management of £157m across the health economy delivered by commissioners in partnership with providers through a range of efficiency programmes previously known as QIPP.
- Financial benefits of £19.4m across corporate and clinical areas as a result of the clinical reconfiguration work that can be enabled by the capital programme. In the event the capital programme is not approved these efficiencies would be at risk.
- Cost efficiency programmes or CIP within the acute providers of £124m, which is equivalent to 4% of the cost base in each of the three providers in 2019-20. For 2020/21 we have planned on 3.0% efficiencies, reducing to 2.2% across the group by 2023/24.
- Financing of deficits. In the event the merger does not proceed these efficiencies would be at risk.
- Due to the risks associated with delivering significant and concurrent cost reduction programmes as well as the dependency of certain benefits on the merger and estates programmes that have not yet received final approval, the baseline position includes a reserve of approximately 2% of the annual allocation by 2023-24.
- There are also efficiencies being delivered in the other members for the purposes of developing SDP reporting including £21m by EPUT.

Our submission is compliant against the control total trajectory set by NHSE and NHSI in the years up to 2023/24 as a system. See Appendix 5 for further detail.
27.2 Efficiency plans
In order to deliver the required efficiencies, the system needs to deliver some £300m savings over five years. This level of efficiency cannot be delivered through usual transactional savings programmes - it requires the whole system transformation described in this strategy and delivery plan. We know that we are likely to have significant investment requirements to enable this level of saving including, but not limited to:
- Further investment to improve mental health services
- Further investment in primary and community care over and above the funding made available through the LTP
- One-off funding to deliver elective care standards (subject to available capacity)
- Investment in prevention activities
- IT investment - funding to bring the basic infrastructure up to standard to support digital transformation plans
- Double-running/additional support for workforce costs
- Investment in community schemes

Partners are working together to address the significant efficiency challenge. The NHS Efficiency Map provides helpful guidance for systems, under three key areas of focus:

<table>
<thead>
<tr>
<th>Enablers for Efficiency - ensuring</th>
<th>Service Efficiency - focussing on</th>
<th>System Efficiency - working together to focus on</th>
</tr>
</thead>
<tbody>
<tr>
<td>System leadership</td>
<td>Workforce optimisation</td>
<td>Urgent and emergency care</td>
</tr>
<tr>
<td>Board capability &amp; governance</td>
<td>Clinical support services</td>
<td>Long-term conditions</td>
</tr>
<tr>
<td>Management capability &amp; capacity</td>
<td>Clinical quality and efficiency</td>
<td>frailty</td>
</tr>
<tr>
<td>Use of evidence and best practice</td>
<td>Procurement</td>
<td>Integration of services</td>
</tr>
<tr>
<td>Controls and reporting</td>
<td>Estates</td>
<td>Integration with social care</td>
</tr>
<tr>
<td>Digital maturity</td>
<td>Corporate Services</td>
<td>Right Care opportunities</td>
</tr>
<tr>
<td></td>
<td>Focus on productivity</td>
<td>Focus on prevention and self-care</td>
</tr>
<tr>
<td></td>
<td>Model Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient Flow</td>
<td></td>
</tr>
</tbody>
</table>

Partners will work together, through the System Finance Leaders Group, to develop options for transformation including investment requirement.

28. Supporting our staff
Clinical Lead: Various
Senior Responsible Owner: Sally Morris, Chief Executive, Essex Partnership University Foundation Trust & Chair of Local Workforce Action Board

Our staff is our most important asset; the lack of available personnel to fill vacant posts is also our biggest risk. All of the transformation programmes we are undertaking are aimed at making the best use of the available workforce, and supporting them to achieve fulfilling careers in our system.

We are supporting a range of innovative programmes to attract new staff and retain the existing and by Q4 2019/20 we will have developed our first joint health and care workforce strategy, with key ambitions for the future. All NHS and local authorities within the mid and south Essex footprint are collaborating on this and we see the development of the strategy as an important milestone in our work together.

In line with the themes of the Interim People Plan the Local Workforce Action Board (LWAB) will support the system to ensure we focus on:
- Making our system the best place to work - offering greater opportunities for flexible working and ensuring that we take positive action to have greater representation of BAME staff on our senior leadership teams.
- Improving leadership culture - executives and chairs in mid and south Essex have been supported by a bespoke development programme enabling those senior leaders to support the cultural values of our Partnership, demonstrating compassionate and inclusive leadership at all levels in our workforce.
- Delivering a holistic approach to workforce transformation and workforce growth – we are developing a greater variety of new hybrid roles (especially on integrated services with local authority and NHS organisations), working closer with social care to develop joint approaches to role development. We are up-skilling staff and developing new roles such as trainee nurse associates and physician associates to resource the establishment of primary care networks.
- Change the workforce operating model – the LWAB has commissioned a bespoke system that will provide quarterly system workforce reports. This will enable us to have greater access to data to monitor workforce themes such reasons for leaving, attrition rates, and the level of vacancies by staff group.
As part of our responsibility of being a good employer and understanding how we can improve access to opportunity and embrace the opportunities that come from a diverse workforce, partners at the MSE Group of trusts have begun some work to gain insight into the workforce and the needs of key populations within. MSE has developed methodologies for organising workforce information by key characteristics and social factors that have potential to contribute to hindrances for some groups in accessing opportunities for development, new experiences or more varied roles. We can use this information to pick up patterns or trends which might need addressing. This is already helping us to identify where data capture can be improved, identify areas for targeted staff engagement and build upon important factors such as action in response to the NHS annual staff survey. We hope to build on this through co-development of plans with staff directly, and for specific work streams such as the NHS Hospital as an Anchor programme.

For our workforce, the Partnership Board as approved the following key priorities for 2019/20:

**Retention & Recruitment**

// A systematic review of the current retention plans to develop a consistent system approach to retention initiatives. This includes identifying reasons for leaving, reviewing attrition rates and reasons, identifying the main areas of concerns in the nursing workforce initially (other staff groups to follow) and reviewing the use of resources such as application of the NHSI retention tools.

// Development of a rotational roles scheme across the system; this will be led by the Directors of Nursing network to develop a system approach to offer greater flexible career opportunities and reduce contractual/employment issues for rotational roles.

// Development of a system approach to return to practice, which we will implement and monitor over a 12-month period.

// Review and streamlining of current recruitment practices, building on the national NHS Employer streamlining hub approach.

// Introduction of alternative workforce roles including physician associates, AHP associates and Advanced Clinical Practitioners. Partners will collaborate on workforce planning for these new roles.

// Further development of the Nurse Association partnership, supported by £240K investment (19/20) from HEE to manage the pipeline and enable 130 additional trainees.

// Explore ways to develop technology enhanced education and training.

**Mid & south Essex Career Framework**

We will develop a virtual “School” that will include the following:

// A system career framework to support development through level one - level five apprenticeships with a whole career pathway. This will better clarify the career pathways and options for nursing staff in order to deliver on the ambition that all staff have the opportunity of embarking on a ‘career and not just a job’ recognising the investment in time and training that this will require.

// Mid and south Essex cadet scheme via engagement with schools through to work-based placements - promotion of careers through ‘chat’ sessions, podcasts of ‘A day in the life of’, intensive simulation training for schools and colleges.

// Development of a system approach to return to practice, which we will implement and monitor over a 12-month period.

// Introduction of alternative workforce roles including physician associates, AHP associates and Advanced Clinical Practitioners. Partners will collaborate on workforce planning for these new roles.

// Further development of the Nurse Association partnership, supported by £240K investment (19/20) from HEE to manage the pipeline and enable 130 additional trainees.

// Explore ways to develop technology enhanced education and training.

// Leadership development programmes - targeted on broadening diversity and inclusion in senior roles; link to the new leadership compact agreement to develop and embed cultures of compassion, inclusion and collaboration in the system.

// Link with the Training Hubs for Primary & Community staff – refine and identify savings as a system on continued professional development courses.

// Create leadership alumni networks (join up existing organisations/local authority).

// Develop the Partnership talent academy to support the High Potential Pilot programme and system talent management approach.
29. Digitally enabled care

Clinical Lead: Various depending on project
Senior Responsible Owner: John Niland, Chief Executive, Provide CIC & Chair of the Partnership Digital Board

29.1 Our Digital Vision

Taking a "digital first" approach is a fundamental part of the design principles we have adopted for our system. Our vision is as follows:

Health and Social Care organisations in Essex share an ambition to improve the services they deliver and the wellbeing and lives of the people they serve.

They will work together with each other and with the local population to organise around the needs and locations of people, rather than boundaries of organisations. They way that technology is used will be improved, with connected systems and better sharing of information to allow Health and Social Care professionals to be more responsive.

Digital services will provide patients and users with the ability and convenience to manage their own information and needs if they want to - just like they can in other parts of their lives (e.g. online banking).

People will be encouraged to be more responsible, active and healthy and they will be provided with technology that helps, like Health Apps and the ability to use information from wearable devices.

Information will be combined and used intelligently to identify needs or issues so that where possible services can be targeted proactively rather than treating problems after they occur.

What this will mean for our workforce

The Health and Social Care workforce in Essex will be a critical part of this plan. Without their involvement and buy-in new technology will fail and no improvements will be achieved. They will be included, educated, equipped and enabled to be successful - with technology being put in place that allows them to focus on caring for patients and citizens.

New services will be designed with users in mind, making the systems intuitive to use and training and adoption less of a hassle. The importance of the safety of the people being cared for will not be overlooked.

How will we work together & with others

These changes will be forward thinking and made collaboratively, listening to people in the region and being honest and practical about what can be done.

We will recognise that some centralised coordination is essential, and respect the decisions that are taken.

We will work with clinicians and patients to co-produce plans and services, working with or convening clinical or citizen groups where required.

Essex will become known as a leading region for working with the vibrant marketplace of Health and Social Care innovation.

New approaches will be welcomed, trialled and adopted. The Essex teams will work with neighbouring systems to ensure that the flow of information follows the flow of people.

How we will work to deliver the vision

Working across the different Health and Social Care organisations in Essex at the same time to improve technology will be hard, and careful prioritisation and management will be needed.

Initial focus and investment will go into a number of fundamental technology foundations, on which other solutions and changes ill be built. Teams will be set-up to deliver these changes that follow the approaches to technology that are successful in the private sector (e.g. agile).

These teams will have multiple skills and people, and an experimental mind-set that will quickly work out the best way of doing things. Where investments are made the teams will be held accountable to make sure that the expected benefits are delivered.
29.2 Our Current Position

As a result of the financial and operational challenges faced across the footprint, the development of technology and digital maturity has been variable and limited to single organisations. We have been without a wider strategic framework for digital for some time.

The system has recently completed a maturity matrix which identified a very low level of digital maturity across the system – including our approach to investment in digital infrastructure. The results of this assessment will help us to set our two and five year strategy for digital transformation which will establish our overarching strategy, resource requirements and our project pipeline. We expect to have the strategy finalised by Q1 2020 following a further evaluation of the technical landscape to be completed as part of Shared Care Record programme.

29.3 Digital Roadmap

The development of the revised digital roadmap in 2018 created a sense of direction and identified nine areas for digital developments

1. Shared Care record
2. Right information right time
3. Joined up hospitals and wider Health and Care Partnership
4. Data quality and standards
5. Staff digital collaboration
6. Patients and citizen collaboration
7. Mobile IT and identity that ‘just works’
8. Operational intelligence
9. Patient and citizen population intelligence

These were later distilled to three priorities for immediate attention:

// Integrated Shared Care Record
// Provider digitisation
// Population health data

The shared record agreement is the first Partnership-wide digital project to be initiated and has been the catalyst for more collaborative digital governance and planning at a system-wide level.

A detailed implementation plan is under development, with the expected implementation dates for the Shared Care Record as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme governance and plan</td>
<td>September 2019</td>
</tr>
<tr>
<td>Integration technical review and planning</td>
<td>January 2020</td>
</tr>
<tr>
<td>Health Info Exchange (HIE) connectors developed</td>
<td>February 2020</td>
</tr>
<tr>
<td>Data sharing agreements in place</td>
<td>February 2020</td>
</tr>
<tr>
<td>Local APIs developed</td>
<td>February 2020</td>
</tr>
<tr>
<td>Local Portal enhanced</td>
<td>March 2020</td>
</tr>
<tr>
<td>HIE links live</td>
<td>March 2020</td>
</tr>
</tbody>
</table>

It should be noted that this will be the very early stages of the programme to establish initial data sharing using technology already available; further developments and expansion will be required to realise the full vision of the Partnership. It is intended that the development of the Digital Delivery Strategy will further develop and inform these plans.

29.5 Provider digitalisation

The three acute trusts have a detailed digitalisation plan initially focused on technology linking across the three sites and wider partners.

The public consultation conducted in 2018 on acute service improvements, and the acute merger business case, all highlighted the need for technology to support the following ambition:

// Build stronger neighbourhoods to deliver a broader range of primary and community services
// Reduce the number of non-elective admissions into acute hospitals
// Reconfigure acute services
// Redesign clinical pathways to deliver improved outcomes
// Support corporate services transformation
// Support digital transformation in the wider health economy

To support these themes, the acute hospitals have adopted the following guiding principles as part of their “digital vision”:

// Rationalise, centralise, consolidate and standardise digital processes
// Remove physical boundaries
// Use of mobile, Wi-Fi, shared infrastructure
// Data capture and (cyber) security
In delivering the digital vision, the digital experience for both staff and patients should be much improved, this work will also underpin the Integrated Shared Care Record as information must be available electronically as a pre-requisite. Further information on mental health provider digital plans can be found in section 15.

Population Health
Further detail on our work on population health management can be found in section 35.

29.8 Region-wide Work – East Accord & the Local Health and Care Record (LHCR) Board
The East Accord, which is a collaboration of digital leaders from across the East of England region are working together to develop an information sharing environment that improves the lives of people in the East of England with the following agreed principles:

// Adopting standards that move towards intuitive and flexible technology that joins up effectively
// Designing safe, secure and useful ways of sharing information to build trust among our partners and people
// Demonstrating digital leadership, creating the conditions for genuine transformation
// Collaborating by default
// Acting as ambassadors and advocates of best practice

The Accord links closely with the Local Health & Care Record Board (LHCR). Both have focused on core activities that can be developed once and used across the region – this includes development of core data standards and a common approach to information governance and information sharing. The work will mature in during 2019/20 to support the formal development of a wave three LHCR application for transformation funding. This will be a multi-year, multi-million-pound accelerant to our local health and care record programmes,

Fundamentally the LHCR approach in the East is about progressing collectively so that:
1. Our residents and staff have easy access to relevant information
2. Our residents and staff are provided useful information
3. Information provides value to our residents, our staff and the wider public sector

We commit to the requirements identified in the LTP for Local Health and Care Records, with the following specific commitments identified:

// Protecting patient’s privacy and give them control over their record
// Ensuring that Patients’ Personal Health Records hold a care plan that incorporates information added by the patient themselves or their authorised carer
// Ensuring LHCR platforms provide open and free APIs for developers to create new solutions
// Moving care plans and Summary Care Record (SCR) to the individual’s local health and care record over the next 5 years
// Ensuring that, by 2024 LHCRs will cover the whole country

29.9 Digital Governance
We have established a Digital Board to oversee digital programmes in the broadest sense (health and care).

Through increasing collaborative working, based on shared objectives, our digital board is progressing and, through alignment with the LTR, our digital priorities are being developed. The governance for the Digital Board is given below:
29.10 Digital Deliverables

Below are the deliverables defined so far as part of the Partnership digital programme, these will be further developed and enhanced as the Digital Board develops and identifies its delivery strategy.

<table>
<thead>
<tr>
<th>Activity</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital strategy completed</td>
<td></td>
<td>Q1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Care record</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stage 1 complete</td>
<td>Q4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Care record</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stage 2 complete</td>
<td>Q3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital Maturity Assessment</td>
<td></td>
<td>Q3</td>
<td>Q1 &amp; Q4</td>
<td>Q2 &amp; Q3</td>
</tr>
<tr>
<td>- Ongoing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Digital Landscape</td>
<td></td>
<td>Q1</td>
<td>Q1 &amp; Q4</td>
<td>Q2 &amp; Q3</td>
</tr>
<tr>
<td>LHCR Governance &amp; Engagement established</td>
<td></td>
<td>Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Digitisation to support acute hospital merger</td>
<td></td>
<td>Q4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See also the Primary Care Digital Transformation in section 11.3

30. Estates

Clinical Lead: Various, depending on specific programme.
Senior Responsible Owner: Kerry Harding, Director of Estates, Mid & South Essex CCGs

Our first system-wide estates checkpoint with NHS England/Improvement was completed with full input from local authorities, providers, and commissioners. We will now produce a full system-wide estates strategy, incorporating individual estates strategies from across partners, ensuring we are able to see clear linkages between them and identify how, as a combined ambition, our estate will facilitate new models of care, best value for money and improved patient outcomes.

We are using our clinical strategy to drive forward estates provision. We have developed a clear governance structure for estates, which has the mid and south Essex Estates Forum at its heart. This forum is attended by representatives across the system including public health and One Public Estate (OPE), as well as digital and workforce leads. The forum is the vehicle for sharing information about proposed and live projects, providing a clear understanding of the work that is being developed across the system and giving the opportunity for projects to evolve to include wider system input. The objective to working in this way is to reduce duplication, promote shared use of buildings and joint projects, and ensure that we look to use current public assets before building new, maximising value for money and sustainability.

The pipeline of estates projects has been developed from the forum and is updated as a live document by all participants. This provides an overview of estates projects either current or identified within individual strategies as requirement for the next 15 years. This transparency has supported the development of joint projects to reduce the overall capital and revenue implications, whilst at the same time supporting new models of care. The information within the pipeline also forms the basis of individual Infrastructure Delivery Plans to support local authority Local Development Plans.

We have developed a robust prioritisation process to enable us, as partners, to consider estates developments in the round and ensure that priority is given to projects that will support the overall aims and priorities of the Partnership.

We are taking an innovative approach to utilise funding streams to address some of our fundamental challenges – such as negotiating S106/CIL funding to support digital/IT initiatives and to cover one-off recruitment costs. We are also currently exploring the possibility of securing funds to pay off university fees for newly qualified clinical staff to support recruitment and retention across the system, so that we can encourage clinical staff to stay in mid and south Essex and develop their careers. We are also utilising traditional S106 capital contributions to new builds to offset future revenue implications.
Our estates plan supports our operating model as follows:

- Increase the availability of services outside of the acute hospital setting
- Develop sustainable and resilient primary care based around 28 PCNs and extend primary care access by:
  - increased operating hours and seven day working to improve access and maximise estate utilisation
  - expanded the range of providers (additional professional groups) working in general practice
  - offer improved access to ‘alternative’ community-based provider services – e.g. MSK, pharmacy, third sector, dental services.
- Integrate primary, community, out of hospital and social care services within neighbourhoods to provide more care closer to where people live
- Place a greater emphasis on prevention and encouraging people to take more responsibility for their own health and wellbeing to include increase in social prescribing
- Support the reconfiguration of mental health inpatient estate to remove dormitories
- Support the digital strategy including developing systems to provide the option for every patient to access digital GP consultations by 2024
- Continued liaison with public health colleagues to deliver and implement objectives to ensure that preventative care is available to the population and that planning policy reflects our agenda to encourage our communities to live well and take greater responsibility for their own health and wellbeing
- Ensure every Place has adequate and appropriate provision, based on its demographic and need, of the following services:
  - Screening and diagnostics
  - Diabetes prevention, treatment and management
  - Treatment and management of respiratory conditions
  - Children’s health services
  - Learning disability and autism services
  - Mental health services for children and adults
  - Healthy ageing services
  - Maternity services

31. Innovation

We have an extensive programme of innovation activity, supporting local innovators and entrepreneurs, helping adopt approved innovations developed externally, and matching local transformation and improvement needs to new models of care.

Our Partnership-wide Innovation Advisory Group is chaired by Professor Tony Young, a consultant urological surgeon from Southend Hospital, and Chair and Director of Medical Innovation at Anglia Ruskin University. Professor Young also leads the NHS Clinical Entrepreneurs Programme and is the National Clinical Lead for innovation at NHS England.

Our innovation programme includes:

- The MSE Innovation Fellowship for local staff members and NHS Clinical Entrepreneurs to receive mentorship, training and support to take forward ideas under the themes of workforce improvement or enhancing patient safety. The scheme will have its second intake in October 2019, and includes mentors from across primary, community and acute sectors.
- Developing local products which meet local needs, such as SMART mortality reporting and quality improvement tool, and the development of the Maternity Direct secure chat service.
- A range of innovation challenges for local staff, as well as support for budding ideas through Health Enterprise East and Invest Essex, with the clinical check and challenge via the Clinical Cabinet.
- Providing direct advice to members of staff with innovative ideas, their development and adoption, with the first dedicated Innovation Programme Manager appointed in November 2018, further expansion of the support team planned in late 2019.
- Promoting and signposting staff to innovation opportunities including new proven products, processes and care pathways, working with Academic Health Science Networks and connecting staff to successful innovators in other provider organisations and signposting staff to regional and national innovation competitions eg. Health Enterprise East’s MedTech Accelerator, national Life Sciences Innovation Fund and recent bids from radiology and stroke services.
- We continue to act as a partner in the NHS England Clinical Entrepreneur programme, now entering a fourth year. This programme has provided selected clinical entrepreneurs with honorary contracts with partnership organisations, to provide them with a real world test-bed site to help develop their innovations.
- We have developed a Ways of Working agreement with the wider health care industry, agreed in March 2019, to help support innovation and bring in additional resources for transformational improvement locally. This has been recognised as national good practice by the AHSN Network and ABPI.
32. Research

Partner organisations are active members of the NIHR Clinical Research Network for North Thames, one of the best recruiting networks in the country.

The merger of our acute providers in April 2020 will improve set up and facilitate recruitment to research studies across a combined patient population of 1.2m. This will attract commercial research activity and associated financial benefits. Research active clinical staff will be able to recruit patients to research studies from whichever site they are working and patients will have an equal opportunity to participate. This increases the research opportunity for patients, increases income to the trusts and encourages recruitment and retention of high calibre research staff.

As founding partners in the UCLPartners Applied Research Collaborative (ARC) we have helped to inform the areas of focus within the ARC. Through the hospitals’ Strategy Unit and the Clinical Cabinet, we will ensure relevant findings are tested and disseminated, as well as having the opportunity to influence the portfolio to support population health.

33. Clinical Leadership

Ensuring the safety and quality of our services is core to our work. It is important that our clinicians and professionals working across the system drive our transformation plans and have confidence in them.

The Clinical Cabinet is a forum of senior clinical representatives from across the system. The Clinical Cabinet oversees and reviews clinical pathway changes that are being considered across the system, ensuring that changes have clinical and professional buy-in and maintain the golden thread of delivering the highest standards of quality and safety.

The Cabinet is multi-disciplinary in nature and comprises senior nurses, GPs, consultants, allied health professionals (including therapists, pharmacists, and paramedics), from across the system who are involved in delivering health and care services to the population. In recognising the critical role that allied health professionals play in delivering health and care services, we will be establishing a Partnership AHP Council in the coming months. The Council will provide an important focal point for developing new models of integrated care.

The cabinet played a critical role in developing options for acute hospital service change, and crucially offered local “check and challenge” to the proposed changes that were later supported by the East of England Clinical Senate and the CCG Joint Committee. It continues to play a role in supporting the implementation of acute hospital service improvements.

Each of our clinical programmes (diabetes, stroke, mental health, maternity, cardiovascular etc) has a designated clinical lead, and each programme feeds into the Clinical Cabinet to provide the clinical “check and challenge” of plans as they develop.

As we move to the next phase of our development - Integrated Care System designation - the cabinet will be considering its future composition in order to ensure broad clinical and non-clinical, professional representation, including Clinical Directors of our Primary Care Networks.
34. Approach to Quality & Safety

The programme of transformation across mid and south Essex presents clear opportunities for health and social care organisations to work together to address current quality challenges. We recognise that each organisation has its own statutory duties in relation to ensuring the quality and safety of services.

Our approach does not seek to replace these duties, rather it aims to deliver:

// A streamlined and efficient approach to quality measurement and monitoring
// Opportunities to increase the voice of patients/residents in defining, measuring and evaluating the quality of services
// A better understanding of quality variation across integrated pathways, rather than looking at quality in silos
// The structure, process and guidance needed by teams working on new models of care to ensure regulatory compliance
// Better use of data, including the effective triangulation of multiple sources of data and quality surveillance that focuses on early warning and prevention rather than multiple investigations after the event
// Agreement on the approach to defining, measuring and monitoring quality which will be required under new contractual arrangements.

Clear quality and health inequality impact assessments are undertaken for all change and transformation programmes.

35. Population Health Management & Prevention

Our approach to population health management and prevention is to make better use of the wealth of data that partners in the system collect and to use this intelligently to understand our population and plan/target interventions appropriately. Collecting, collating and analysing data can be achieved at system level, enabling the targeting of interventions locally where these have most impact.

Population health management will:

// Support front line teams to design and deliver care and support to meet individual needs.
// Enable our PCNs to work with local partners to deliver personalised care
// Support NHS and local authority commissioners to better predict need and design services to meet needs more appropriately.

Capabilities for Population Health Management

There are three core capabilities required for an impactful population health management programme:

// Infrastructure – the basic building blocks including a defined population, digitalised providers and linked records, digital infrastructure and information governance processes
// Intelligence – building the capacity and capability within the system to support analytical requirements and provide system-wide insight. Using this intelligence to make best impact and report on progress for the system.
// Interventions – using proactive clinical and non-clinical interventions to prevent ill-health, reduce risk and address inequalities. This will support us to realign our workforce, target assistive technologies and digital tools to support patients and being able to use information to build aligned incentives.

We are developing our system-wide Population Health Management & Prevention Strategy and this will be approved by the Partnership Board in December 2019.

Our strategy uses the framework of the 3 core competencies, with key priorities within each. We will use specific areas/conditions to test and learn our approach.
36. Building our Integrated Care System

36.1 Existing system governance arrangements

At present, the Mid and South Essex Health and Care Partnership Board comprises chief executives of provider organisations, accountable officers from the CCGs, lead officers from the three local authorities and a number of representatives from advisory groups and partner organisations. The Board has no decision-making authority as this resides within individual organisations. An overview of current governance and key programmes is given below:

We are working with colleagues across the region to develop our approach and ensure we make best use of resources.

Population Health Approach in Action

The strategy unit of MSE University Hospitals Group is working with partners in south east Essex to combine CCG and hospital data to understand more about the south east population by looking from both perspectives at demand. We are focusing on respiratory (specifically COPD) as a proof of concept to build up an understanding of the pathway of patients with COPD prior to an admission to hospital, and identify the significant factors that drive admission. In doing this we hope to understand more about the needs of the population and how to respond more preventatively to these to avoid escalation of COPD in the future where possible. All data will be presented at a locality level.

By combining data from multiple sources we can begin to develop predictive models, allowing us to predict hospital admission beforehand and understand when and how to intervene. There are limitations to these models, largely based on data availability, rules regarding sharing, and also some topics do not lend themselves as easily to prediction, so this is part of our exploration. By doing this we can start to use data more intelligently as a predictive tool that allows us to focus on prevention rather than reacting to growing demand. The technique may also help us to support patients effectively to reduce escalation of conditions by focusing on preventative action in a more targeted way.

It is an immediate priority of the newly appointed independent chair to review the governance and delivery structure for the Board to enable development to an Integrated Care System.
36.2 ICS development plan
In line with LTP requirements, partners are committed to the Mid and South Essex Health & Care Partnership achieving Integrated Care System designation by April 2021. We will draw upon learning and published research to ensure that we use experiences from other systems who are further along this journey.

36.3 Benefits of ICS Designation
We believe that achieving ICS designation will provide the following benefits:

- Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them.
- Support system partners to collaborate and to take decisions together.
- Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure.
- Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area.
- Enable a collaborative approach to improving our performance and outcomes against national standards, demonstrating real impact for our population.
- Commission against consistent standards and outcome measures, rather than traditional methods of commissioning and contracting.
- Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a “system” ethos.
- Safely and securely share information and records across the NHS and local authority partners – and use the vast quantity of data we have to effectively target resources and interventions.
- Reduce waste, duplication of effort and resource to unlock efficiencies.
- Streamline decision-making and governance processes.
- Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery.
- Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.

36.4 Our plan to achieve ICS designation
In July 2018, we undertook a self-assessment against a number of criteria set out by NHSE/I. Through this self-assessment, we identified that our key areas for development were:

- Our relationships with and between wider system partners, particularly our Health and Wellbeing Boards and Integrated Care Partnerships at Place level as these develop.
- Our leadership – to ensure streamlined decision-making and closer collaboration of partners.
- Our commissioning approach – with the streamlining of NHS commissioning functions under the direction of a single accountable officer and executive team for the five CCGs in mid and south Essex.
- Our governance – to ensure that decisions are taken at the right level, by the right partners, to support good governance and stewardship of public money, while also supporting the integration and collaboration of services in an “organisationally agnostic” manner.
- Our methods of ensuring a strong user “voice” in local plans, and ensuring that insight gained from local co-production and engagement work is used at system level.
- The need to progress to a population health based system that encourages partnership working for a defined population, has access to, and uses population-level data to understand needs, focusing on prevention and the wider determinants of health.
- Developing an outcomes focussed approach in everything we do.
- Our ability to self-regulate – particularly on matters of operational performance and sustainability – ensuring we can hold ourselves to account for the performance of our system and that we take the appropriate steps to ensure sustainability of our services.
- Our financial strength – both to ensure our plans support bringing the system into financial balance, and also to ensure we have robust and aligned mechanisms to take decisions about public money at a system level, where appropriate.
- The efficiency of our work – reducing duplication and consolidating “back office” functions to support the system.
- Defining the transformation resource requirements, ensuring we have the right resources in place to deliver on our transformation plans.
36.5 System architecture & leadership

At present, partners operate in a complex system and this creates challenges for effective and streamlined decision-making. There will be, however, significant change to our current system architecture that will help to simplify the system:

- In April 2020, our three hospitals will merge, creating a single organisation with a consolidated clinical strategy. This will streamline functions and decision-making across the hospital group and release significant efficiencies which will be reinvested in our new operational model.
- Early in 2020, our five CCGs will appoint a single accountable officer to operate across the five organisations.
- It is our intention for this joint accountable officer to also be the lead executive for the Health & Care Partnership.
- All five CCG Governing Bodies have agreed to commence work on a merger application to be made in September 2020. This will be subject to wide stakeholder engagement in the coming months, particularly with member practices.

36.6 Developing our approach to strategic commissioning

Effective commissioning at the right level across the ICS will be vital to create an environment in which our system is focused on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.

This will require significant changes to the way in which we commission services, involving co-design with our communities and a much greater focus on prevention and population health. Statutory commissioning organisations will need to work differently with providers in order to have maximum influence on the health and wellbeing of our population. We must better involve community and voluntary sector organisations and develop asset-based and outcomes-focussed commissioning frameworks. We also need to ensure that we commission at the most appropriate level across the system.

As described above, our CCGs will have a single accountable officer and executive team – and will be required to deliver 20% savings on running costs. The single AO will also be the executive lead for the ICS and will play a significant role in supporting the Independent Chair to deliver the agreed ICS objectives and build relationships with internal and external stakeholders. The AO will also play a key role in the development of our four Integrated Care Partnerships, supporting them to ensure effective local delivery.

Early in 2020 we will appoint the Joint Accountable Officer and Health and Care Partnership/ICS Executive Lead. During 2020/21 they will:

- Consider the resource required to support ICS development. Their priority will be to ensure capacity to support system moving forward by refocussing resource currently within five CCGs to a system-wide purpose.
- Appoint to the joint executive team for the CCGs.
- Prepare an application for CCG merger in September 2020, which will be subject to agreement by CCG Governing Bodies and approval by NHS England. If approved, CCGs will merge in April 2021.
- Continue to operate with 5 CCGs, but as an interim measure towards greater collaborative working, consider whether the current CCG Joint Committee arrangements can be expanded to enable more decisions to be made once across the system.
- Develop a plan for the movement of delegated commissioning so that by April 2021, the five CCGs have taken on this function. While there are no current plans to take on commissioning of pharmacy, optometry and dentistry services, we will continue to work in close partnership with NHSE/I to ensure we are obtaining maximum impact from these services for our populations at neighbourhood and place level.
- In line with strategic commissioning plans, continue to work in partnership with NHS Specialised Commissioning with the longer-term aim to be more involved in the commissioning of specialised services provided across mid and south Essex. Some work has already started, for example, in relation to mental health provider collaboration.
- Continue to work with Specialised Commissioning on health and justice commissioning, particularly on pathways into and out of detention and links with children and young people’s mental health.

36.7 System performance oversight and intervention

As we become an Integrated Care System, we will need to develop our approach to self-assurance and regulation against national standards. Our Health and Wellbeing Boards will play a role in holding the ICS and our Places to account for delivery of our plans and our ability to positively impact outcomes for our population.

Health Overview and Scrutiny Committee (HOSC) functions continue to play an important role their statutory role in scrutinising major service change. Where changes span the three local authorities, a Joint HOSC will be formed.
36.8 ICS financial framework

The NHS has set control totals for organisations within the system. Partners are collectively responsible for meeting the allocated total and are plans are geared towards achieving this.

Our finance leaders are developing a financial framework for our ICS, which will require strong leadership and an approach to system-wide understanding and management of financial risk. The framework will also identify a system-wide approach to managing investment decisions, with priorities agreed by the Partnership Board.

We expect this framework to be in place by the end of Q4 2019/20, with regular reports to the Partnership Board.

36.9 On-going engagement with partners, public and patients

Understanding the views of our population will help us to explore ideas such as the smarter use of technology, providing care in different settings closer to home and support the Partnership to seek ways to reduce health inequalities. Feedback is important to ensure we have taken into consideration the needs and expectations of as many of our partner organisations and our local population as possible.

We will want to hear the views of and work with our staff, patients, and communities and have set as one of our design principles the commitment to use the insight gained from our engagement work to inform what we do.

We have embarked on work to co-design our engagement strategy through a series of Engaging our Communities workshops.

Through this work we are talking to and working with service users, voluntary and community sector colleagues, our Healthwatch organisations, charitable and support groups, youth councils and engagement professionals working in our system.

These conversations and workshops aim to develop an overarching engagement framework which sets out the opportunities at neighbourhood, place and system for involvement and community engagement and where appropriate to be more formally consulted about proposals for change. At system level we will seek to build on existing good practice, avoid duplication and add value to ensure the voice of local people is recognised. The framework will seek to demonstrate that different approaches will be needed taking into account the types of changes, but also recognise that we need to widen the scope of input across our population and offer varying methods of engagement.

Our work to develop a system wide citizens’ panel, called Virtual Views, is part of this work and will help to seek and understand the opinions of a demographically representative, statistically significant sample of mid and south Essex residents.

We also want to go further and ensure co-production and co-design defines the way we work as a Partnership across all our levels.

Co-production supports the basis of our five year strategy by helping seek the solutions to keeping people well together, and by ensuring our services truly reflect the needs of local people.

To achieve this we will learn from the work already underway particularly in our local authorities through Asset Based Community Development (ABCD). This approach is based on the premise that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognised assets.

We will also seek to support our teams and residents through offering development sessions and training to ensure over time this becomes our norm.
### 36.10 ICS Development timeline:

<table>
<thead>
<tr>
<th>Activity</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
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<tbody>
<tr>
<td>LEADERSHIP</td>
<td></td>
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</tr>
<tr>
<td>Appointment of Independent Chair</td>
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<td></td>
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<tr>
<td>Central resource infrastructure agreed</td>
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<tr>
<td>Review of clinical and professional leadership</td>
<td></td>
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<td></td>
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<tr>
<td>Implement new model for clinical and professional leadership</td>
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<tr>
<td>RELATIONSHIPS &amp; GOVERNANCE</td>
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<tr>
<td>Secure resources to support for system governance review</td>
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<tr>
<td>Review of governance arrangements at system level to include decision-making, accountability, self-regulation.</td>
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<tr>
<td>Agree relationships between “place” and “system” to enable places to deliver</td>
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<tr>
<td>Test governance arrangements with stakeholders</td>
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<tr>
<td>Agree framework for service user input</td>
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<tr>
<td>Implement Citizen’s Panel</td>
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<table>
<thead>
<tr>
<th>Activity</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
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<tbody>
<tr>
<td>FINANCIAL MATURITY</td>
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<tr>
<td>Agreement of 5 year control totals</td>
<td>✓</td>
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<tr>
<td>Review of finance oversight arrangements (NHS)</td>
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<tr>
<td>Test and agree finance oversight arrangements with regulators</td>
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<tr>
<td>Delivery of agreed financial recovery plans</td>
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<tr>
<td>SELF-REGULATION – QUALITY, SAFETY &amp; OPERATIONAL PERFORMANCE</td>
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<tr>
<td>Agree system-wide objectives with regulators (care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance)</td>
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<tr>
<td>Run assurance processes in shadow form (with regulators)</td>
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<tr>
<td>Evaluate self-regulation approach and agree future arrangements with regulators</td>
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| PROVIDER DEVELOPMENTS | | | |
| Acute trust merger | | | |
| Mental health provider collaborative (new care models) | | | |
| GPs/PCNs deliver new service specifications | | | |
37. Arrangements for Ensuring Delivery

This section sets out the practical steps needed to deliver our five Year Strategy and LTP commitments. It includes programme resources, governance, risk management.

37.1 Programme management and resources

The Partnership will implement a robust programme management and governance structure which ensures accountability through clear allocation of roles and responsibilities, and provides assurance through regular reporting, enabling quick identification and addressing any issues as they arise.

37.2 Governance Structure

In order to deliver the requirements of the LTP and achieve ICS designation, detailed work will be undertaken on our governance structure at system level, and our governance arrangements between system and “place”. This will include a review of the current Partnership Board, work programmes and advisory mechanisms.

37.3 Programme roles and responsibilities

An executive delivery group has been established, chaired by the Programme Director. Its membership includes the executive lead for each current work stream to ensure that colleagues are aware of developments. The programme meetings occur bi-monthly and the outcome, in the form of programme overview plans are submitted to the Partnership Board for information.

Once governance arrangements are agreed, we will review existing Executive Delivery Group arrangements to ensure that agreed priority programme achieve their objectives in full and on time.

37.4 Approach to risk management

The Partnership approach to risk management is designed to ensure that the risks and issues are identified, assessed, and mitigation plans developed in a risk management plan. All risks will have a responsible owner identified.

Each specific programme has its own risk log and items elevated to Partnership level are those significant risks that require partners to address together.
The overarching risk management policy is based on an iterative process of:

- Identifying and prioritising the risks to the achievement of the programme aims and objectives;
- Evaluating the likelihood of those risks being realised and the impact should they be realised;
- Managing the risks efficiently, effectively and economically.

The key risks for the Partnership are as follows:

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners do not agree the core vision for the Partnership</td>
<td>Partnership Board clarifies and agrees the core vision for the Partnership.</td>
</tr>
<tr>
<td>The system does not manage demand for services effectively</td>
<td>Focus on prevention and wider determinants of health – work to agreed outcomes framework to monitor progress, Aligned plans across partners to reduce avoidable admissions, improve performances and reduce length of stay. Teams aligned to PCNs to ensure community capacity to meet demand.</td>
</tr>
<tr>
<td>Failure to attract and retain an appropriately skilled health and care workforce.</td>
<td>Address workforce needs by developing new roles, and career opportunities for current staff. Work with partners to address eg housing and education needs. Exploit partner organisations as Anchors programme – seek to raise educational attainment and aspiration and attract staff to public sector roles.</td>
</tr>
<tr>
<td>Financial risks are not managed appropriately</td>
<td>System finance leaders developing ICS financial framework which will describe how control totals and risk will be managed collectively. Partners support resolving system challenges together.</td>
</tr>
<tr>
<td>System governance does not provide for effective transparency and accountability to the public</td>
<td>Develop system governance framework with openness and transparency at the center. Publish information about allocation of resources and expected outcomes.</td>
</tr>
<tr>
<td>Access to treatment (including cancer, elective care and emergency care) is below standard and does not provide good care for our residents</td>
<td>Integrated programme agreed to tackle prevention, early intervention and diagnosis, waiting times for treatment and support post-treatment. All partners in the system are involved and engaged.</td>
</tr>
</tbody>
</table>

The Programme Office maintains the Risk Register for the Programme. Project risk registers are maintained by the project manager/work stream leads and risks escalated where necessary via reporting.
Appendices

1. Mid & South Essex Health & Care Partnership Profile
2. NHS Long Term Plan Engagement; report of Thurrock Healthwatch
3. Mid & South Essex Outcomes Framework (draft)
4. Mid & South Essex Workforce Plans
5. Mid & South Essex NHS Finance Plans
6. Mid & South Essex Cancer Transformation Plan
7. Mid & South Essex Mental Health Plans
8. Mid & South Essex Local Maternity Services
9. Mid & South Essex NHS Estates Strategy

Glossary of Terms

#

111 The NHS 111 service is a free-to-call, non-emergency medical helpline, available 24 hours a day, to be used for health information, advice and access to urgent care.

A

A&E Accident and emergency

Academic Health Science Network (AHSN) Created by NHS England to work with local health and care systems to select, encourage, develop and deliver innovative solutions that improve patient care and aid economic growth across our region

Acute care health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or recovery from surgery

Acute medical unit The first point of entry into hospital for patients who have been referred as emergencies by their GP or who require admission from the A&E department.

Advanced Nurse Practitioner (ANP) The role includes assessing the patient, making differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

Agenda for Change The main pay system for staff in the NHS, except doctors, dentists and senior managers. Abbreviated to AfC and also know as NHS Terms and Conditions of Service

Allied Health Professionals (AHPs) AHPs is an umbrella term for therapists, chiropodists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists, psychologists, psychotherapists, radiographers, and speech and language therapists among others.

B

BAME Black and minority ethic

Better Births policy to improve maternity provision and services

Better Care Fund (BCF) A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

C

CAMHS Child and Adolescent Mental Health Services

Care Quality Commission the body which regulates health and care services in England to ensure they are safe, effective, compassionate and well led.

CIC community interest company with the objective of benefiting society rather than financial gain

Clinical Commissioning Group (CCG) Clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.
Commissioning The process of planning, agreeing and monitoring services. Commissioning of health services can take place at the local level by CCGs, or at a nation-wide level by NHS England. Local authorities also commission social care.

Co-morbidity Co-morbidity is the simultaneous presence of two or more health conditions or diseases in the same patient.

Continuing Healthcare NHS continuing healthcare is health and social care outside of hospital that is arranged and funded by the NHS. It is available for people who need ongoing healthcare and is sometimes called fully funded NHS care.

Consultation Public bodies have a duty to consult people when changing commissioned services. The decision to consult is usually triggered when there is a legal requirement to do so and this depends upon the level of service change.

COPD Chronic obstructive pulmonary disease

Co-production Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Fundamentally, co-production recognises that people who use services (and their families) have knowledge and experience that can be used to improve services. The Social Care Institute for Excellence describes co-production as “people who use services and carers working in equal partnerships with professionals toward shared goals.”

D

DASS Director of Adult Social Services

Deprivation lack of the basic resources considered necessary for well being

DHSC the government’s Department of Health and Social Care

Discharge to Assess Short term funded support to enable discharge from hospital, whilst still requiring some level of care

DPH Director of Public Health

Domiciliary Care Worker A domiciliary care worker is someone who visits a person’s home to help them with general household tasks, personal care or any other activity that allows them to maintain their independence and quality of life at home.

E

Elective care Treatment that is scheduled in advance as it does not involve a medical emergency.

Enabler A person or system that makes something possible. In the NHS enablers are the systems and processes that help achieve change and improvement.

End of Life Care care provided in the last months or weeks of life to provide relief and support prior to death

Engagement a term commonly associated with many forms of patient, service user or public involvement. It describes processes, both formal and informal, through which commissioners may invite local communities to become involved in discussion about the shape of their local services.

Equity Impact Assessment (EIA) A process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

Estates Strategy Supports the delivery of the system’s overall strategy and vision for estates.

FIT Bowel Cancer screening The faecal immunochemical test (FIT) is an improved screening test that detects hidden traces of blood that could indicate bowel cancer or pre-cancerous growths known as polyps.

Frailty a collection of symptoms including weakness as a result of being older

G

Global Digital Exemplar An internationally recognised NHS provider delivering improvements in care quality through world-class digital technologies and information.

General Medical Council (GMC) The GMC works to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

General Medical Services Contract (GMS) The GMS contract is the contract between general practices and the NHS for delivering primary care services to local communities. It is a nationally negotiated contract that sets the core range of services provided by family doctors (GPs), their staff and a national tariff.

Governance The way that organisations ensure they run themselves efficiently and effectively, and the way organisations are open and accountable to the people they serve for the work they do.

GP general practitioner

H

Health and Wellbeing Board a statutory formal committee of the local authority that promotes greater integration and partnership between bodies from the NHS, public health and local government. It produces a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Health Education England Health Education England is an executive non-departmental public body which provides national leadership and coordinates education and training within the health and public health workforce within England.

Health inequalities Differences in health status between different population groups, or in the personal, social, economic, and environmental factors that influence health status.

Health Overview and Scrutiny Committee (HOSC) Reviews and scrutinises matters relating to the planning, provision and operation of local health services. A Joint Health Scrutiny Committee oversees matters that span the Mid & South Essex Health and Care Partnership.

Healthwatch Local organisations which listen to the needs, experiences and concerns of people who use health and social care services to make sure that service commissioners and providers put people at the heart of care. Healthwatch Thurrock, Healthwatch Southend and Healthwatch Essex work across mid and south Essex.
I

IAPT Improving Access to Psychological Therapies A service providing evidence-based treatments for people with anxiety and depression.

Inpatient resident attending hospital who is required to stay in overnight or more to receive treatment or care.

Integrated Care System (ICS) A partnership of NHS organisations, local councils, the voluntary sector and others in a geographical area, who take collective responsibility for managing resources, standards, and improving the health of the population they serve.

Joint Strategic Needs Assessment (JSNA) This looks at the current and future health and care needs of local populations to inform and guide the planning and social care services within a local authority area.

K

Learning from Deaths Review (LeDeR) National programme to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

LOS: Length of stay – The time a patient will spend in hospital.

Local Medical Committee (LMC) represent the interests of NHS general practitioners in a defined location.

Local Pharmaceutical Committee (LPC) represent the interests of NHS pharmacists in a defined location.

Local Workforce Action Board (LWAB) Support Health and Care Partnerships across a broad range workforce and HR activity, and the local delivery of the Health Education England Mandate and other key workforce priorities in line with national policies.

Long Term Condition a condition that cannot be cured; but can be controlled by medication and other therapies such as diabetes.

M

Magnetic resonance imaging (MRI) An imaging technique that uses powerful magnetic fields and radio waves to provide detailed cross-sectional or three-dimensional images of the body.

Model of Care A model of care is the overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and defined standards which broadly define the way health services are delivered.

Mortality Rate Mortality rate, or death rate, is the rate of actual deaths to expected deaths.

Multi-disciplinary team A team of professionals from one or more disciplines, which can include social care as well as health, who together make decisions regarding recommended treatment of individual patients. Such teams may be organised for a specific condition, e.g. cancer, or in a specific setting, e.g. a hospital.

MyCOPD An app helps people with COPD (chronic obstructive pulmonary disease) to better manage their condition.

MyDiabetes An app that helps people with diabetes to better manage their condition.

N

National Institute for Health and Care Excellence (NICE) Evidence-based guidance for clinicians, commissioners and providers of health and care.

Neighbourhood integrated care across a range of services around populations of between 30,000 and 50,000. These services typically include general practices, community teams, some mental health services and adult social care.

NHS England/Improvement (NHSE/I) Sets the priorities and direction of the NHS in England, and encourages and informs the national debate to improve health and care. It commissions some NHS services directly, and delegates authority to CCGs to commission other services.

NHS Long Term Plan The plan for the transformation of NHS services in England over the next 10 years, to improve quality of care and the health outcomes of the population.

NMC The Nursing and Midwifery Council. A regulatory body that maintains a register of nurses, midwives and health visitors.

O

Outcome the result of treatment, surgery or support from health and care services.

Out of hospital care A form of care that is available outside of major hospitals, often referred to as primary and community care. ‘Primary care’ is the advice and treatment you receive from your local GP.

Outpatient resident attending a planned hospital appointment for treatment or care but not staying overnight.

P

Pathways A patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre until the patient leaves.

Personal Health Budget (PHB) An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioner. It is a different way of spending health funding to meet the needs of an individual, and gives the individual greater choice and control over their care.

Personalisation Shifting the culture and practice of care so that services are better coordinated and centred around the individual.

Perinatal status immediately following the birth of a child.


Population health management Collection and analysis of data on patients and the public, to help improve planning and management of health and care services in the local system.
Prenatal stage of pregnancy before giving birth of a child

**Primary care** Primarily GP practices, but also includes community pharmacists, dentists and opticians.

**Primary Care Networks (PCN)** Groups of GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas.

**Providers** Acute, ambulance, community and mental health services that treat patients and service users in the NHS; social care providers including local authorities, care homes and home care organisations; and community and voluntary organisations.

**Public Health** Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.

**Quality, Innovation, Productivity and Prevention (QIPP)** transformation programme for the NHS, involving all NHS staff, clinicians, and the voluntary sector aimed at improving the quality of care the

**Quality and Outcomes Framework (QOF)** Indicators of the overall achievement of a GP practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points.

**Re-ablement** Services to maximise people's long-term independence, choice and quality of life, while at the same time attempting to minimise the need for ongoing support.

**Reconfiguration** Changing the arrangement, structure or model of organisations or services.

**Referral to Treatment (RTT)** The framework for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently.

**Residential Care** Residential care refers to long-term care provided to adults or children in a residential setting rather than their own homes. Some residential settings are designed to meet a specific care need e.g. those living with dementia or a terminal illness.

**Rightcare** NHS programme to improve spend and outcomes in care, by diagnosing the issues and using evidence to identify opportunities for improvement, developing solutions and delivering improvements for patients, populations and systems.

**Risk stratification** Identifying patients who are at high risk of an adverse event so that they can be offered preventive care and support to avoid health problems.

**Secondary care** Either planned (elective) care such as surgery or an operation, or urgent and emergency care provided by a hospital.

**Self care or self management** All the actions taken by people to recognise, treat and manage their own health, either independently or in partnership with the healthcare system.

**Skills for Health** Skills for Health provide workforce solutions designed to improve healthcare, raise quality and improve productivity and financial performance. Skills for Health is a not-for-profit organisation for the whole UK health sector.

**Slope Index of Inequality (SII)** A measure of the difference in life expectancy between the most and least deprived sections of the local population.

**Social Care** Social care is the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

**Social Prescribing** Social prescribing is a means of referring patients to a range of local, non-clinical services which are typically planned and delivered by voluntary and community sector organisations.

**Sustainability and Transformation Partnership (Health and Care Partnership)** Created in 2016, to bring local health and care leaders together to plan around the long-term needs of local communities. England is divided into 44 Health and Care Partnerships, including our area, mid & south Essex.

**System** unified health and care commissioners and providers operating to deliver what cannot be achieved in neighbourhoods and places, to improve and transform care, to provide oversight and accountability at ICS level.

**T&O** Trauma and orthopaedic. Covers injuries and conditions relating to bones, joints, ligaments, tendons, muscles and nerves

**Tertiary care** Treatment given in a regional hospital that provides highly specialised care, for example in cardiac surgery or cancer care.

**Third sector** The third sector encompasses the full range of non-public, not-for-profit organisations that are non-governmental and ‘value driven’, that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

**Urgent and emergency care (UEC)** Services the NHS provides if you need urgent or emergency medical help

**VCS** Voluntary and Community Sector

**WTE** Whole time equivalent: A way to measure an employees' hours of work for example 1WTE equals a person working full time hours
Call 01268 594534 or email btu-tr.midsouthessexstp@nhs.net

Mid and South Essex Health and Care Partnership
c/o Basildon Brentwood CCG,
Phoenix Court, Christopher Martin Road,
Basildon, Essex SS14 3HG

Working together for better lives
Our 5 Year Plan for Improving Health and Care

Mid and South Essex Health and Care Partnership

DRAFT

Working together for better lives
Introduction

The way we live and the lifestyles we lead have changed a great deal over the years.

Our population is growing, new technology is being developed and research into the things that affect our health and wellbeing is providing new answers.

We are living longer, but not all of those extra years are spent in good health and some of our communities experience significantly poorer health than others. Our health and care staff are also under a great deal of pressure coping with increased demand for our services.

All of this means that the support and help we sometimes need to lead a happy and healthy life must change and adapt too.

We want our residents to have a good quality of life, from education and employment opportunities, to making better choices about being active and what they eat.

So we are changing the way we work together and our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

It also explains our how locally we will deliver the commitments set out in the national NHS Long Term plan (www.longtermplan.nhs.uk)

But our plan isn’t just about the NHS because we need to think wider than that. We have linked up with our local councils and social care teams, look at housing, our environment and air quality as well as how we can prevent poor health in to first place.
Our Partnership

Our five year plan has been written by the Mid and South Essex Health and Care Partnership, which brings together all of the health and care organisations working to support healthier communities in our area.

Our Partnership includes local GP practices, our hospitals, community care, social services and mental health teams.

Together we are committed to finding lasting solutions to the common challenges that can prevent us from delivering the best possible care and support services to the 1.2 million people who live in mid and south Essex.

This document is a summary of our plans over the next five years and the full document is available to read on our Partnership website.

You can find out more about us and our plans at www.msehealthandcarepartnership.co.uk
Our Population

Our public health teams have created a Mid & South Essex Population Profile to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint Strategic Needs Assessments and strategies of our three top tier Health & Wellbeing Boards, has helped to define our priorities.

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

// The total population size of Mid and South Essex is projected to increase by 5.22% over the next 5 years and 14.70% over the next 20 years.

// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.
Education, Employment & Prosperity

// Deprivation has increased across the 1.2m population
// Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work
// The productivity gap is increasing between mid and south Essex and national comparators.
// Homes have become up to 58% less affordable over the last decade.

Health Behaviours & Outcomes

// There are high and increasing proportions of overweight or obese adults.
// There are increasing numbers of overweight or obese children in early years schooling
// Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease
// More people in this area die from cancer, heart disease and liver disease than expected
// More people are being diagnosed with dementia
// Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing
Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system.

This means:

Healthy Start – helping every child to have the best start in life
- supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
- supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide.

Healthy Places – creating environments that support healthy lives.
- creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – which spring from participation
- making sure everyone can participate in community life, empowering people to improve their own and their communities’ health and wellbeing, and to tackle loneliness and social isolation.

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
- helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home
- from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

Our Ambitions

The health and wellbeing of people in some of our areas is much poorer and on average people die younger there than in other areas. As a Partnership our aim is to change this.

We have set four ambitions to help us reduce inequality, achieve our aims and deliver our vision:

1. Creating Opportunities
   For our communities to thrive we need good education, opportunities for employment, decent housing and a vibrant local economy. Our Partnership represents some of the largest employers and purchasers of goods and services locally, so we have an important role to play. By working together, we can harness these opportunities for the benefit of local residents.

2. Supporting Health and Wellbeing
   By working in different ways and in closer partnership with our communities, we can do more to prevent the things that can cause us to have poor health and mental illness. Up to 40 per cent of ill health can be avoided so by getting a grip on issues sooner we can stop them becoming bigger problems in the future.

3. Bringing Care Closer to Home
   Joining up our different health, care and voluntary services means we can bring services closer people’s homes – whether that is through support on-line, or by bringing health and care services into the community such as some hospital outpatient appointments, tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

4. Improving and Transforming Our Services
   We want to make sure our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can. Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage and avoid more serious illness.
Why We Need To Change

We are helping more people than ever before

We need to change how local NHS and care organisations work together to care for people. The way we currently work together is too disjointed and this puts pressure on our staff and services. We need to be better at planning together so that we can make sure there aren’t gaps in services, that there isn’t any duplication or waste, and so that people who need care, can get it easily.

If we don’t do anything, the pressure on our services will only increase, and we will not have enough money or staff to keep caring for people in the same way we do now.

Our population is growing

Our population is growing, people are generally living longer and the type of care that people need is changing. The number of people living in mid and south Essex will grow by over five per cent in the next five years and by more than 14 per cent in the next 20 years. Not all of these extra years are spent in good health either. As people get older, they are more likely to have several different health conditions at once. This has a real impact on day-to-day lives and can mean more support is needed to remain independent, as well as more care from a range of different professionals.

Supporting our staff

Across health and care recruiting people to work in a wide range of jobs is becoming more difficult and puts added pressure on our staff.

From nurses and social workers, to therapists and consultants across our area we have a large numbers of vacancies.

It’s not just about how we attract new staff, we also want to make the working lives of our staff and for those in caring roles better for people. We want to develop more flexible careers and opportunities for training more fulfilling roles and a better work/life balance.

Technology is changing how we live and work

Too much of our technology is out of date and often our computer systems don’t “talk” to each other and at the same time new technology is changing what we can do to look after ourselves, as well as how health and care services can treat and support people. We need to make the most of the opportunities that new technology offers so that we can provide the type of care that people now need, reduce the pressure on our services, make it easier for our staff to get the information they need to care for people, and so that people don’t have to repeat their story as often.
What you have told us

We’ve heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan.

Here’s a summary of what we have heard and how we are responding:

We should do more to keep people healthy and well, and prevent people from getting ill.

Our approach to prevention will have a focus on children and young people, together with support for parents and carers, on building active and involved communities.

We have committed to addressing the wider determinants of health, such as housing, education and income through our Partnership recognising it takes everyone to join forces and tackle inequalities if we are going to make a real difference.

People don’t want to have to repeatedly tell their story to different health and care professionals.

Our plan describes how we will better coordinate different professionals and services supporting individuals, working with them to shape their care, in locally based teams. We are also developing a shared care record which will enable all professionals to access to vital information when they need to improve how we join up the care we provide.

We aren’t making the most of the opportunities that new technology offers to improve people’s care.

From the success we have already seen in projects across mid and south Essex we know that investing in technology it will help to reduce the pressure on our services and are committed to focusing on digital transformation across health and social care to benefit both our residents and staff.

Recruiting more people to work in health and care, and supporting our workforce must be a priority.

Our plans are nothing without dedicated teams delivering high quality person-centred care. Ours plans sets out how we will recruit new people to work in the health and care sector, as well as do much more to retain our existing NHS and social care workforce.

People have difficulty in being able to get an appointment at their GP surgery.

We have and are continuing to invest in primary and community care so that different health and care professionals work together in teams based around groups of GP practices. This is as a real opportunity to make sure our residents get the right care they need by the most appropriate professional, at the time they need it.

Improving mental health care needs to be a priority area.

We want people of all ages to be able to get the help and support they need quickly and easily, so that their mental health needs are treated early. We are increasing our focus on prevention and wellbeing, as well as providing appropriate support for people in crisis and effective inpatient care.

We should work more closely with local community groups, voluntary organisations and faith groups.

Our plan is centred around linking up everybody in our communities to help keep people healthy, well and active, to support people when they’re ill and care for people when they need help.

It’s important we consider travel and transport to and from health services and activities which keep people healthy and well.

We recognise transport can be a barrier to people getting to services and the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities to make support available closer to where people live. And if they need to travel for very specialist care, support is in place for those who need it.
Our five year plan

Our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

Starting with you, your family and social networks, the first section of our plan describes how we will make it easier to find out about ways to prevent you from becoming unwell and where you can get support to make the changes you need to improve your health.

If you have a long term condition such as diabetes or breathing problems, you will be able to work together with range of health and care professionals to explore the support you need to manage your health and prevent more serious illness developing.

To do this we are setting-up teams comprising different health and care professionals to provide joined up care. These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector, working together in Primary Care Networks.

Supporting Primary Care Networks will be four “Place” partnerships covering the areas South East Essex, Thurrock, Basildon and Brentwood and Mid Essex.

These will bring together groups of Primary Care Networks, with local council teams, community service and mental health providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

We have also set out our ambition to become a fully Integrated Care System for our 1.2 million residents, by 2021 as set out in the NHS Long Term Plan. This will bring significant benefits to our area through more funding and joined up planning to avoid wasteful duplication.

As well as explaining how we will work together we also set out in our plan how we will deliver over the next five years the commitments set out in the national NHS Long Term Plan for improving care for major health conditions (www.longtermplan.nhs.uk)

We set out the actions we’re taking to improve care for conditions such as cancer, mental health conditions, cardiovascular disease, diabetes and for people at key points in their lives, for example having a baby or at the end of their life. These include:

**Prevention**

- Providing information and support for people to look after themselves including on-line and digital options.
- Work on reducing childhood obesity through the adoption of the “Daily Mile” across our schools.
- Increasing physical activity in adults, linking with Sport England and Active Essex.

**Cancer**

- Introducing a new test to help detect and diagnose bowel cancer earlier, so we can treat people quicker and improve their health outcomes.
- Setting up a Rapid Diagnostic Centre for patients with non-specific symptoms which could indicate cancer.
- Becoming a pilot area for the National Targeted Lung Health Check to support earlier diagnosis of lung cancer.

**Mental Health**

- Creating safe places for people to walk-in such as community cafés, where they can find emotional support when they feel their anxieties or other mental health problems are escalating.
- Setting-up mental health support teams in schools to provide therapy and support to children and younger people.
- Improving how we support people with a personality disorder at an early stage, so that they can manage their condition and are less likely to need to go to hospital.

**Cardiovascular disease**

- Focusing on atrial fibrillation (irregular and often abnormally fast heart beat) to improve earlier detection and treatment to prevent stroke.
- Reviewing existing patients to ensure their medication is appropriate.
- Improving access to specialist care at the Essex wide Cardiothoracic Centre with more patients requiring an angiography being seen within 72 hours.
Diabetes
- rolling-out the NHS Diabetes Prevention Programme to provide personalised support to people to reduce their risk of developing diabetes
- reducing the impact of diabetes among harder to reach/less engaged groups
- piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition and reduce the risk of more serious complications developing

Maternity
- launching the Maternity Direct App to allow mums-to-be to speak online with an NHS midwife about non-urgent concerns at anytime
- creating personalised care plans to support women to have choice and opinions about the care they receive
- reviewing our current mental health services to support women both before and after birth to make it easier for those in need to access support.
Place - Based Plans

Our “place based” systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

P R I O R I T I E S:

1. Implementation of the aligned team model
2. Support patients and carers to better manage their own health and wellbeing
3. Support residents to access alternative services

P A R T N E R S H I P:
Basildon & Thurrock University Hospitals NHSFT
North East London NHSFT
Basildon & Brentwood CCG
Essex Partnership University NHSFT
Essex County Council
Brentwood Borough Council
Basildon Council
Community Voluntary Sector
Primary Care Networks – 6

P R I O R I T I E S:

1. Ensure every child can have a good start in life
2. Wider primary care network development, including a focus on prevention and population health
3. Attracting staff to want to work and live in mid Essex

P A R T N E R S H I P:
Mid Essex CCG
Essex County Council
Chelmsford City Council
Braintree & Witham District Councils
Maldon District Council
Provide CIC
Mid Essex Hospital
Fareleigh Hospice
Community Voluntary Sector
Anglia Ruskin University
Essex Partnerships University NHSFT
Primary Care Networks - 9

P R I O R I T I E S:

1. Strengthened GP services
2. Appropriate access to secondary care
3. Improve outcomes for all-age mental health
4. Support self-care and prevention for all

P A R T N E R S H I P:
Southend CCG
Castle Point & Rochford CCG
Southend Borough Council
Essex County Council
Castle Point Borough Council
Rochford District Council
Essex Partnerships University NHSFT
Southend University Hospital
Community Voluntary Sector
North East London NHSFT
Primary Care Networks - 9

Basildon & Brentwood
Predicted population growth

<table>
<thead>
<tr>
<th>Age Band</th>
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<th>2041</th>
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Mid Essex
Predicted population growth

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Thurrock
Predicted population growth

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<td>30-64</td>
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South East Essex
Predicted population growth

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<td>0-14</td>
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<td>15-24</td>
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<td>Total</td>
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<td>410.1</td>
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</table>
How will we know if we’ve made a difference?

Linked to our ambitions we have developed a set of outcomes we can measure to keep us on track in the key areas we believe, by working differently we can make a difference.

This plan for is for the next five years but we know that some of our ambitions and goals will take longer, particularly how we tackle some of the wider causes of poor health and wellbeing such as education, employment and income opportunities.

We all have a role to play in how we work together to do that – as public services, as individuals, families and communities - all taking responsibility to think differently about our health and wellbeing.

We believe that together we really can make a difference.

<table>
<thead>
<tr>
<th>How will we know we’ve made a difference?</th>
<th>Reducing Inequalities</th>
<th>Creating Opportunity</th>
<th>Health &amp; Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inequality will reduce and our residents will enjoy longer, healthier lives.</td>
<td>Our children achieve good development and educational attainment.</td>
<td>Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.</td>
<td></td>
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<tr>
<td>What metrics will we use to track progress?</td>
<td>Slope Index of Inequality</td>
<td>School Readiness</td>
<td>% of adults classified as overweight or obese.</td>
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<tr>
<td></td>
<td>Healthy Life Expectancy measures</td>
<td>Percentage of people in employment</td>
<td>Reception and year 6 prevalence of overweight children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educational attainment</td>
<td>% of adults physically active</td>
</tr>
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<td></td>
<td></td>
<td>Statutory homelessness</td>
<td>Smoking prevalence</td>
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<tr>
<td></td>
<td></td>
<td>Number of non-decent dwellings</td>
<td>Admissions for alcohol related conditions</td>
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<td></td>
<td></td>
<td>Air quality</td>
<td>QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>% of people self-caring after reablement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patient Activation Measures</td>
</tr>
</tbody>
</table>

Moving care closer to home

Our residents report good access to and experience of primary and community services.

Transforming our services

Our residents have consistent, timely access to safe, high quality health and care services.

The outcomes from our services are improved.

How will we know if we’ve made a difference?

Inequality will reduce and our residents will enjoy longer, healthier lives.

Our children achieve good development and educational attainment.

Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.

Reducing Inequalities

Creating Opportunity

Health & Wellbeing

What metrics will we use to track progress?

Slope Index of Inequality

Healthy Life Expectancy measures

School Readiness

Percentage of people in employment

Educational attainment

Statutory homelessness

Number of non-decent dwellings

Air quality

% of adults classified as overweight or obese.

Reception and year 6 prevalence of overweight children

% of adults physically active

Smoking prevalence

Admissions for alcohol related conditions

QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol.

% of people self-caring after reablement

Patient Activation Measures

Reduction in depression cases

Reduction in self-harm

Reduction in suicide

Treatment and recovery rates for IAPT services

Physical health checks for patients with serious mental illness

Mental health admissions to hospital

Patients reporting good overall experience with practice appointment times and good experience of making an appointment.

Patients reporting a positive experience of their GP practice.

Delayed transfer of care

A&E attendances conveyed by ambulance

Breast and bowel screening uptake

Cancer waiting times

Elective waiting times

% of residents with high self-reported happiness

Reduction in depression cases

Reduction in suicide

Treatment and recovery rates for IAPT services

Physical health checks for patients with serious mental illness

Mental health admissions to hospital
Call 01268 594534
or email btu-tr.midsouthesussexstp@nhs.net

Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG,
Phoenix Court, Christopher Martin Road,
Basildon, Essex SS14 3HG

Working together for better lives
SUMMARY REPORT

BOARD OF DIRECTORS
PART 1

Report Title: CQC Update

Executive/Non-Executive Lead: Sally Morris
Chief Executive

Report Author(s): Amanda Webb
Compliance Officer

Report discussed previously at: Quality Committee 16th January 2020

Level of Assurance: Level 1 ✔ Level 2 ✔ Level 3

Purpose of the Report

This report provides a summary of progress being made to respond to the findings of CQC inspections of Trust services.

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Summary of Key Issues

- **Preparing for Annual Inspection:** the CQC has requested completion of a Provider Information Request for Rawreth Court and Clifton Lodge

- **Progress with Existing Action Plans:** as at the end of December, 116 (53%) internal actions have been reported as complete. This is an increase from 70 (32%) reported at the end of November 2019.

There has been slippage reported with 12 (6%) internal actions, which is an increase from 5 (2%) reported as at the end of November 2019 to the Quality Committee.

Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes ✔
SO 2: Achieve top 25% performance ✔
SO 3: Valued system leader focused on integrated solutions ✔

Which of the Trust Values are Being Delivered

1: Open ✔
2: Compassionate ✔
3: Empowering ✔

Relationship to the Board Assurance Framework (BAF)

Are any existing risks in the BAF affected? Yes
If yes, insert relevant risk BAF 6, 9, 10, 20, 32, 35
Do you recommend a new entry to the BAF is made as a result of this report? No
<table>
<thead>
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<th>Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</td>
<td>✓</td>
</tr>
<tr>
<td>Data quality issues</td>
<td></td>
</tr>
<tr>
<td>Involvement of Service Users/Healthwatch</td>
<td></td>
</tr>
<tr>
<td>Communication and consultation with stakeholders required</td>
<td>✓</td>
</tr>
<tr>
<td>Service impact/health improvement gains</td>
<td>✓</td>
</tr>
<tr>
<td>Financial implications:</td>
<td>Capital £</td>
</tr>
<tr>
<td></td>
<td>Revenue £</td>
</tr>
<tr>
<td></td>
<td>Non Recurrent £</td>
</tr>
<tr>
<td>Governance implications</td>
<td>✓</td>
</tr>
<tr>
<td>Impact on patient safety/quality</td>
<td>✓</td>
</tr>
<tr>
<td>Impact on equality and diversity</td>
<td></td>
</tr>
<tr>
<td>Equality Impact Assessment (EIA) Completed?</td>
<td>YES/NO</td>
</tr>
</tbody>
</table>

| Acronyms/Terms Used in the Report |
| --- | --- |
| CQC | Care Quality Committee |
| PIR | Provider Information Request |

| Supporting Documents and/or Further Reading |
| --- | --- |
| Accompanying Report |

<table>
<thead>
<tr>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Morris</td>
</tr>
<tr>
<td>Chief Executive</td>
</tr>
</tbody>
</table>
1.0 Introduction

This report provides an update on the activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust’s ambition of achieving an outstanding rating by 2022.

2.0. Preparing for Annual Inspection

2.1. Rawreth Court Provider Information Request (PIR)

The Rawreth Court Provider Information Return (PIR) request was received by the Registered Manager on 5th November 2019 and all data required by the CQC was submitted by the deadline of 6th December 2019. The PIR is to help the CQC identify areas to explore in more detail as part of their continuous monitoring of the service and ahead of a site visit.

2.2. Clifton Lodge Provider Information Request (PIR)

The Clifton Lodge Provider Information Return (PIR) request was received by the Registered Manager on 8th January 2020 and all data is required to be submitted to the CQC by the deadline of 7th February 2020. The PIR is to help the CQC identify areas to explore in more detail as part of their continuous monitoring of the service and ahead of a site visit.

3.0. Progress with Existing Action Plans

3.1. CQC Well Led Inspection (July – August 2019)

The action plan developed following the focused CQC Well Led Inspection (July-August 2019) was submitted to the CQC on the 19th November 2019 following approval by the Chair on behalf of the Board of Directors. The action plan identified 218 individual actions to deliver the 18 “Must Do and 29 “Should do” actions identified by the inspection. Three further internal actions have been identified as the action plan has progressed to ensure all issues have been fully resolved and a total of 221 internal actions have now been identified.

The table below provides the position with the action plan as at the end of December 2019:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Action Type</th>
<th>Must Do / Should Do Actions</th>
<th>Specific Actions That Address Must Do/Should Do Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Actions</td>
<td>Actions Complete</td>
</tr>
<tr>
<td>Overarching Actions</td>
<td>Must Do</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Acute Wards for Adults &amp; PICU</td>
<td>Must Do</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Core Service</td>
<td>Action Type</td>
<td>Total Actions</td>
<td>Actions Complete</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Wards for Older People with MH Problems</td>
<td>Must Do</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Long Stay / Rehab</td>
<td>Must Do</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Must Do</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>End of Life</td>
<td>Should Do</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Should Do</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Overall</td>
<td>Must Do</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Core Services Total</td>
<td>Must Do</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Should Do</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>47</td>
<td>11 (23%)</td>
</tr>
</tbody>
</table>

The table above shows that as at the end of December, 116 (53%) internal actions have been reported as complete. This is an increase from 70 (32%) reported at the end of November 2019.

There has been slippage reported with 12 (6%) internal actions, which is an increase from 5 (2%) reported as at the end of November 2019 to the Quality Committee.

There were a large number of actions (107) due in November and December (48% of total actions identified), and although 12 have not been completed within the timescale originally agreed, 95 actions were completed which equated to 89% of target actions being achieved. There are 36 actions due in January.
The Quality Committee agreed that the actions set out below are reported as having passed the originally agreed timescale.

**Overarching Actions:**

**Regulation 17 Good Governance**

**M1** The trust must review their governance arrangements for ligature risk assessment and management (Acute Adult & PICU)

**S1.** The trust should review their management of ward and garden blind spots. (Acute Adult & PICU)

**S2.** The trust should ensure staff fully assess the ward environment for ligature risks and blind spots. (Long Stay Rehabilitation)

- Review Ligature Audit Tool to ensure that there is explicit reference to all previous Health Building Notices – It is confirmed that this would be included in Appendix 9 of the Ligature Risk Assessment and Management Policy (CP75); which will be going to the LRRG for sign off Jan-2020. Inspectors are reviewing the ligature inspection tool; options being considered will be included and implemented by the end of Feb-2020.

- Review blind spot at xx (anonymised for safety reasons) Unit and confirm action to resolve and ensure this is implemented / reflected on the ligature risk assessment – A visit has been undertaken by Estates and Risk where the blind spot was identified. The long term solution is that CCTV will be installed by end of Mar-2020 therefore as a short term solution, it has been agreed that patients should be observed in the garden.

**Regulation 12: Safe Care and Treatment**

**M2.** The trust must review their risk management systems to prevent overly restrictive ward rules (Acute Adult & PICU)

**M3.** The trust must ensure that blanket restrictions like locking patients' bedroom doors are reduced and regularly reviewed. (Wards for Older People)

**M4.** The trust must ensure that staff complete records of patients placed into seclusion in line with best practice standards

**S3.** The trust should review its system for monitoring and learning from incidents involving the use of prone restraint.

- Review and agree governance process for Restrictive Practice, including over-arching group, leadership roles, such as Executive-lead, Lead Medical Staff Member and a Senior Clinician – West Medic representative has been appointed. New Terms of Reference going to the Restrictive Practice meeting on the 29th January 2020 for sign off.

- Review Datix reporting to ensure there is a distinction between planned prone restraint for injection (patient determined) and resisted restraint – The Risk Analysis and Systems Manager has approached other Trusts to identify their practices. Hertfordshire Partnership University Trust willing to engage and currently waiting for their Datix Manager to get in touch. East London NHS Foundation Trust confirmed they do not use Datix to go into this level of detail.

**Regulation 17 Good Governance**

**M6.** The trust must review their governance arrangements to ensure actions identified from incident investigations are applied consistently across wards. (Acute Adult & PICU)

**S5.** The trust should consider the effectiveness of the systems in place to share learning from incidents. (Trustwide)

**S6.** The trust should ensure staff are aware of all safety incidents and lessons learned. (Long Stay Rehabilitation)

- Initiate Quality Improvement Programme where differences in practice are identified to ensure consistency - The Quality Improvement Forum commenced in Q2 2019 and the next meeting is 21st January 2020 (Work stream feedbacks)
Regulation 12: Safe Care and Treatment
M7. The trust must ensure that they eliminate mixed-sex accommodation on Henneage ward to uphold patients’ privacy and dignity.

- Review single-sex accommodation at Henneage Ward to understand the issue and identify a solution – the Trust is exploring the feasibility of designating all wards single sex. Recommendations are to be presented to EOSC in February 2020. If Henneage is not to be designated single sex, an estates solution is also being considered.

Regulation 10: Dignity and Respect
M8. Staff must record when they spoke to informal patients about their rights. (Long Stay / Rehabilitation)

- Review local Operational Policies to ensure the process for informing informal patients of their rights is included – S131 form was approved at the Mental Health Act and Safeguarding Sub-Committee on the 29.11.19 and was implemented on the 02.01.2020. All areas were asked at the Inpatient CQC 2 Outstanding meeting to check and confirm that their local operational policies included the process. Confirmation received that this will be completed by end of Feb-2020.

S8. The trust should review the efficiency of its data systems

- Discuss content of Smart Ward to confirm what should be included within the programme – The ‘Smart Wards’ have been identified and a project meeting has been set up for the 29th January. In the meantime, site visits are being undertaken to identify what is needed in preparation for the project meeting.

Core Services Must Do Actions:

Regulation 9: Person Centred Care
M15. The provider must ensure patients have access to appropriate psychological therapies.

- Development of a proposal for ET to identify the requirement observed by the CQC and provide costings for ET consideration to provide a 0.5wte band 8a Clinical Psychologist at Ipswich Rd – Clinical Director of Psychological Services Greg Wood confirmed that a Business Case is due to be presented to EOSC on the 28th January 2020 outlining the proposal to develop Clinical Associates in Psychology posts in the adult in-patient wards which will include Ipswich Road.

Regulation 17 Good Governance
M13. The trust must review their staff recruitment and retention processes for acute mental health wards and psychiatric intensive care units

- Initiate a review of staffing and skill mix requirements to be undertaken every six months - A full establishment review has taken place to align with budget settings; and the report will be discussed at the Board of Directors on the 29th January 2020.

Core Services Should Do Actions

S11. The trust should improve the way they get feedback from patients and carers and involve them in the development of the ward service.

- Undertake regular carers engagement events with Matrons / Ward Managers – At the Inpatients CQC 2 Outstanding meeting held on the 07.01.2020, it was agreed Matrons have been tasked with holding events (Started in some areas). Services managers are to pull together a strategy to ensure consistent offer across inpatient services that also focuses on the family’s needs. Associate Director (LG) leading on community strategy following community survey.
S12. The trust should review their systems for ensuring staff complete regular checks of patients' physical health.

- Ensure that when a physical health check is declined by a patient that this is recorded along with a minimum timeframe set for a repeat attempt - At the Inpatients CQC 2 Outstanding meeting it was agreed that this would form part of the physical health care plan to ensure that staff are recording patient that have declined a health check and review date set for repeat attempt. Confirmation received that this will be completed by end of Jan-2020.

4.0 Recommendations and Action Required

The Board of Directors is asked to:

1. Note the contents of this report
2. Identify any further action that is required to be taken.

Report Prepared by:

Amanda Webb
Compliance Officer

On behalf of:

Sally Morris
Chief Executive
**SUMMARY REPORT**

<table>
<thead>
<tr>
<th>BOARD OF DIRECTORS PART 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item No: 9b</td>
</tr>
<tr>
<td>29 January 2020</td>
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</tbody>
</table>

**Report Title:** PHSO and HSE Steering Group Assurance Report  
**Executive/Non-Executive Lead:** Alison Davis  
Non-Executive Director / Chair of the PHSO Steering Group  
**Report Author(s):** Gill Brice  
Associate Director of Planning  
**Report discussed previously at:** N/A  
**Level of Assurance:** Level 1 ✓ Level 2 Level 3

### Purpose of the Report

This report is provided to the Board of Directors by the Chair of the PHSO and HSE Steering Group. This is a Task and Finish Group established by the Board to oversee the work relating to the PHSO and HSE requests for information.

### Recommendations/Action Required

The Board of Directors is asked to:

1. Note the summary of the meeting held on 11 December 2019.  
2. Confirm acceptance of assurance given in respect of the actions identified.

### Summary of Key Issues

The PHSO & HSE Steering Group met on 11 December 2019. The following items were discussed:

- Action Log  
- PHSO Action Plan  
- HSE Investigation  
- Public Administration and Constitutional Affairs Committee Meeting (PACAC) Report

### Relationship to Trust Strategic Objectives

SO 1: Continuously improve service user experiences and outcomes ✓  
SO 2: Achieve top 25% performance ✓  
SO 3: Valued system leader focused on integrated solutions ✓

### Which of the Trust Values are Being Delivered

1: Open ✓  
2: Compassionate ✓  
3: Empowering ✓

### Relationship to the Board Assurance Framework (BAF)

Are any existing risks in the BAF affected? Yes  
If yes, insert relevant risk: BAF 15  
Do you recommend a new entry to the BAF is made as a result of this report? No
### Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

<table>
<thead>
<tr>
<th>Assurance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</td>
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</tr>
<tr>
<td></td>
<td>Communication and consultation with stakeholders required</td>
</tr>
<tr>
<td>✓</td>
<td>Service impact/health improvement gains</td>
</tr>
<tr>
<td></td>
<td>Financial implications: Nil</td>
</tr>
<tr>
<td>✓</td>
<td>Governance implications</td>
</tr>
<tr>
<td>✓</td>
<td>Impact on patient safety/quality</td>
</tr>
<tr>
<td>✓</td>
<td>Impact on equality and diversity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES/NO</th>
<th>If YES, EIA Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

### Acronyms/Terms Used in the Report

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHSO</td>
<td>Parliamentary and Health Service Ombudsman</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
</tbody>
</table>

### Supporting Documents and/or Further Reading

### Lead

Alison Davis  
Non-Executive Director / Chair of the PHSO & HSE Steering Group
PURPOSE OF REPORT
This report is provided to the Board of Directors by the Chair of PHSO and HSE Steering Group. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisations objectives are being managed effectively.

EXECUTIVE SUMMARY
PHSO and HSE Steering Group 11 December 2019
The PHSO and HSE Steering Group met on 11 December 2019. The Steering Group had a robust and thorough discussion on a number of key areas. The following matters were considered:

1. Steering Group Action Log
   Updates were received and no slippage was identified.

2. Final PHSO Action Plan
   The Group received confirmation that all actions on the plan are on target with the exception of one which has unfortunately been delayed due to the rollout of the new National Serious Incident (SI) Framework and training. In addition a new action was identified connected to the training for SI investigators once the new framework is in place.

3. HSE Investigation
   The Group received an update on the work being undertaken in relation to the HSE investigation. This included progress on actions identified to be taken forward by the relevant leads. No slippage has been identified.

4. Public Administration and Constitutional Affairs Committee Meeting (PACAC)
   The Group discussed the actions arising from the PACAC report dated 4 November 2019 and agreed that an assurance assessment against the key areas highlighted would be undertaken.

5. Risk
   No risks were identified.

ACTION REQUIRED
The Board of Directors is asked to:

1. Note the summary of the meeting held on 11 December 2019.
2. Confirm acceptance of assurance given in respect of the actions identified.

Report produced by:
Gill Brice
Associate Director of Planning

On behalf of:
Alison Davis
Non-Executive Director / Chair of the PHSO and HSE Steering Group
Report Title: Safe Working of Junior Doctors Quarterly Report
Executive/Non-Executive Lead: Dr Milind Karale
Executive Medical Director
Report Author(s): Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
Report discussed previously at: N/A
Level of Assurance: Level 1 x Level 2 Level 3

Purpose of the Report
This report provides assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of their Contract.

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

1. Note the contents of the report and the concerns raised by doctors at the Junior Doctors Forum.

Summary of Key Issues
1. There were 6 Exception Reports raised by the Doctors, 3 did not meet the criteria for exception reporting, hence there were closed with no further action needed.
2. 2 Exception Reports were resolved by offering the trainees time off in Lieu and extra payment (details are in the report).
3. Information is awaited in respect of 1 Exception Report raised by a junior trainee.
4. No fines were issued in this quarter.
5. There are gaps in the on call rota. These are currently filled by LAS and MTI doctors and no agency locums were used.
6. The funding (£30,000) from Health Education England for Junior Doctors will be discussed, agreed and signed off in the next Junior Doctors Forum on 30th January 2020.

Relationship to Trust Strategic Objectives
SO 1: Continuously improve service user experiences and outcomes ✓
SO 2: Achieve top 25% performance ✓
SO 3: Valued system leader focused on integrated solutions

Which of the Trust Values are Being Delivered
1: Open ✓
2: Compassionate ✓
3: Empowering
### Relationship to the Board Assurance Framework (BAF)

| Are any existing risks in the BAF affected? | No |
| If yes, insert relevant risk | |
| Do you recommend a new entry to the BAF is made as a result of this report? | |

### 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 £ |
| None |

**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

| JLNC | Joint Local Negotiating Committee | GP | General Practitioner |
| ECG | Electrocardiogram | FY | First Year |
| LAS | Locum Associate Specialist | JDF | Junior Doctors Forum |
| MTI | Medical Training Initiative |

### Supporting Documents and/or Further Reading

None

### Lead

Dr Milind Karale
Executive Medical Director
Quarterly Report on Safe Working of Junior Doctors

1 Purpose of Report

This report provides assurance to the Board that doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of their contract.

2 Executive Summary

This is the tenth quarterly report submitted to the Board on safe working of junior doctors for the period 1st October to the 31st December 19. The Trust has established robust processes to monitor safe working of junior doctors and report any exceptions to their terms and conditions.

Exception Reporting

1) 27/12/19: (North) Junior doctor worked an extra 45 mins due to a medical emergency on the ward. Following an initial review by the trainee’s clinical supervisor it became apparent that the reason for the doctor remaining on shift was because of their conscientious and caring attitude and the duty doctor could have taken over the care of the patient.

Outcome: This did not meet the criteria for Exception Reporting and hence no further action was required.

2) 27/12/2019: (North) Junior doctor reported a variance from their work schedule, the doctor had to cancel a scheduled home visit due to lack of junior doctor cover on the ward and no consultant approval to attend. The initial review by the trainee’s clinical supervisor stated that “the Junior Doctor knew in advance about the reduced staffing levels, so could have taken this into consideration when arranging the home visit”.

Outcome: No further action was required and the Exception Report was closed.

3) 09/10/2019 (South): The Junior doctor stayed an extra 1 hour and 30 minutes on the ward to attend to a medical emergency. The clinical supervisor’s review indicates that the doctor chose to stay back and assist rather than to hand over to the Duty Doctor.

Outcome: This did not meet the criteria for Exception Reporting and hence no further action was required.

4) 30/10/2019 (South): Exception Report was raised by a Senior Trainee following a busy on call, resulting in lack of adequate rest periods.

Outcome: Time off in Lieu for half a day was given.

5) 29/11/2019: Exception Report raised by a Junior Doctor for doing a routine ECG during an on call shift.
Outcome: More information has been requested from the Junior Doctor on reasons for this request.

6) 24/12/2019: (South): A Senior Trainee had raised this Exception Report for stepping down to cover the on call for a Junior Doctor for 6 and a half hours during the weekend.

Outcome: The Doctor was offered extra payment for the hours that she stepped down. The Doctor has accepted the offer.

Work Schedule Report

Work schedules were sent out to all Foundation trainees prior to their start date on the 4th December 2019.

Doctors in Training Data

The foundation doctors all rotated on the 4th December 19 so this data captures Trust wide information from that date:

- Number of doctors in training (total inclusive of GP and Foundation) 122
- Number of doctors in psychiatry training on 2016 Terms and Conditions 49
- Total number of vacancies 31
- Total vacancies covered LAS / MTI / Agency 21
- 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:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of shifts requested</th>
<th>Number of shifts worked</th>
<th>Number of shifts given to agency</th>
<th>Number of hours requested</th>
<th>Number of hours worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy/Maternity/sick</td>
<td>138</td>
<td>138</td>
<td>0</td>
<td>1501.5</td>
<td>1501.5</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>138</td>
<td>0</td>
<td>1501.5</td>
<td>1501.5</td>
</tr>
</tbody>
</table>

Actions taken to resolve issues

The Trust has taken the following steps to resolve the gaps in the rota.

1. Rolling Adverts on NHS Jobs—we have recruited several LAS doctors to cover from Feb 2020
2. Advertised doctors to join the bank (within our Trust) to have a list of doctors to do on-calls when necessary—this was not particularly successful and resulted in 2 doctors joining bank
3. Email 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

No Fines were issued in this quarter.
Issues Arising:

1. The number of vacancies and the gap in the rota remains the same.
2. Doctors have asked for an updated stepping down policy, this was discussed in JLNC.
3. Junior doctors are in the process of finalizing on how to use the funding money of £30,000 from the Health Education England. This will be agreed in the next JDF meeting scheduled on 30th January 2019.

3  Action Required

The Board of Directors is asked to note the contents of the report and the concerns raised by doctors at the Junior Doctors Forum.

Report prepared by:

Dr P Sethi MRCPsych
Consultant Psychiatrist and Guardian of Safe Working Hours
January 2020
SUMMARY REPORT

<table>
<thead>
<tr>
<th>BOARD OF DIRECTORS PART 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report Title:</strong> Use of Corporate Seal</td>
</tr>
</tbody>
</table>
| **Executive/Non-Executive Lead:** Sally Morris  
Chief Executive |
| **Report Author(s):** Angela Horley  
PA to CEO, Chair and NEDs |
| **Report discussed previously at:** n/a |
| **Level of Assurance:** Level 1 [x] Level 2 Level 3 |

29 January 2019

**Purpose of the Report**

This report updates the Board of Directors of when the Trust Corporate Seal has been used.

**Recommendations/Action Required**

The Board of Directors is asked to:

1. Note the contents of the report.
2. Request any further information or action.

**Summary of Key Issues**

The EPUT Corporate Seal has been used on the following occasions this month:

- **11 December 2019: Coach House Group – Transfer to Chartwell**
  In December 2017, the Trust agreed a new lease with Chartwell Care Services Ltd. Chartwell had taken over the existing service provision from Mosaic Housing Association at the Coachouse, Grays. The lease was for ten years and included an option to purchase the premises that was valid for two years up to December 2019. Chartwell exercised the above option in December 2019 and the property was sold to Chartwell Care. The sale completed on the 18th of Dec 2019.

**Relationship to Trust Strategic Objectives**

SO 1: Continuously improve service user experiences and outcomes
SO 2: Achieve top 25% performance
SO 3: Valued system leader focused on integrated solutions

**Which of the Trust Values are Being Delivered**

1: Open [x]
2: Compassionate
3: Empowering

**Relationship to the Board Assurance Framework (BAF)**

Are any existing risks in the BAF affected? No
If yes, insert relevant risk
Do you recommend a new entry to the BAF is made as a result of this report? No
Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:

<table>
<thead>
<tr>
<th>Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan &amp; Objectives</th>
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<tbody>
<tr>
<td>Data quality issues</td>
</tr>
<tr>
<td>Involvement of Service Users/Healthwatch</td>
</tr>
<tr>
<td>Communication and consultation with stakeholders required</td>
</tr>
<tr>
<td>Service impact/health improvement gains</td>
</tr>
<tr>
<td>Financial implications:</td>
</tr>
<tr>
<td>Governance implications</td>
</tr>
<tr>
<td>Impact on patient safety/quality</td>
</tr>
<tr>
<td>Impact on equality and diversity</td>
</tr>
<tr>
<td>Equality Impact Assessment (EIA) Completed? YES/NO If YES, EIA Score</td>
</tr>
</tbody>
</table>

Acronyms/Terms Used in the Report

Supporting Documents and/or Further Reading

Lead

Sally Morris
Chief Executive