NHS
Essex Partnership University
NHS Foundation Trust

SAFETY FIRST, SAFETY ALWAYS

Essex Partnership University NHS Foundation Trust

TWO YEAR REPORT

EPUT

FOREWORD

We launched our patient safety strategy, *Safety First, Safety Always*, in 2021 with an ambition to provide the safest possible care for our patients.

This commitment applies in all settings, whoever and wherever people receive our care. Our first and most vital priority was to set out and deliver improvements in inpatient care, so that patients and their families can feel assured that they will be well looked after and protected from harm whenever they are in our care.

Our Executive Team and local leadership teams are wholly committed to delivering this vision of making Essex Partnership University Trust (EPUT) the safest possible organisation. This is the agenda that drives everything we do and the evidence shows that is having a real, visible and measurable effect in the organisation.

At the end of the second year of the strategy we must recognise that while there has been progress there is more to do to build the confidence of patients, families and partners.

Our 'Safety First Safety Always' strategy will continue to adjust to reflect learning within the organisation alongside recommendations arising from the Essex Mental Health Independent Inquiry (EMHII) which commenced in April 2021.

It is also important that we reflect on the successes we have achieved with our staff, patients, communities and partners.

Staff across the Trust have shown extraordinary commitment throughout the pandemic and beyond, giving far more than could be asked of them. Against a backdrop of both unprecedented demand and workforce challenges, staff across the Trust have embraced the *Safety First, Safety Always* message.

Our work has gained national recognition in some areas, including our national award-winning apprenticeship in Clinical Psychology, which is helping to address the workforce challenges of the present and future.

As we move into year 3 of the strategy, there is more to do and we look forward to doing this in collaboration with patients, carers, families and partners to make EPUT the safest possible organisation for delivering patient care.

INTRODUCTION

OUR STRATEGY FOR ENSURING INPATIENT SAFETY

The Safety First, Safety Always strategy was agreed by Trust Board in February 2021, following widespread engagement with Trust staff, Non-Executive Directors, Governors and partners.

The strategy set out our ambition to be an organisation that consistently places patient safety at the heart of everything it does.

We recognised that this could only be achieved through a transformation of culture and an organisation-wide mindset of Safety First, Safety Always. This strategy also reflects our learning from the past and the themes arising from historic incidents over the past 20 years.

We set out five key ambitions and outcomes:

- ☑ **Patients and families feel safe in EPUT's care**
- ☑ **Stakeholders have confidence that EPUT is a safe organisation**
- ☑ **No preventable deaths**
- ☑ **A reduction in Patient Safety Incidents for Investigation (PSII)**
- ☑ **A reduction in self-harm**

This report highlights the progress we have made against the priorities within the safety strategy and against the four priority areas for quality improvement in the Mental Health Safety Improvement Plan.

It also sets out our ambition for the third year of the strategy and beyond to ensure that EPUT is a leader in providing outstanding patient safety and care.

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ESTABLISHING THE CONTEXT

BACKGROUND TO THE STRATEGY AND WHAT WE PLANNED TO ACHIEVE

EPUT

LOCAL AND NATIONAL CONTEXT

Demand for services is rising across the NHS. Government announced an additional £500m in 2021 as part of its Mental Health Recovery Action Plan, but this falls far short of the historic and projected increase in demand. The additional funding represents 4% of national spend on mental health services, whereas there has been a 21% increase in demand since 2016.

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

The end of the pandemic is not the end of its effects. Research shows that a 1% increase in long-term unemployment increases the suicide rate of a population by 0.83%. While the **long-term effects of COVID on mental health** are not yet known, the evidence points to an increase in demand on services that could last up to 18 years, alongside the challenge of a diminishing workforce.

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

Staff at EPUT and nationally have made extraordinary efforts during the pandemic and have given more than could have been asked of them. But putting more pressure on staff is not a sustainable solution and there are systemic workforce issues to be addressed in the NHS. There is a national nursing shortage, with the most significant shortages in mental health, learning disabilities and community nursing. We are seeing the effects of this in the form of unprecedented industrial action, which many nurses nationally concerned they do not have the resources to provide acceptable levels of care.

The Trust is working closely with the Essex Mental Health Independent Inquiry (EMHII) and is actively identifying learning from past incidents dating back to the year 2000.

Despite these very significant challenges, the outlook is optimistic. We have made very encouraging progress in a number of areas of patient safety and are embedding the learning from successes into good practice and continuous improvement throughout the organisation.

SAFETY AND COVID-19 THE EFFECTS OF THE PANDEMIC

- The Trust redirected significant resources to respond to COVID-19, from the initial outbreak to present day
- We successfully delivered a vaccination programme across a population of 1.8million people, at a time when demand for mental health services was at an all-time high
- We have moved the dial on some of our key safety indicators, despite the pressure of COVID working against them
- At the end of year 1 of the strategy, we reported an 88% reduction in the use of prone restraints since January 2020. Taking into account data up to November 2022, use of prone restraints has now decreased by almost 95%. There was no use of prone restraints across the Trust in September and November 2022
- Other types of physical intervention are a more complicated picture, with the data showing a variable trend. During the pandemic, we often had to move patients to maintain social distancing and to prevent infection. Staff treated each instance of assisting patients between locations as a 'physical intervention' but the majority of these were not restraints in the usual sense. This was done in the context of staff being encouraged to report more and to speak up

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REVIEWING OUR PROGRESS

WHAT WE'VE DELIVERED FOR OUR PATIENTS AND POPULATION

EPUT

5 KEY OUTCOMES

1. Patients and families feel safe in our care
2. Stakeholders have confidence we are safe
3. No preventable deaths
4. A reduction in self-harm
5. A reduction in patient safety incidents

OUTCOME 1: PATIENTS AND FAMILIES FEEL SAFE IN OUR CARE

480%
INCREASE IN LIVED EXPERIENCE AMBASSADORS SINCE 2021

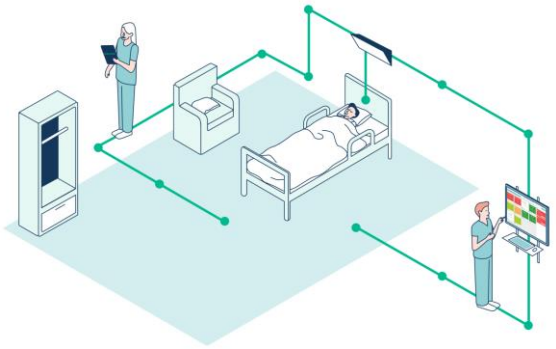
"I THINK OXEVISION MAKES US FEEL VERY SAFE ON THE WARD."
– MENTAL HEALTH INPATIENTS SERVICE USER

Roll out of

iWantGreatCare
Transforming Healthcare

will ensure that the patient voice is heard, understood and acted upon.

"This is the best ward I have been to. The environment is therapeutic. I would be happy to pay for my stay here."
– MENTAL HEALTH INPATIENTS SERVICE USER



"THE TIDE IS FINALLY CHANGING. THANK YOU." – LIVED EXPERIENCE AMBASSADOR

OUTCOME 2: STAKEHOLDERS HAVE CONFIDENCE WE ARE A SAFE ORGANISATION

"OUR RELATIONSHIP WITH EPUT AS A STRATEGIC PARTNER HAS ENABLED US TO ENSURE THAT PATIENT VOICE IS INTEGRAL TO ALL THE DECISION-MAKING" – HEALTHWATCH ESSEX

"THIS WAS A VERY POWERFUL AND PRACTICAL WORKFORCE INITIATIVE WHICH HITS THE PURPOSE OF THIS AWARD ON THE HEAD" – HSJ AWARDS JUDGES' VERDICT

SAFETY SUMMITS ARE BRINGING TOGETHER PARTNERS TO TAKE A WHOLE-SYSTEM APPROACH TO SAFETY, QUALITY AND IMPROVEMENT

WINNER OF THE

FOR HEALTHCARE LEADERS
HSJ
AWARDS

WORKFORCE INITIATIVE OF THE YEAR

The Great British Workplace Wellbeing Series with WELLITY

HERE FOR YOU SERVICE NOMINATED FOR NATIONAL AWARD

OUTCOMES 3&4: NO PREVENTABLE DEATHS REDUCTION IN SELF-HARM

80%

OF PATIENTS WHO HAVE SELF-HARMED SAID THEIR URGE TO DO SO REDUCED AS A RESULT OF A SELF-HARM REDUCTION PILOT PROJECT

94%

OF STAFF SAY THAT OXEVISION ENABLES THEM TO IDENTIFY INCIDENTS THEY MAY NOT HAVE KNOWN ABOUT

"IT'S GOOD TO KNOW THAT OXEVISION CALLS FOR HELP WHEN YOU NEED IT, BUT ALSO WHEN YOU DON'T THINK YOU NEED HELP."
- MENTAL HEALTH INPATIENTS SERVICE USER

Reviewed key themes for learning over a 20 year period. This information has helped to inform our work around preventable deaths and a reduction in self harm

OUTCOMES 5: REDUCTION IN PATIENT SAFETY INCIDENTS

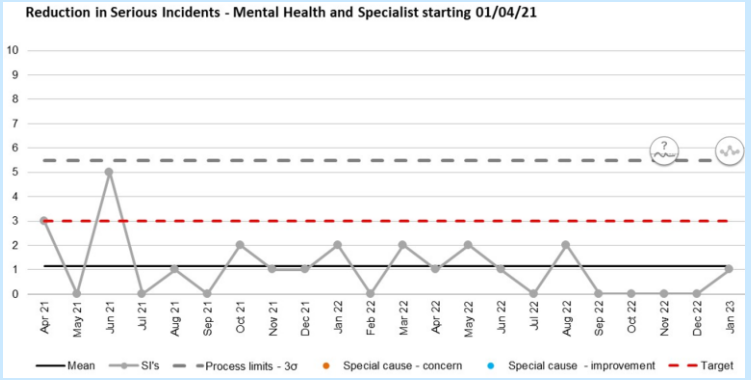
80%
REDUCTION IN SECLUSION INCIDENTS SINCE NOVEMBER 2020

95%
REDUCTION IN USE OF PRONE RESTRAINTS SINCE JANUARY 2020

AS AN EARLY ADOPTER OF PSIRF, WE'RE EMBEDDING LEARNING FROM PATIENT SAFETY INCIDENTS ACROSS THE TRUST – AND SUPPORTING OTHER TRUSTS WITH THEIR IMPLEMENTATION

90%
STAFF STATED THAT OXEVISION HAD ENABLED THEM TO PREVENT A POTENTIAL INCIDENT FROM OCCURRING

A SUSTAINED REDUCTION IN SERIOUS INCIDENTS

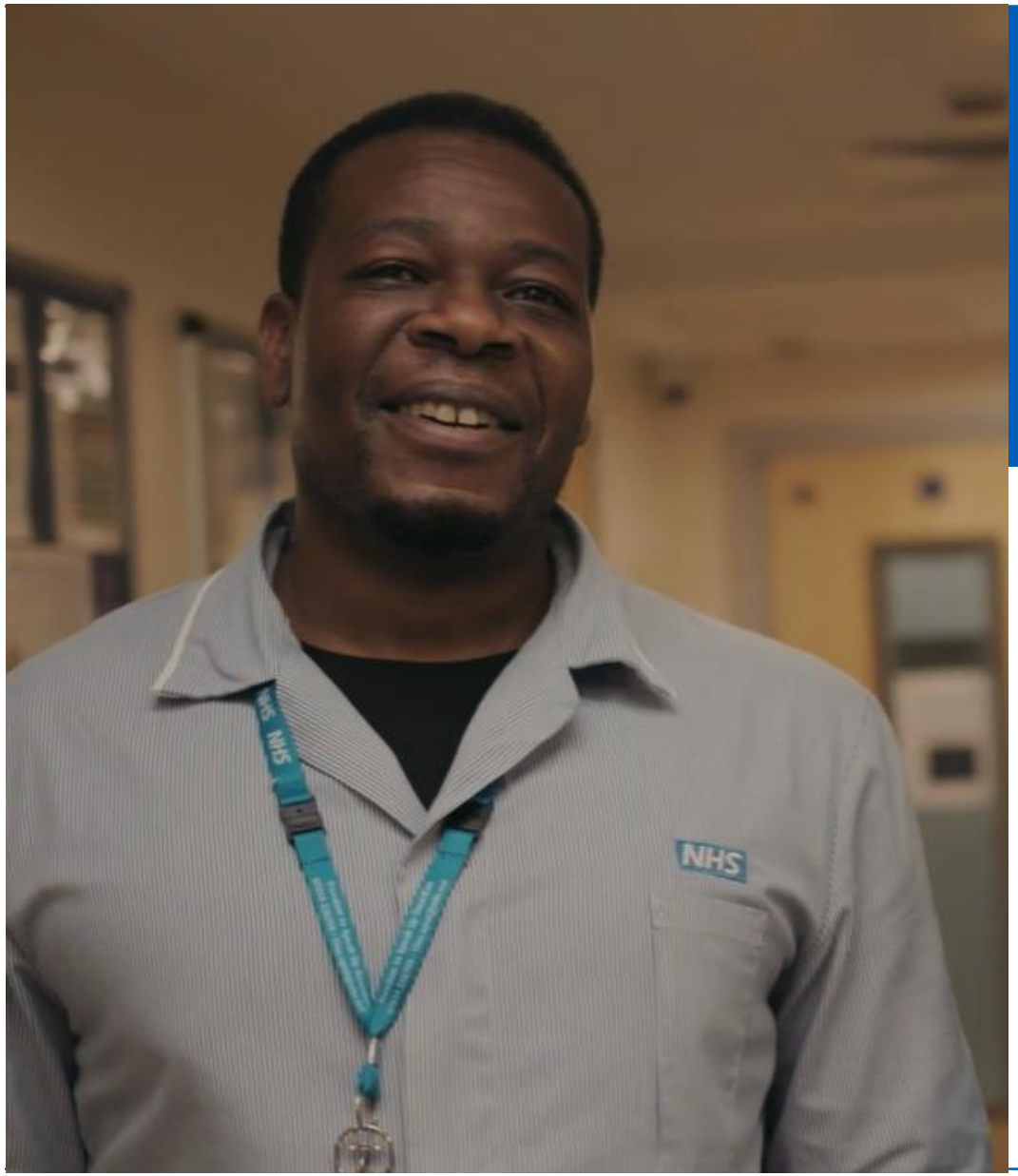


THE SEVEN PRIORITIES

OUR OVERARCHING FRAMEWORK FOR SAFETY IMPROVEMENT

The strategy focused on seven priority areas for safety improvements across the Trust. These were selected as cross-cutting themes that were relevant to all staff regardless of role to drive safety in a collaborative and systematic way:

1. **Leadership** - Ensuring there is buy-in, ownership and accountability across the Trust for putting Safety First, Safety Always and delivering this through leadership at all levels from ward to board
2. **Culture** - Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility
3. **Continuous Learning** - Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff. This includes learning from the past and focusing on any recommendations and learning arising from the EMHII
4. **Wellbeing** - Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care
5. **Innovation** - Facilitating and inspiring patient safety initiatives through new ways of working
6. **Enhancing Environments** - Ensuring our buildings and estates support the Safety First, Safety Always agenda
7. **Governance and Information** - Building the foundations for safety through governance, processes and availability of information that put safety first



7 THEMES TO ENSURE SAFETY FIRST, SAFETY ALWAYS

1. LEADERSHIP
2. CULTURE
3. INNOVATION
4. CONTINUOUS LEARNING
5. WELLBEING
6. ENHANCING ENVIRONMENTS
7. GOVERNANCE AND INFORMATION

LEADERSHIP

In our ambition to be an industry leader in patient safety, our staff are advocates for Safety First, Safety Always throughout the organisation.

Leadership in patient safety takes place at all levels of the Trust – from ward to board – ensuring patient safety is everyone's responsibility.

Image shown: EPUT RISE Graduation Ceremony

LEADERSHIP AND COVID-19

SAFETY THROUGH THE PANDEMIC AND BEYOND

- There are regular site visits by Directors and Non Executive Director visits, providing staff with the opportunity to raise concerns and for risks to be identified
- An 'L50' meeting of the organisation's 50 senior leaders provides an opportunity to collaborate, cascade key messages and ensure that leaders are all working to the same priorities
- These sessions have been used to engage the Trust's wider leadership team on the safety strategy, to share successes, consolidate learning and plan the next wave of improvement actions
- Wednesday Weekly is a weekly newsletter that provides all staff with updates. This supplements the all-staff briefings and ensures that staff who can't attend are still kept in the loop. A regular learning lessons newsletter is also produced and shared on the intranet and via Wednesday Weekly
- 'The Grill' provides an opportunity for our Staff Engagement Champions to engage with senior leaders and discuss questions of interest to the workforce

- In parallel to our response to the pandemic, we also transformed our leadership capability
- Significant changes have been made to our Executive Team, starting with the appointments of a new Chief Executive and Chief Finance Officer
- New roles have also been created at Executive Team level, including an Executive Director of Strategy, Transformation and Digital and a Senior Director of Corporate Governance. These roles support our ambition to transform safety through innovation, information and good governance
- Leadership is more visible in our organisation than ever before. All-staff updates were held fortnightly throughout the pandemic and have continued on a regular basis. These sessions, which average 300 attendees, facilitate two-way feedback, supporting a culture of openness and one where safety is everybody's responsibility

TARGET OPERATING MODEL

CREATING EMPOWERMENT AND ACCOUNTABILITY

- We've organised the Trust so that our staff have time to build effective local partnerships
- The Care Units have been established with dedicated leadership teams to own safety, quality and improvement at a local level – and to take accountability for driving these forward
- Local leadership teams now include an Operational Director supported by Deputy Directors for Quality and Safety, and Deputy Medical Directors. This ensures that the Care Units have the capacity and expertise to drive continuous improvement and innovation
- We've appointed a senior safety specialist who advocates for patient safety across the Trust
- Our Target Operating Model is driving the transition to distributed leadership and creating a culture of accountability and empowerment at all levels in the Trust
- By giving our new Care Units greater responsibility for clinical and operational practice, we will move decision making closer to patients, empowering our staff to provide outstanding care and involving patients, families and carers in the decisions that affect them
- This approach will allow our staff to be agile in responding to changing patient needs and changes in the external environment

CARE UNITS

- PSYCHOLOGICAL SERVICES
- URGENT CARE AND INPATIENT SERVICES
- SPECIALIST SERVICES
- COMMUNITY NORTH EAST ESSEX
- COMMUNITY WEST ESSEX
- COMMUNITY MID AND SOUTH ESSEX

BUSINESS UNITS: (PEOPLE AND CULTURE, FINANCE, INFORMATION TECHNOLOGY)

ACCOUNTABILITY FRAMEWORK

PUTTING CARE CLOSER TO PEOPLE

The Accountability Framework has devolved decision making to those best placed to make decisions for and with patients, while setting a clear set of guiding principles for all our staff and a framework for raising visibility of issues.

Five clear domains of decision making set out the accountabilities of staff at all levels:

- **Quality and safety**
- **Performance**
- **Workforce and culture**
- **Finance**
- **External relations**

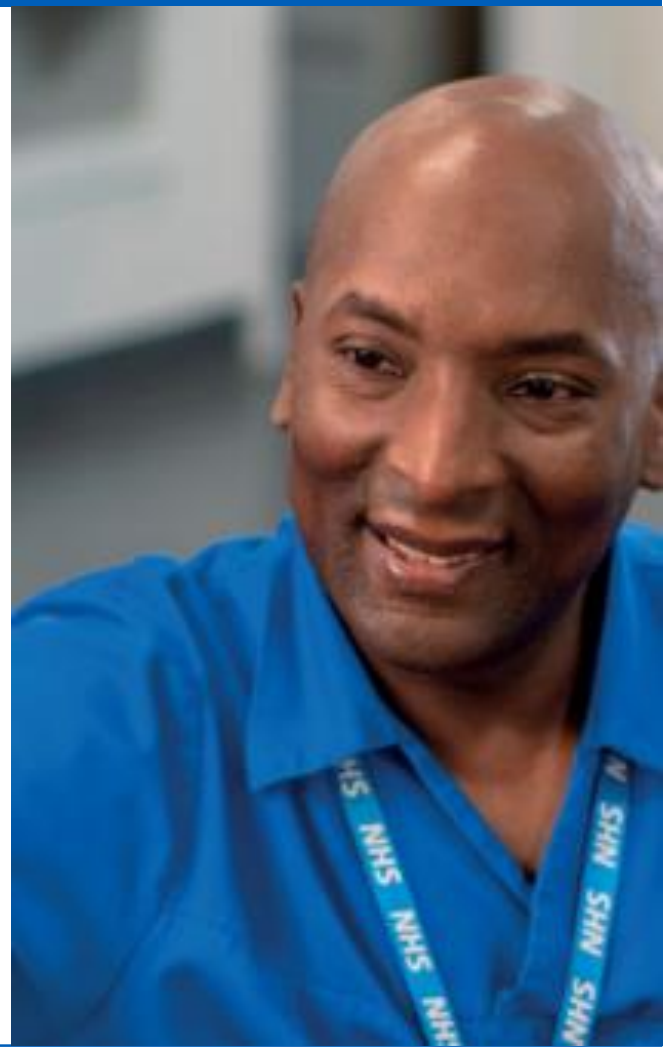
This framework is key to our Target Operating Model, supporting the Care Units to take decisions in patients' best interests and make informed decisions in an agile way at local level.

The Accountability Framework is now the primary vehicle through which Care Unit delivery within the Trust is monitored, managed and improved.

We are still testing and improving the approach, but it has already supported measurable improvements in reducing the number of absconsions, physical interventions and ligature incidents.

As we learn from the successes of embedding the framework within Care Units, we plan to update it and roll it out across our corporate services Business Units, to ensure a consistent approach for decision making and organisational accountability.

In an independent review of stakeholder perceptions in 2021-2022, stakeholders recognised the largescale change taking place at EPUT. There was awareness of the new operational structures, care units and strategic objectives. There was clear recognition of EPUT's new attitude and approach, describing a marked change in culture and improved stakeholder relationships.



CULTURE

We have continued to build our environment of Safety First, Safety Always, incorporating a Just Culture to drive a workplace of safety for patients and one of physical and psychological safety at work for our staff.

Creating an ethos of strong accountability – but not of blame – has encouraged staff to speak up, raise concerns and report incidents. This kind of transparency, equality and fair treatment creates better environments for our staff, patients, their families and our partners.

JUST CULTURE

RESPECT, FAIRNESS AND TRUST AS THE FOUNDATIONS OF PATIENT SAFETY

In promoting and creating a positive workplace culture of civility and respect we will improve staff experiences, wellbeing and retention, ultimately leading to improvements in patient care and safety.

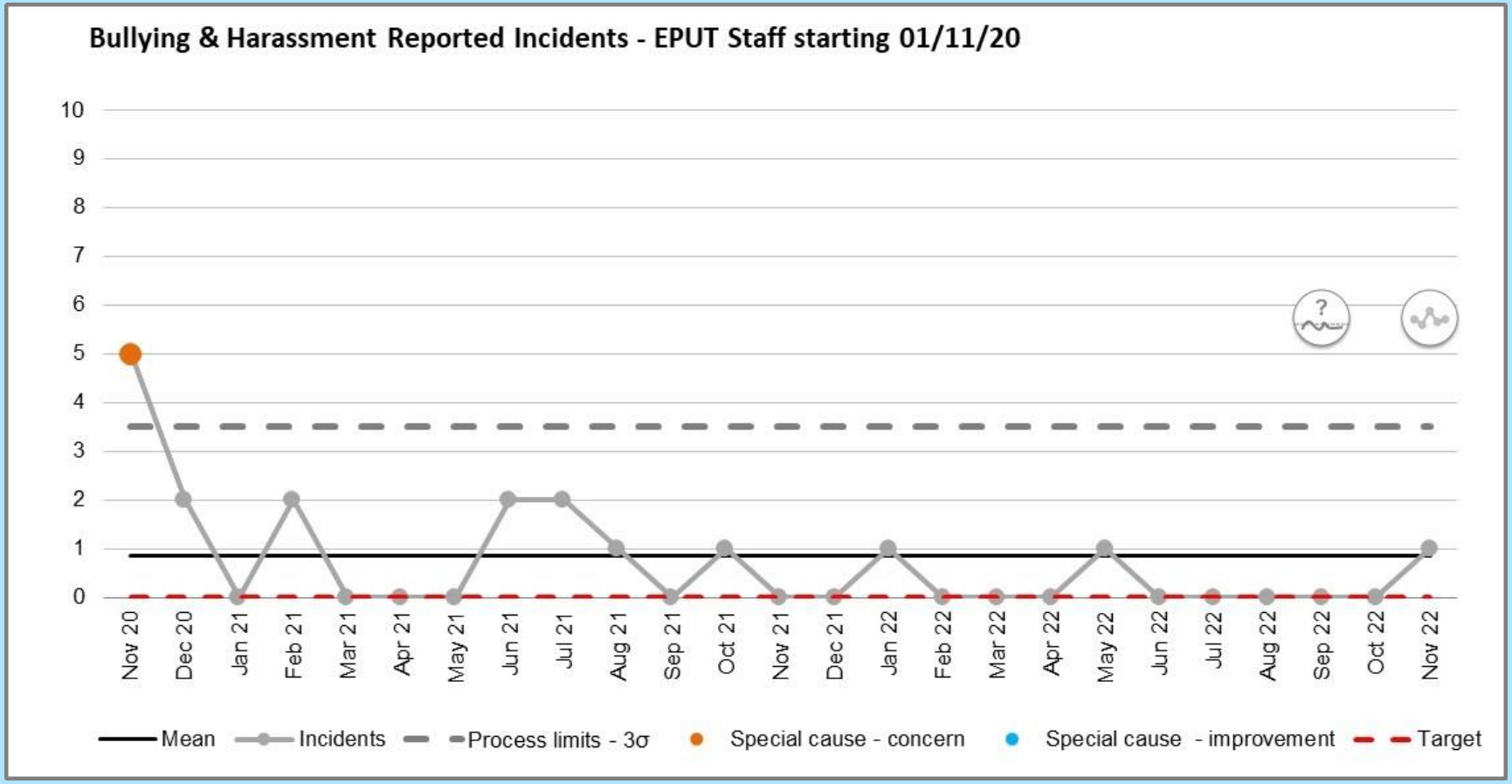
Crucially, we will also give staff the confidence to speak up and speak out without fear of unfair treatment, whenever they witness or experience something that could jeopardise patient safety or quality of care. Notable achievements so far:

- The Trust's Disciplinary Policy has been redesigned in line with a Just, Learning and Caring Culture
- A Conduct Investigation Toolkit has been produced to ensure all involved in an investigation know what to expect and where to get support
- There were no claims made at an Employment Tribunal during 2021/22 which relate to conduct
- Only 0.4% of the substantive workforce was subject to a conduct investigation in 2021/22. This is a 60% reduction since 2020/2021
- We've appointed a 'Freedom to Speak Up Guardian' who will allow staff to raise concerns to senior leadership anonymously
- In 2023, a new Behavioural Framework will be released, based on Trust's values. This sets out the standards of behaviours we all need to follow and uphold in our day-to-day roles, and will support the promotion of behaviours conducive to improving safety and driving the culture of learning

60% REDUCTION IN CONDUCT INVESTIGATIONS SINCE 2021

BULLYING AND HARASSMENT *SIGNIFICANT IMPROVEMENT*

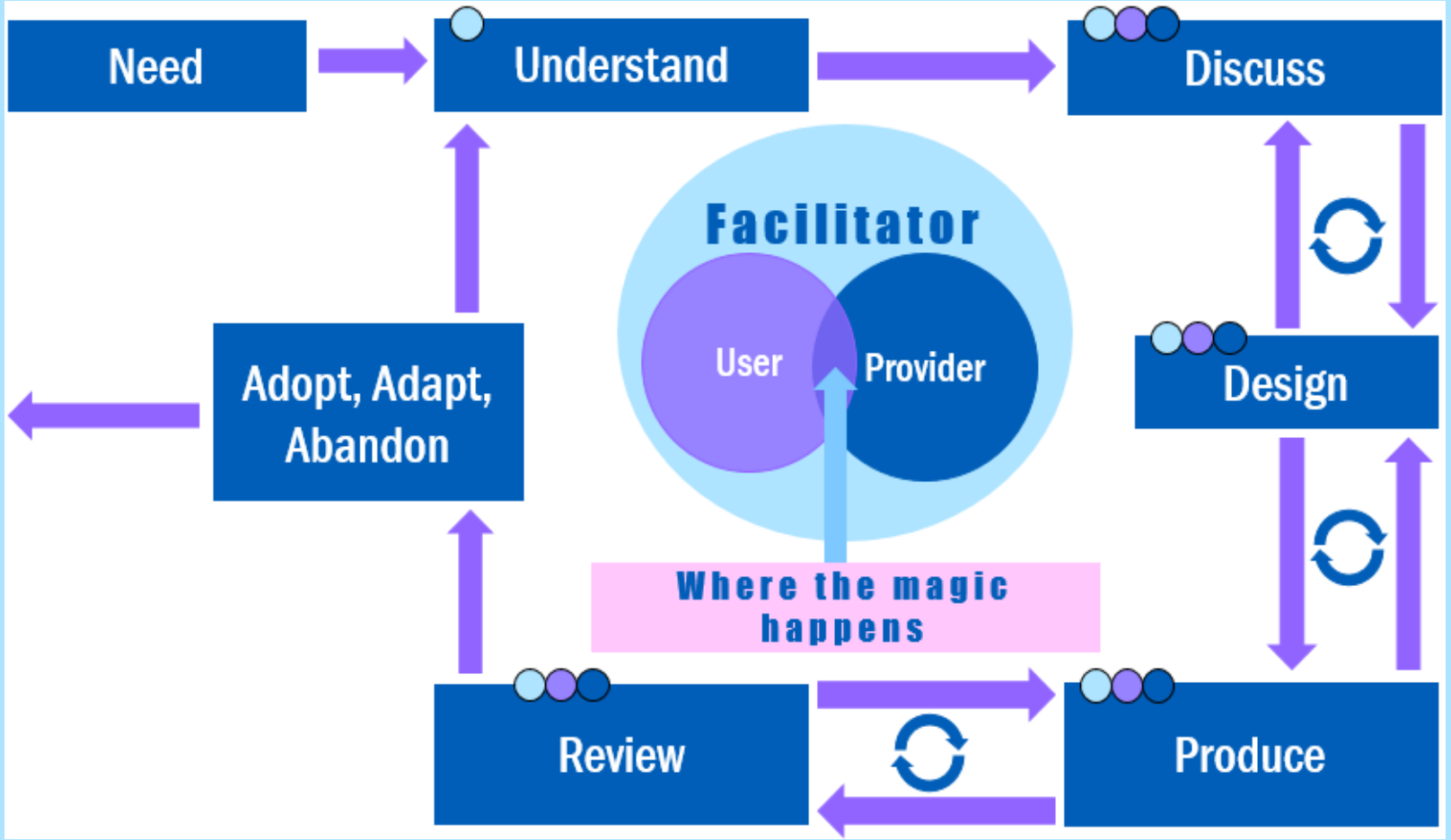
Bullying and harassment incidents have fallen significantly in the last 24 months, with a maximum of one incident a month since August 2021 and several months with no incidents.



CO-PRODUCTION

CREATING A CULTURE OF SAFETY THROUGH CO-PRODUCTION

'Co-production is when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered' - The Care Act



The Co-production Model for EPUT

CO-PRODUCTION

CREATING A CULTURE OF SAFETY THROUGH CO-PRODUCTION

We recognise our service users as strategic partners with crucial knowledge and understanding to support our continuous improvement.

We have built an approach to co-production led by a facilitator to ensure that neither the provider or the user are at risk of bias (this is supported by our co-production model).

We currently have five Patient Safety Partners at EPUT, they support improvement work across the Trust and meet monthly to provide their Lived Experience perspective on how we can improve patient safety.

Patient Safety Partners conduct safety walk-arounds supported by a series of quality and safety questions they have developed based on their lived experience.

Co-production in action:

The involvement group was formed as part of the Mental Health Urgent Care Department (MHUCD) in the summer of 2022 and is formed of people with lived experience of mental health and physical disabilities, people who care for others with lived experience and relevant Voluntary Care Sector (VCS) organisations. Engagement has been widespread, including:

- Development of the business case, including examples of the impact of the service on our patients
- Development of communication materials for the service
- Development of the estates architectural designs, including accessibility considerations and furniture designs
- Involvement in interview panels for the recruitment of the MHUCD workforce
- Development of training for staff

PATIENT SAFETY PARTNERS

CO-PRODUCTION IN ACTION

EPUT has recruited five Patient Safety Partners to support the Trust in achieving its Safety Strategy. They are the voice for patients, their families and carers. They gather and raise their concerns and views in the governance and management process to improve patient safety across EPUT.

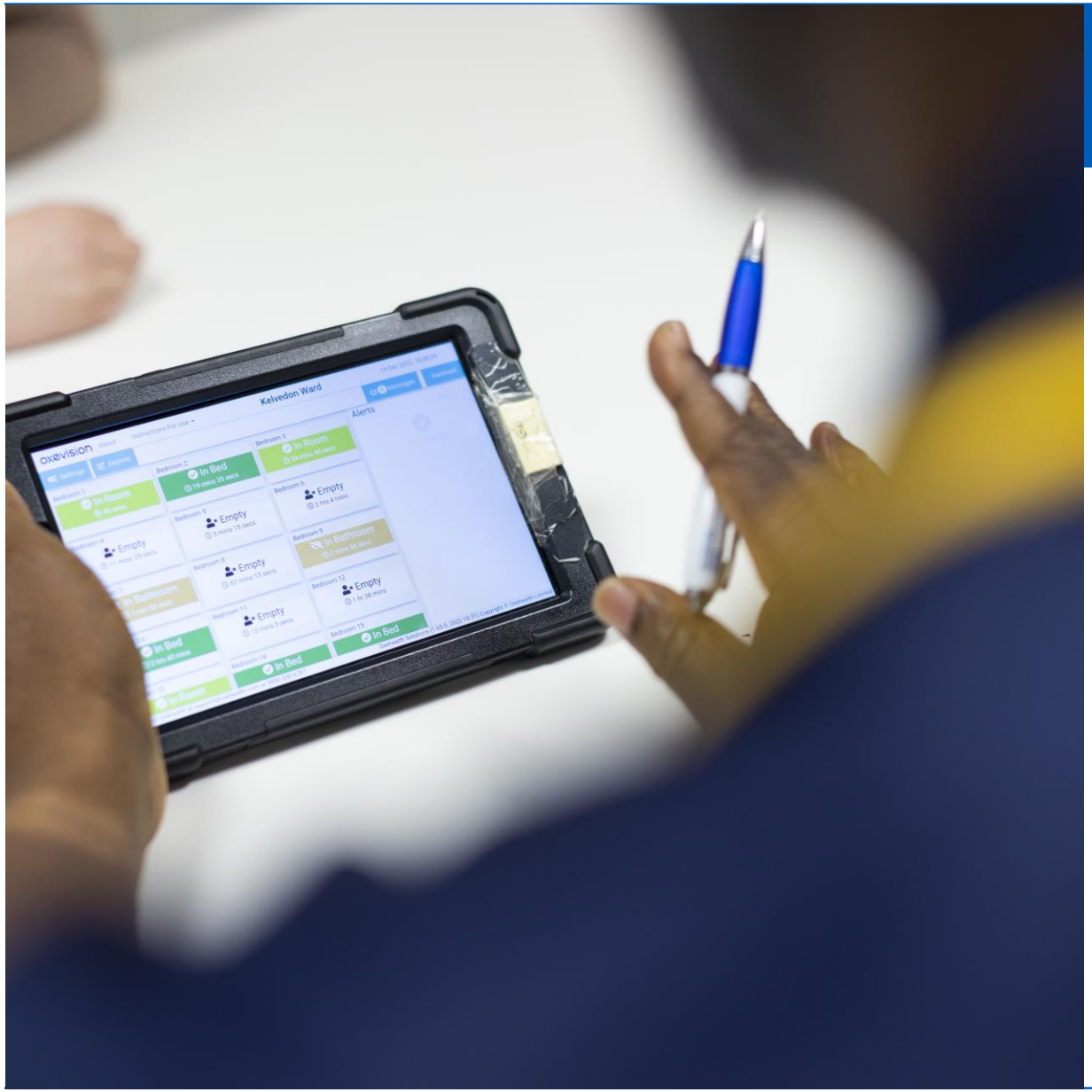
Patient Safety Partners recognise the importance of involving patients, their families and carers in all aspects of healthcare. The partners support and challenge the Trust, acting as a critical friend to ensure that the diverse perspectives of patients, families and carers are fully represented. They will influence the future development of services from the point of view of service users.

The Patient Safety Partners will conduct "safety walk-arounds" to visit teams and talk with patients and carers to gather their views on safety.

The feedback of patients, their families and carers will be shared with the team supporting them in improving patient safety and experience within our services. The findings will inform how safety issues should be addressed and provide an appropriate challenge to ensure learning and positive organisational change.

From Right to Left – Dr Nicola Armstrong, Siobhan O'Connell, Mark Dale, Rosario Gullotta and Moriam Adekunle

Patient Safety Partner uniform



INNOVATION

Innovation includes new ways of working and technologies that could enhance patient safety. We also look to engage more with our partners, patients, carers and families to improve our services and their safety.

Image shown: Oxehealth's Oxevision and Oxeobs being used on a tablet

AWARD WINNING APPRENTICESHIP SCHEME FOR CLINICAL PSYCHOLOGISTS

"This award goes to show that all of that incredible hard work and innovative thinking has had a valuable effect. "

The NHS needs to increase its psychology workforce by 60% by 2024. However, figures show that only 18% of psychology graduates are accepted onto Clinical Psychology courses via traditional training routes.

This is the challenge that EPUT set out to tackle as part of a Trailblazer Programme with our partners at East London Foundation Trust and Sheffield Health and Social Care Foundation Trust.

Clinical Psychology leads from all three Trusts came together to develop the Clinical Associate in Psychology (CAP) training programme. The programme was created with a vision to grow a sizeable, sustainable and diverse psychology workforce representative of the communities it supports.

By building partnerships with universities, the initiative creates locally relevant training programmes alongside strategic workforce plans, to ensure that the mental health workforce of the future has the capacity and sustainability it needs.

The wider health sector recognised the power of this programme, which won the **HSJ Award for Workforce Initiative of the Year 2022.**

FOR HEALTHCARE LEADERS
HSJ
AWARDS

AWARD WINNING APPRENTICESHIP SCHEME FOR CLINICAL PSYCHOLOGISTS

Clinical Associates in Psychology (CAP) aims to increase the national number of qualified psychologists and offer talented graduates who might have faced barriers to training the opportunity to train on the job. And the evidence shows that it's working:

- EPUT now has 44 Clinical Associates in Psychology, who have recently completed or are currently in training through the apprenticeship programme. A further five have completed their training and progressed to other posts
- CAPs are working on our inpatient wards, in community teams, perinatal services, Early Intervention in Psychosis (EIP) and are planned in many other services

"This was a very powerful and practical workforce initiative which hits the purpose of this award on the head".

– HSJ Awards Judges' Verdict

FOR HEALTHCARE LEADERS
HSJ
AWARDS

DIGITAL STRATEGY

This strategy was formed through over 400 direct engagements with EPUT staff

We developed a new five-year digital strategy which was signed off in February 2022.

This strategy was formed through over 400 direct engagements with EPUT staff using a series of workshops and interviews which set out a blueprint for the digital future of EPUT. There was an agreement from those consulted on the following core objectives:

- A single electronic patient record (EPR)
- An electronic prescribing and medicines administration (EPMA) capability
- A need for joined up people systems and staff management processes supported by digital – a consistent theme across front line staff as well as the People and Culture team
- A need for a strong focus on enabling technology at the front line
- The development of the Health information Exchange (HIE)

The Digital Strategy Group, chaired by the Executive Director of Strategy, Transformation and Digital is directing 13 strategic schemes.

This strategy is an enabler for change and has committed over £2m of capital towards the schemes that are important to the Trust's transformation.

These include:

- EPR levelling up programme
- Development and deployment of power BI as the gateway to data driven decision making
- Upgrades to ESR to streamline and drive efficiency for staff and managers
- Enablement of the EPUT culture of learning agenda
- Further expansion of trust Wi-Fi
- Ensuring a futureproof digital infrastructure

DIGITAL STANDARD OPERATING PROCEDURES

This work aims to co-author a suite of gold standard standard operating procedures (SOPs) to reduce unwarranted variation in order to reduce clinical risk and serious incidents.

SOPs will be made available to staff on a bespoke platform to support adherence and compliance monitoring.

The key benefits of this are:

- A reduction in unwarranted variation in clinical and administrative processes
- Reduction in time and resources wasted
- Improved support for staff working in challenging and high stress environments

Staff will be able to easily access SOPs that are relevant to them through the digital solution.

Updating SOPs will be simplified with a process to alert appropriate users and advertise the changes made.

Compliance monitoring will be improved with managers having the ability to assess compliance of areas and individuals.

The system will be auditable and allow us to provide evidence of the SOP that was in place on a given day in the past.

This digitalised approach will also improve the on boarding process, providing new staff with easy access to the best practice as defined by the organisation

STRATEGIC PARTNERSHIP WITH OXEHEALTH

EPUT has collaborated with Oxehealth to implement a safety monitoring system on our wards. The Oxevision system allows us to take remote measurements of patient vital signs, but is not a substitute for in person observations.

We have also been working together to develop an electronic observations feature with the objective of increasing the frequency and quality of inpatient observations.

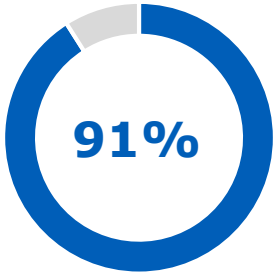
Better and more frequent observations will improve the safety and outcomes of our patients, including a reduction in falls and self harm.

The system has been installed on 23 wards, five health-based places of safety and five sites with seclusion rooms.

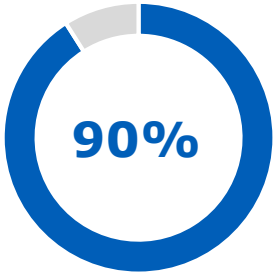
A recent study at EPUT by Oxehealth showed that patients and staff have responded positively to Oxevision.

"I think Oxevision makes us very safe on the ward. I find it hard to ask for help when I need it, or even admit to staff that I might need help. It's good to know that Oxevision calls for help when you need it, but also, when you don't think you need help."

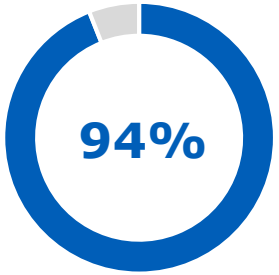
– Former Mental Health Inpatient



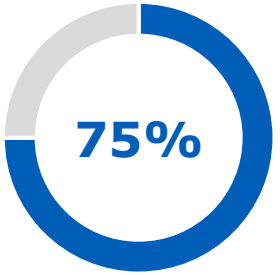
Staff agreed patient safety had improved



Staff stated that Oxevision had enabled them to prevent a potential incident from occurring



Staff stated they could identify incidents they may not have known about before



Patients felt Oxevision helps staff to keep them safer

MANAGEMENT AND SUPERVISION TOOL

MaST

MaST is an easy to use software platform which analyses data and information from multiple sources to help our teams make informed care pathway and resource allocation decisions to provide safe and effective care.

Community mental health teams in Castle Point, Rayleigh, Rochford, Brentwood and Thurrock have been using the digital Management and Supervision Tool.

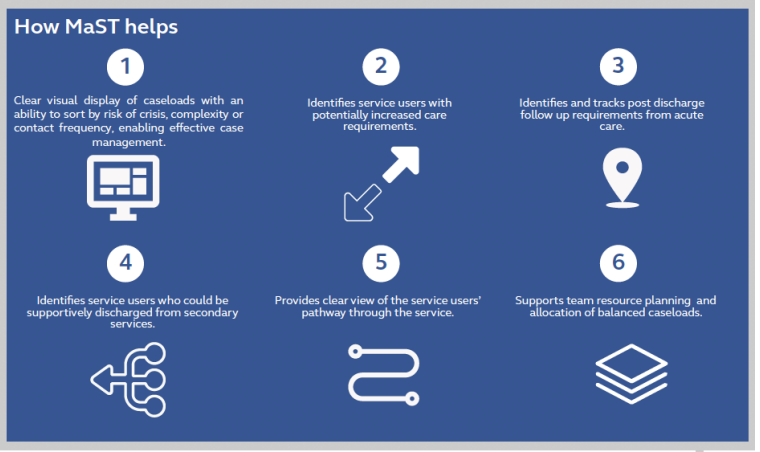
One of the key challenges nurses face is balancing large and complex caseloads. In just 10 minutes a day, MaST helps nurses prioritise their patients' care and flags any issues in urgent need of attention. MaST employs an algorithm which takes into account a number of different factors that might influence a patient's needs – like housing, medications, disabilities and other health conditions – and highlights where a patient may need additional support.

The dashboard highlights patients who may be at increased risk of crisis. It also flags when patients have not been contacted recently, or need a follow-up appointment.

Feedback from our staff has been positive:

"We use MaST within our team, and I have found the information dashboards very helpful. They are easy to use and give us an overview of our caseloads and any outstanding tasks. We use MaST regularly in our clinical supervisions."

"By rolling out MaST across our community mental health teams, we are empowering our nurses to manage their priorities and provide safe, effective care to our patients."



SELF-HARM REDUCTION PILOT

'The feedback we have received from both staff and patients has been very positive; with comments about the impact it has had on the ward culture and atmosphere'

The aim of the pilot was to diminish serious incidents (including self-harm and suicide attempts) relating to boredom by increasing recreational activities to provide daily structure for inpatient service users, freeing up clinical staff to increase therapeutic intervention offers, supporting patients in managing their self-harming behaviours and enhancing staff's skills.

Sensory Modulation training is complete, rooms and resources are available and Occupational Therapy (OT) staff are carrying out interventions.

Psychology have completed dialectical behavioural therapy (DBT) training and provided in-house training for ward staff on managing difficult behaviours associated with trauma.

Activity Coordinators have been recruited on virtually all adult inpatient wards in the Trust. Including weekends.

Positive patient outcomes

- 100% of respondents reported they attend activities on the ward
- 40% attend an activity more than once a day and 26.7% attend at least once a day
- 62.5% have found the activities to be very helpful for their mental health. 37.5% found the activities helpful
- 68.8% felt there were enough activities on at the weekend
- 31.3% of respondents reported they currently self-harm or have previously used self-harm as a coping strategy. Of those, 60% found activities on the ward helpful in reducing urges to self-harm and 20% found the activities very helpful
- 40% reported that ward activities help to reduce the severity of self-harming and a further 40% reported the severity of self-harming has partly reduced

EPUT NEUROMODULATION SERVICE (ENS)

EPUT has launched the first Neuromodulation service in the East of England

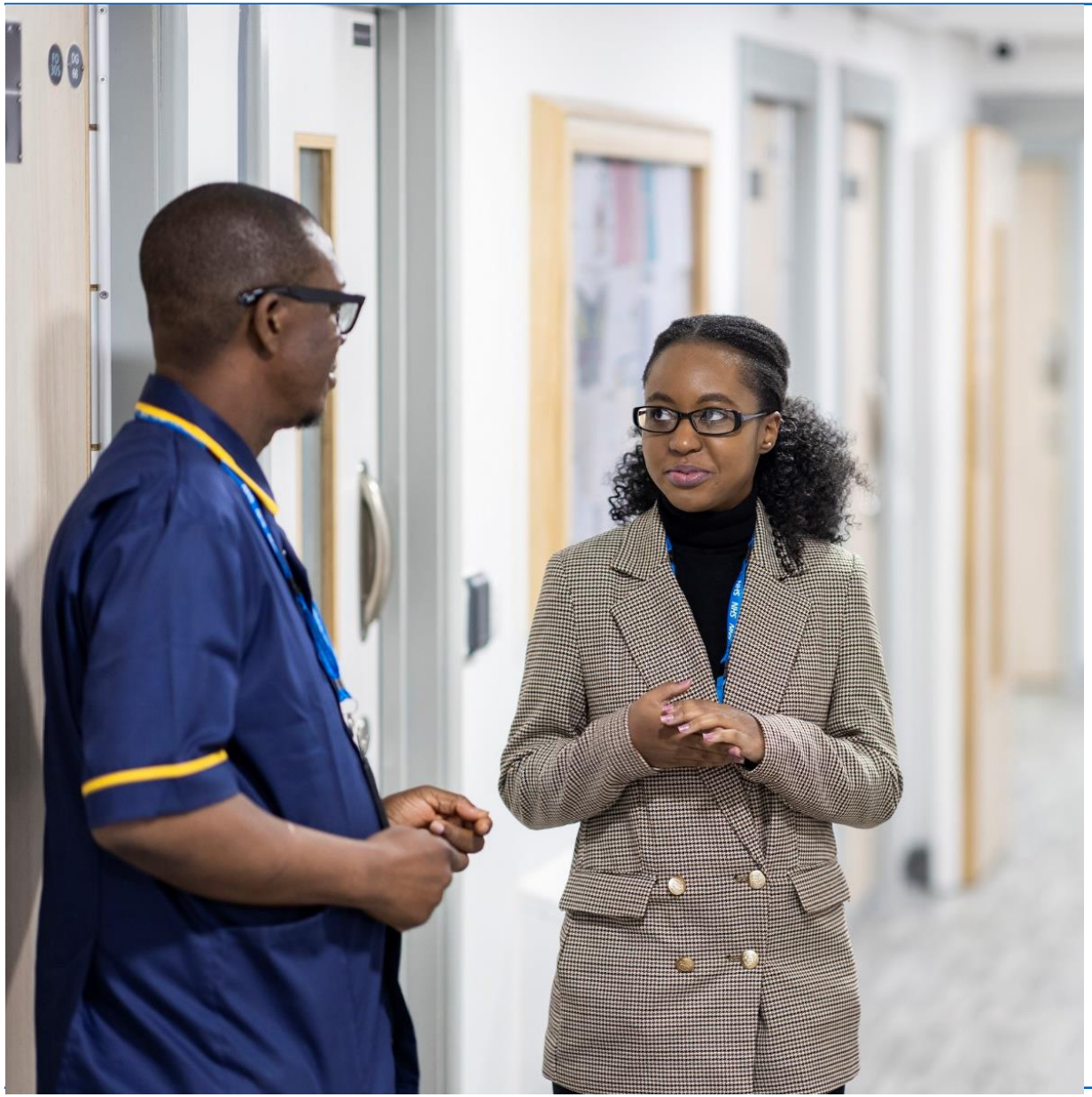
Essex Partnership University NHS Foundation Trust (EPUT) launched the first specialist Neuromodulation service in the East of England.

Advances in Neuromodulation are transforming the lives of patients with Treatment Resistant Depression (TRD) who have tried different types of anti-depressant medication but experienced no improvement in symptoms.

Neuromodulation uses targeted delivery of either chemical, electro-magnetic or electrical stimulation to alter nerve activity in the part of the brain that regulates mood, helping to reduce and relieve symptoms of depression and anxiety.

Thomas, a patient at Essex Neuromodulation Service, has seen a significant improvement in his mental health as a result of regular treatment. He said: "I was in a pretty bad way when I was first referred but I can now say very definitely that I am in a much better place. The treatment is giving me the ability to start focusing on my wellbeing and looking after myself again. It has got me doing things I enjoy again like reading and cooking."

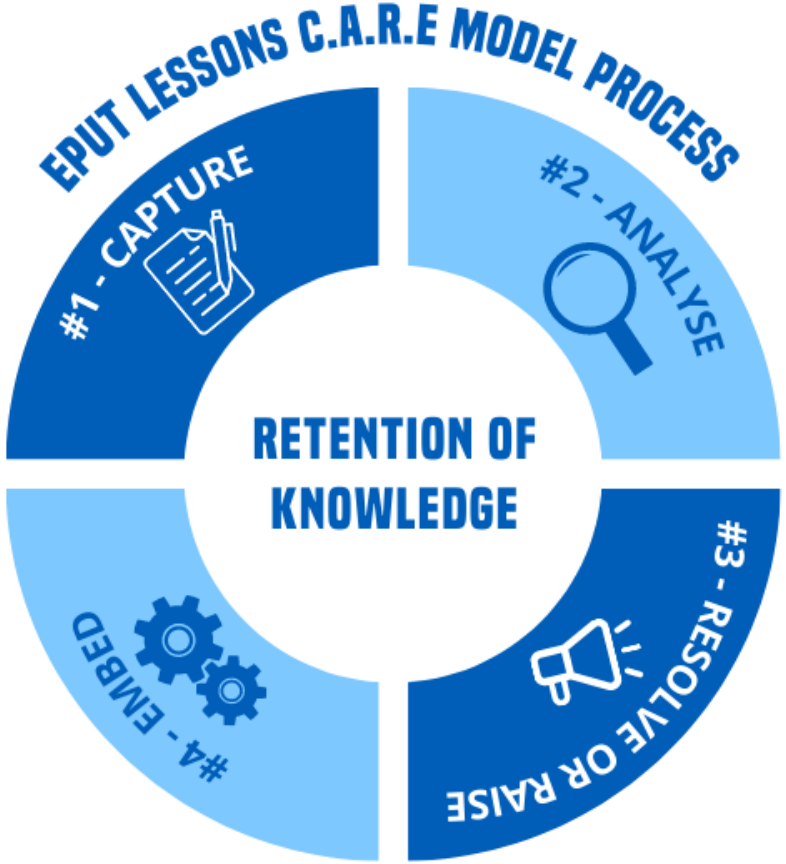
The pioneering new clinic based at Brentwood Resource Centre in Greenwich Avenue offers Repetitive Transcranial Magnetic Stimulation (rTMS) and Vagus Nerve Stimulation (VNS) alongside the Trust's existing Electroconvulsive Therapy clinics in Colchester, Basildon and Chelmsford, bringing all Neuromodulation treatments under one umbrella service.



CONTINUOUS LEARNING

We recognise that safety and improvement are continuous processes and so is the learning that underpins them. We have been developing an approach to learning where we see every event as an opportunity to learn and ensure lessons are shared across the trust and with partners, not just applied within the single area the incident occurred.

CULTURE OF LEARNING



At EPUT, we are ensuring that learning is an 'Always Event' where we all have a responsibility to seek improvement, learn from mistakes or good practice and adopt positive changes to provide excellent and safe care.

EPUT's Culture of Learning (ECOL) is focussing on ensuring our organisation has the right capabilities and environment to adapt and respond to challenges, and recognise opportunities to learn lessons in an agile and effective way.

The programme set out to improve how information is cascaded by increasing visibility, accessibility and awareness of lessons learned, best practice articles and other learning material.

We have been taking a collaborative approach to learning supported by the launch of the Learning Collaborative Partnership Group (LCP) in July 2022.

Left: To support learning within the Trust, we developed the C.A.R.E model.

Six Safety Action Alerts have been cascaded to staff since March 2022 and the ECOL intranet page has been viewed 5600 times since July 2022. These sources prove staff with the most up to date guidance and learning.

Quality and Safety Champions have been established, raising awareness of Trust policy and best practice across the organisation.

ECOL is now part of the Trust induction for new starters. We have also been holding Trust-wide live events to share learning on topics like ligature risk and drug abuse.

In 2023 we aim to:

- Publish a Trust-wide Learning Lessons e-training package
- Launch Learning Matters live sessions
- Develop a database platform that allows the investigation and documentation, management and analysis of lessons

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

HOW EARLY ADOPTION HAS PUT US AHEAD IN PATIENT SAFETY

EPUT participated in the early adoption of the Patient Safety Incident Response Framework (PSIRF).

PSIRF intends to reduce the likelihood of similar incidents recurring compared to the outgoing Serious Incident (SI) Framework.

This new approach acknowledges that outcomes are most impacted by processes and systems, the investigations therefore focus primarily on these areas.

We have received positive feedback on incidents investigations conducted under PSIRF with the coroner describing one report as ”exemplary”.

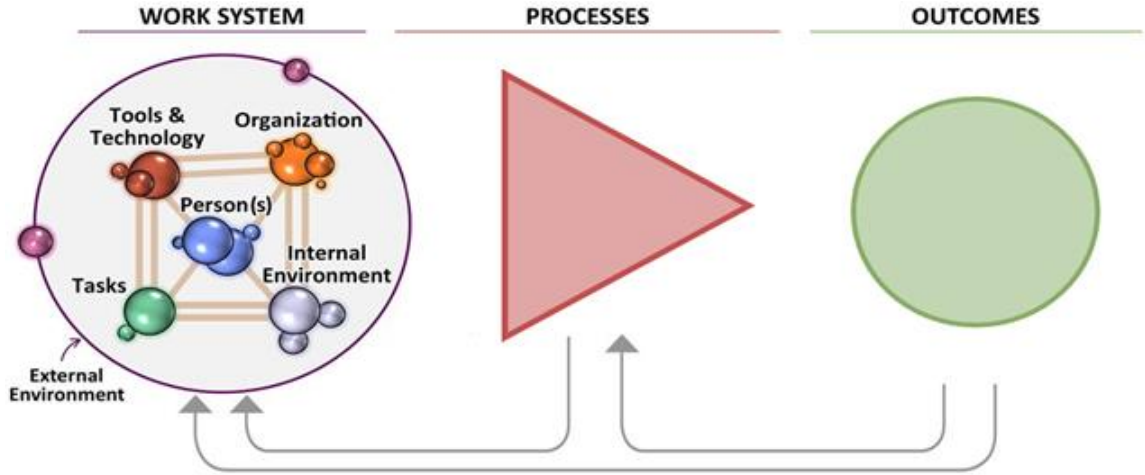
PSIRF encourages looking at incidents together in Safety Improvement Plans (SIPs) to find common themes rather than looking at incidents in isolation.

The Trust also produces Immediate Safety Actions to respond to short term learning from incidents.

The SIPs that EPUT have developed will implement learning from incidents across the Trust, rather than just at the sites where the incidents occurred.

We are currently providing other trusts with support for their PSIRF adoption based on our learning as an early adopter.

The model below is from the Safety Engineering Initiative for Patient Safety which supports the approach taken in PSIRF. This documents the link between outcomes, processes and the supporting work systems.



MANDATORY TRAINING

Wider Training Review

We're dedicating resource to complete an entire review of training in 2023 to ensure that we provide colleagues with the most suitable knowledge to effectively support and protect the safety of our patients.

This wider review will evaluate the facilities requirements for our growing training needs, the appropriate training depending on position and that this reflects any regulatory requirements.

Mandatory training is compulsory training that is determined essential by the organisation for the safe and efficient delivery of services. This training is designed to reduce organisational risks and comply with our local or national policies and government guidelines.

COVID restrictions meant in person mandatory training sessions were postponed or cancelled and we recognised an emerging risk to training compliance. To address this a project focussing on mandatory training was scoped and initiated in partnership with the Transformation and the Education Teams.

The work identified a number of quick wins to boost compliance rates across all courses, but also raised key concerns specific to Trauma and Self Injury (TASI) training and the extra time, resource and governance this back log will take to resolve.

TASI

A TASI training plan was approved by the Executive Team, with all elements other than a suitable long-term use venue in place to commence this work. The Executive Team recently approved the re-prioritisation of a Training Room 1 @ The Lodge to expedite TASI recovery from January of 2023.

As a result of the planning undertaken to date, we procured a further 12 months TASI accreditation from BILD (British Institute of Learning Difficulties)

Approval was received to recruit two additional TASI trainers with the team to deliver a full programme of training across all Trust sites.

In addition we have increased the availability of mandatory training by running additional sessions and providing staff with paid overtime to complete training.

LEARNING FROM DEATHS

Learning from deaths and ensuring that we use this learning to inform future practice is a key part of strengthening our safety culture. In April 2022, the Trust implemented new processes to facilitate learning from the deaths of people receiving care.

The aim of these revised processes, which replaced the previous mortality review arrangements, was to:

- Learn from our experiences of the previous policy
- Simplify our processes
- Ensure focus on learning outcomes
- Align with PSIRF arrangements
- Embed robustly in every day operation of frontline clinical services

The new processes involves an initial review (stage 1) of the clinical records and circumstances of the death by the local service to determine any learning and whether the death should be referred on for a more detailed clinical case note review (stage 2).

Examples of actions that have been taken by local services in response to the learning identified from stage 1 include:

- Enhanced internal local team communication processes put in place
- Addition of a flag on the service clinical information system to denote when next of kin details have not been completed in the record to ensure the clinician continues to seek this information in contacts with the client
- Sharing of learning with partner care providers
- Exploring how different teams involved can work together more effectively to support patients who are receiving community psychology and community mental health services

Sharing of local learning from Stage 2 reviews is being co-ordinated by Deputy Directors of Quality and Safety (DDQSs), working with local clinical / service leaders to identify and implement change. Also being used to inform subject matter for quarterly learning events being designed and delivered for each Care Unit by DDQSs.

WELLBEING

Patient safety begins with a workforce who are happy, healthy, safe, and supported to do their job. We have been supporting the wellbeing of our staff so that they are enabled to provide the best care for our patients, carers and families.

TIME TO CARE

The challenges EPUT currently face cannot be addressed through incremental change. A new and ambitious approach is required to set firm foundations for the future.

The Time to Care programme was established with the aim of releasing significant and quantifiable time to care on inpatient mental health wards. This is to be achieved through:

- A **Staffing Model Redesign** to increase capacity, safety and quality on the wards
- **Process Improvement**, identifying quick wins, plus medium and longer-term solutions and embedding effective processes and training
- **Data and Technology** to improve the use of current data and technology to support teams and delivery of care
- **Engagement, Inclusivity and Wellbeing**, co-designing and implementing proposals with staff and Lived Experience representatives

So far, the Time to Care programme has delivered a number of initiatives, including:

- A Ward Manager Development Programme, designed and developed by over 20 EPUT leaders
- A SMART Bed Management tool
- Co-production of a behavioural charter and new pharmacy posters to improve working relationships
- Digital System Optimisation and Compliance Assessment
- Access to Shared Care Records
- Creation of a Safe Staffing Dashboard (shown below)

HERE FOR YOU – NOMINATED FOR A NATIONAL AWARD

The Great British Workplace Wellbeing Series with WELLITY

Great British Workplace Wellbeing Awards 2022 – Nominated in the category 'Team of the Year'

Here For You is a confidential mental health and wellbeing service available to all health, social care and voluntary sector workers across Essex and Hertfordshire.

The service is made up of psychologists, psychological therapists and mental health professionals, and is delivered in partnership by EPUT and Hertfordshire Partnership University NHS Foundation Trust. Our EPUT staff are both providers and utilisers of the service.

The Here for You service is able to support individual staff by facilitating confidential and sensitive access to appropriate services, directly supporting staff wellbeing and recovery.

Here for You also works with teams after a staff or patient safety incident, working with trauma and building a culture of psychological safety.

The service supports wider staff wellbeing by providing psychologically informed guidance and support through resources and webinars.

The service aims to be both responsive to reduce staff distress and proactive to enhance staff wellbeing.

Since starting, the service has carried out more than 1,900 rapid clinical assessments.

The Here for You System

CAVELL STAR AWARD WINNERS

We have been proud to celebrate the achievement of two of our nurses from the Epping Forest District Nursing Team who have been presented with a Cavell Star Award in recognition of their hard work and dedication to patients.

The Cavell Star Awards is a national programme that celebrates the dedication of nurses, midwives, nursing associates and healthcare assistants and recognises the care they provide to patients, families, and colleagues.

Colleagues have described them as "loyal teammates" who care when you are having a tough day and put their arms around the whole team.

They said: "Amanda and Tracy are trusted colleagues who ensure their patients are always safe, comfortable and informed."

"They go the extra mile to make patients' families also feel part of the care journey."

"They don't only go above and beyond for their patients; they also go out of their way to support other members of staff."

Cavell Star Awards

EQUALITY, DIVERSITY AND INCLUSION

EPUT's race equality action plan has been rated outstanding by NHS England.

Bullying and Harassment

Our focus has been, and continues to be, on taking an intersectional approach to tacking bullying and harassment by implementing a robust campaign which will enable us to make transformative changes to the culture in the workplace.

This year has seen a strong start in increasing awareness of bullying and harassment in the workplace, including:

- Delivery of a webinar to over 140 members of staff
- Upcoming workshops targeted at middle managers across EPUT
- Refreshing and updating the Bullying at Work guide and policy
- Working with relevant teams to implement the updated Zero Tolerance policy
- Guidance for management on appropriately handling issues raised

Development of Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) Action Plans

- The Action Plans are produced to monitor the activity and progress against indicators of the WRES and WDES Breakdown and Metrics and close the gaps between white and Black and Ethnic Minority (BME) and Disabled staff of their experience in the workplace. They include objectives and assigned nominated leads with responsibilities and tasks to make the delivery of the plan impactful for employees
- Our WRES action plan has been rated outstanding by NHS England for the first time. This is the highest level we could have achieved and it has been awarded for good use of positive action, measured interventions and using data and evidence to support change
- In 2021-2022, there has already been some improvement for our BME staff on five of the WRES Indicators, and for our Disabled Staff on eleven of the WDES indicators

ENHANCING ENVIRONMENTS

Our buildings and facilities play a crucial role in safety. A safe environment limits the opportunities for patient harm and a therapeutic environment is essential for supporting our service user's recoveries. We have been working to improve the standard and quality of our estates across the Trust.

Image shown: The Crystal Centre in Chelmsford after refurbishment

MENTAL HEALTH URGENT CARE DEPARTMENT

We have developed a 24-hour Mental Health Urgent Care Department that will be integral to the Urgent Care Pathway and integrated with wider services including Assessment Unit and Crisis alternatives.

There are many benefits associated with this approach to mental health urgent care:

Patients in crisis will get the most appropriate care at the earliest opportunity allowing us to prevent further deterioration of their mental health.

"Thank you for all your support and kindness over the last few days. As lovely as you all are I hope I don't have to see you again, not within this setting anyway! Fingers crossed I am on the mend." – EPUT Diversion Service User

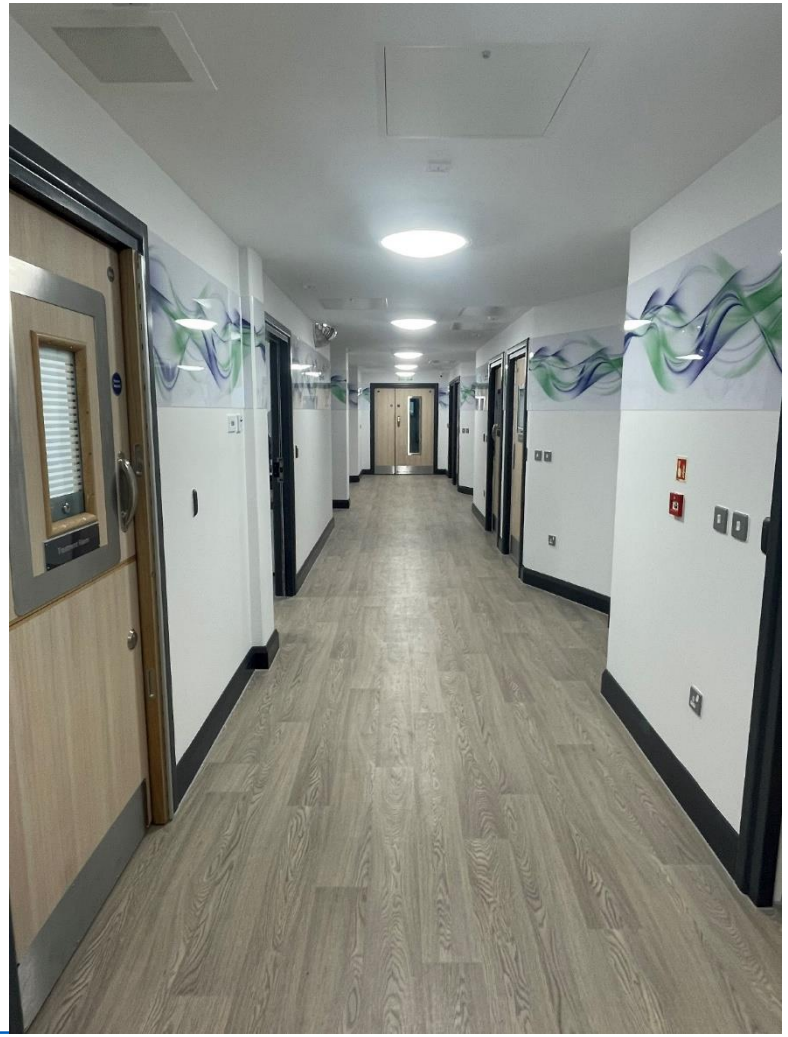
Patients will be seen in an environment more conducive to the assessment of patients in crisis resulting in better patient experience, a reduction in self harm and improved visibility for observations

Improved patient flow and reduced length of patient stay will result in fewer patients absconding, this is currently around 300-500 at local emergency departments.

While the full implementation of the Urgent Care Department is planned for next year, we have trialled a diversion pathway at Basildon Hospital as an initial pilot.

The diversion pathway went live in late January 2022 and provided a suitable space for the assessment of patients attending the Basildon Emergency Department. Some of the benefits and successes of this trial were:

- Diversion rate of between 18% and 22% of mental health attendances at Basildon emergency department
- Occupation rate of the 2 diversion rooms between 95% and 99%
- Supporting the system through the recent OPEL 4 pressures



LIGATURE RISK REDUCTION

As a result of the focus on our estates, we've seen a ~30% reduction in the number of fixed-point ligatures in 2022 compared to 2020.

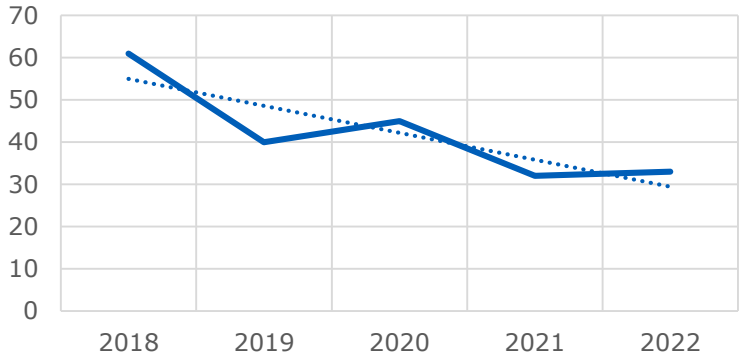
A data-led, thematic investigation of ligature incidents helped us to identify and mitigate risks for patients. The investigation identified:

- The environmental and non-environmental factors in ligature risk
- Awareness of policy and procedures
- Commonalities in the day(s) of the week and times that incidents were occurring

This analysis was used to identify the improvements and interventions that would have the biggest impact on safety. In particular, we expanded the focus of improvement work to include training and raising awareness of the policy.

The evidence-led nature of this work was key, because it demonstrated the case for a shift in focus from the physical environment only to policy, training, awareness and compliance.

Work on the estate has already seen a 30% reduction in fixed ligature points. Our ambition is to remove all fixed ligature points across all sites.



Fixed-point ligatures per year

Work on the training and policy is expected to further result in:

- A reduction in the number of overall ligatures
- A reduction in levels of harm associated with ligatures
- Improved staff wellbeing
- Reduction in incidents referring to policy and training issues

LIGATURE RISK REDUCTION

The Trust has completed 32 ligature-related estates projects since April 2022, including:

- Installation of 68 fire call switch toppers at Rochfield House
- Replaced 399 door hinges across the Trust, with a further 52 scheduled to be fitted by 31/03/23
- 560 radiator covers replaced across the Trust
- Installing new ligature-reduced garden furniture at Rainbow Ward, Christopher Unit and Finchingfield Ward
- Installing Access Control on Cedar Ward and Willow Ward
- Installing 32 shower timing devices across the Derwent Centre
- Installing 60 soft bins to trial. Due to the success of the trial a programme to roll these out across the Trust has been established
- Refurbishing the Linden Centre Health Based Place of Safety
- Installing soft doors in all ensuites at Grangewater
- Installing 100 noticeboards across the Trust in patient areas
- Delivering additional security blankets to all wards uplifting to five per ward from three per ward

AWARD WINNING REFURBISHMENT PROJECT AT BASILDON

A key component of our Estates improvement plan has been a £12.5 million investment to eliminate the remaining dormitory accommodation at Basildon Mental Health Unit, as recommended by the CQC.

The refurbishment includes the leading safety improvements available along with decoration that has also been carefully selected to improve mental wellbeing and encourage creativity.

Throughout the design process, both service users and staff were instrumental in contributing to improving patient experience and providing a safer environment.

The project won the Best Patient Safety Initiative category in the Building Better Healthcare Awards. It was also shortlisted in the Best Interior Design and Best External Environment categories.

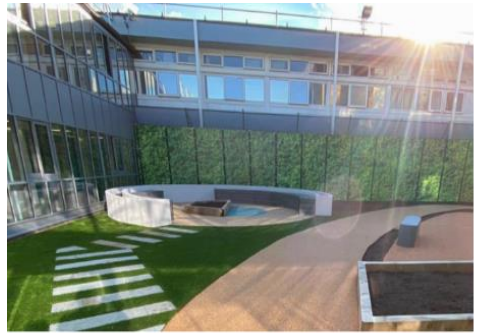
The improvements have also received positive feedback from our service users:

"I feel so much safer already knowing I have my own room. Not having to share with other people will make such a difference to me and my recovery"

"This is the best ward I have been to; it is like a hotel. I would be happy to pay for my stay here. The ward environment is therapeutic"

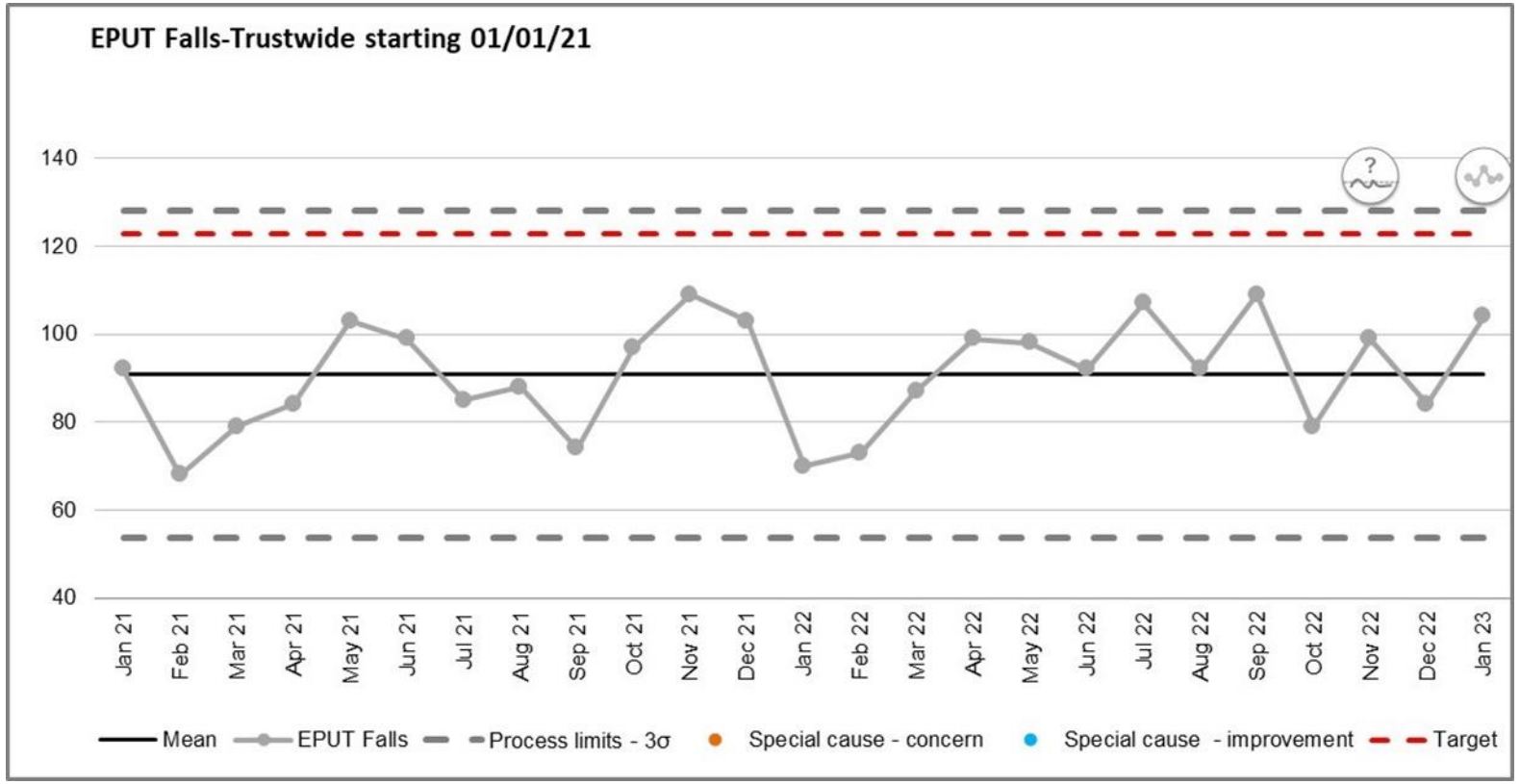
"This will make such a difference. Previously I shared with someone who liked the light on, and it meant I couldn't sleep properly."

BUILDING BETTER HEALTHCARE AWARDS 2022



PREVENTING FALLS

CONSISTENTLY BETTER THAN TARGET



Patient falls across the Trust have been significantly better than target over a sustained period.

There is some variation from month to month, which is to be expected, but we have maintained patient falls at a level that is both significantly below target and close to the mean.

GOVERNANCE AND INFORMATION

The foundations of a safe organisation are built on solid governance, process and access to information. Our work has been focussed on providing decision makers across the organisation with access to as near to live data as possible so that data driven decisions can be made as well as allowing decisions to be made as locally as possible.

EXECUTIVE AND BOARD SAFETY OVERSIGHT GROUPS

The Executive Safety Oversight Group (ESOG) was formed in November 2020 and is chaired by the Trust CEO. Membership includes the Executive Team and the Director of Transformation, the Director of Safety and Patient Safety Specialist, the Deputy Director of Compliance.

The primary focus of the group is to oversee and provide assurance on the development, planning and delivery of the safety strategy, encompassing (but not limited to) physical environment, staffing & management structures, leadership & culture and record keeping.

The group also oversees the development and delivery of action plans relating to: CQC reports, HSE reports, PHSO reports and any other expert or external review recommendations.

The Board Safety Oversight Group (BSOG) was formed in November 2020 and is chaired by a member of the Trust Board. Membership includes the ESOG members, the Trust Secretary and two further Non-Executive Directors.

The BSOG provides assurance to the Trust Board that the safety strategy is being delivered to the agreed time, cost and quality parameters.

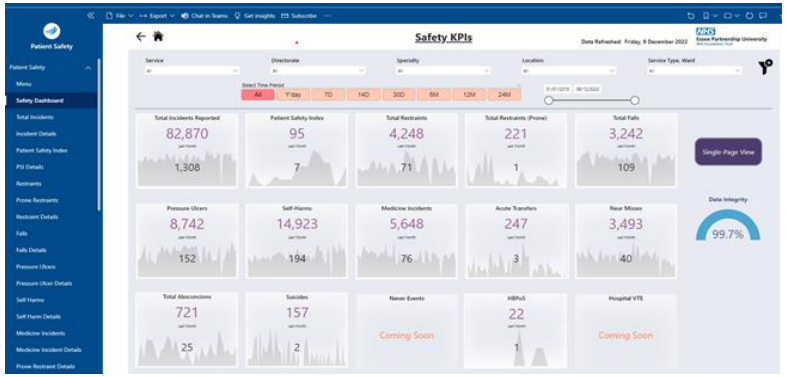
It also ensures adequate processes and governance are in place to safely enable successful delivery of the safety strategy alongside effective and sufficient availability of resources to support the safety strategy priorities.

SAFETY DASHBOARD

The success of this approach will be measured through a significant reduction in the repetition of similar patient safety incidents

We have developed a Safety Dashboard with the purpose of learning from adverse events and good practice, building on the approach used in NATO, the Ministry of Defence and Aviation Industries.

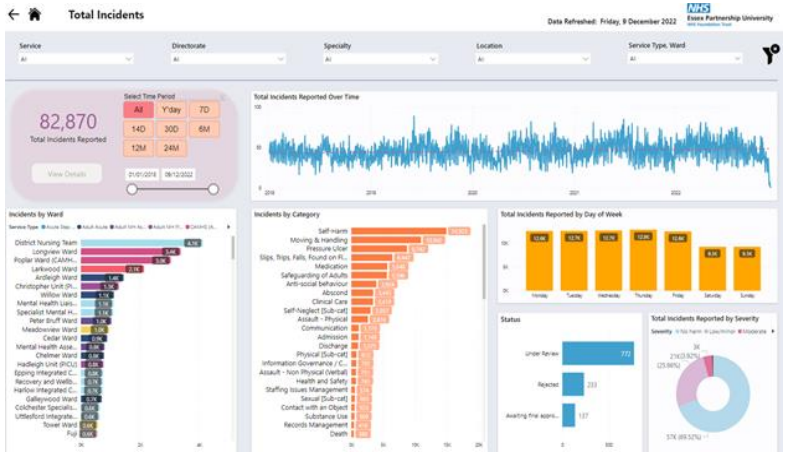
This dashboard integrates with the Datix and other data sources in the Trust. It currently provides data on Safety and Quality KPIs, Operations and Patient Experience. This approach to reporting supports a transition to proactive rather than reactive decision making by enhancing our learning capability.



High Level Safety Dashboard showing the Trusts Key Performance Indicators

The success of this approach will be measured through a significant reduction in the repetition of similar patient safety incidents in the Trust as identified in the trust Patient Safety Incident Response Plan.

To get the most from these dashboards, we will set and measure some KPIs to demonstrate compliance with the outcomes of the safety strategy and intervention from our learning lessons capability.



The dashboard allows us to dive deeper into our data to discover new learning

ELECTRONIC PATIENT RECORD

IN PROGRESS
2022 - PRESENT

Objective

To ensure that EPUT meets its fundamental objective of safe care to our patients there is a need to de-complicate the multiple electronic patient record systems.

The aspiration is to deliver a modern, robust and sustainable single EPR across EPUT. Taking this a step further, the digital team are working in collaboration with system partners to consider what a converged EPR opportunity could enable by bringing together mental health services, community health services and acute care settings into one electronic record.

Progress

Stakeholder engagement workshops were conducted prior to an options appraisal. A strategic outline business case was produced in August 2022 and approved by the Trust Board.

A business case is under development to select an EPR system that will:

- Enable the rationalisation and modernisation of the Trust's existing EPRs
- Support the Trust's clinical and administrative processes
- Improve the safety and delivery of patient care
- Improve patient experience and outcomes
- Enable patients to share and own their records

ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION

IN PROGRESS

JANUARY 2019 - PRESENT

Objective

In the last two years, EPUT reported over 2,300 medication related errors.

In a sample of nearly 13,700 EPUT medications orders over 24 months, 4.6 percent were found to contain one or more prescribing error.

Research shows that an ePMA system can provide:

- 60% reduction in prescribing errors
- 10% reduction in pharmacy workload
- 5% reduction in omitted dosages
- 63% reduction in clinical incidents
- 63% reduction in potential Adverse Drug events (ADEs)
- 206% rise in the accuracy of discharge medicine prescribing

Progress

A bid was submitted in January 2019 for funding made available to achieve the NHS Long Term Plan commitment of replacing paper prescribing with electronic by 2024.

An initial outline business case for ePMA was approved in 2019 with a full business case post the Covid-19 pandemic being presented to the Trust Board in March 2023. Once approved the programme is anticipated to take 2 years to deliver.

The trust awarded a contract to EMIS Health in January 2020, with the contract signed in March 2020.

EMIS

Currently we are working with EMIS to upgrade the pharmacy system from v10.15 to v10.22 which will bring performance improvements to pharmacy management and administration.

Our vision is to have an ePMA platform that integrates with our EPR systems.

NHS
Essex Partnership University
NHS Foundation Trust

LOOKING TO THE FUTURE

OUR PLANS FOR YEAR 3 OF THIS STRATEGY

EPUT

OUR CONTINUED AREAS OF FOCUS

OUR FOCUS FOR YEAR 3 AND BEYOND

During the lifecycle of the *Safety First, Safety Always* strategy, our performance has continued to progress across many of our key metrics. Despite this, we know the journey is not complete and we continue to push for improvement and innovation to provide consistently safe care. Safety never stops and as we enter the final year of the strategy, our focus will be on five priority areas:

Patient Voice in Safety

We will ensure patients and families are involved in our quality improvement

- Increasing our number of people with lived experienced engaged in improvement
- Further development of *I Want Great Care*

Creating a Culture of Safety

Embedding the highest professional standards to become a Patient First organisation

- Creation and implementation of EPUT's People Charter
- Continuing to enable a reporting culture to encourage our people to speak up

Data Informed Safety

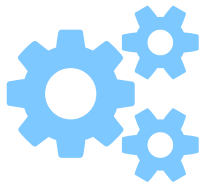
We will use data to inform of safety decision making and oversight

- Better use of our safety dashboard data from Board to Ward
- Widespread engagement with lessons learned collected and shared across services
- Learning from past incidents and the Essex Mental Health Independent Inquiry (EMHII) and their conclusions on culture will be applied to our future areas of focus

Partnerships and Safety

We will build our system partnerships to best deliver patient safety

- Build our work of Patient Safety Partners to co-design and co-produce services
- Essex Police Mental Health Team
- Mental Health Urgent Care Department
- Deepening our partnership with primary care



Embedding Lessons in Safety

We will continue to embed what we have learned since the launch of this strategy to ensure consistent good practice across our Trust.

- Better evidence tracking of benefits realised through new ways of working
- Continued use of PSIRF and promoting our role supporting other Trusts implementing the framework
- Rollout of SIPs across all service areas
- Implementation of any learning from the EMHII

PATIENT VOICE IN SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Ensuring the patient voice is listened to, understood and acted on is key to embedding safe, good quality care throughout the organisation in all our care settings.

Priority Initiatives for Year 3

- Further development of *I Want Great Care* to enhance the quality, quantity and application of patient feedback to care practices
- Instil a culture of systematically capturing and embedding patient feedback in everything we do
- Further increasing the number of people with lived experience engaged in our improvement work
- Increasing the number of our Patient Safety Partners, strengthening their voice and enhancing their role in safety and quality improvement

CULTUTRE OF SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Embedding the highest professional standards to become a Patient First organisation.

Priority Initiatives for Year 3

- Creation and embedding of the Trust's People Charter
- Continuing to foster a culture of reporting and speaking up
- Instilling a sense of empowered leadership throughout the wards
- Identify any learning or recommendations emerging from the EMHII
- Rolling out Quality Together to ensure a shared culture of accountability, working with system partners and patients
- Truly embedding our process and practice improvements at ward level and throughout every care setting
- Enhancing the outcomes of our work using Quality Improvement methodologies

DATA-INFORMED STRATEGY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Making the best use of data to inform decision making, oversight and continuous improvement.

Priority Initiatives for Year 3

- Review our Business Intelligence capability and develop a new future-state model
- Turning our data into insight to improve the quality of prioritisation and decision making
- Embedding use of Safety Dashboard data from ward to board
- Development of ward-level quality assurance framework that provides oversight and evidence on safety of care

PARTNERSHIPS AND SAFETY

YEAR 3

IMPROVEMENT PRIORITY

Objective

Building system partnerships and working ever more closely with colleagues to provide the safest possible care.

Priority Initiatives for Year 3

- Build on the work of our Patient Safety Partners to co-design and co-produce services
- Using Quality Together to improve collaboration with ICBs and other system partners
- Essex Police Mental Health Team
- Mental Health Urgent Care Department
- Deepening our partnership with primary care
- Increasing the presence and visibility of Independent Mental Health Advocates

EMBEDDING LEARNING

YEAR 3

IMPROVEMENT PRIORITY

Objective

We will continue to embed what we have learned since the launch of this strategy to ensure consistent good practice across our Trust.

Priority Initiatives for Year 3

- Improved evidence tracking of benefits realised through new ways of working
- Continued use of PSIRF and promoting our role supporting other Trusts implementing the framework
- Rollout of SIPs across all service areas
- Identify any learning or recommendations emerging from the EMHII
- Continuing to get the basics rights and upholding the highest professional standards
- Evidencing the ‘feedback loop’ from patients, families and partners in our improvement work
- Benchmarking our safety work against national leaders in health and across industries

NHS
Essex Partnership University
NHS Foundation Trust

APPENDIX

EPUT

AWARDS

CELEBRATING THE WORK OF OUR STAFF

2022

Apprenticeship scheme wins national award

Dedicated staff recognised in national awards

Partnership Award for Mid Essex Rough Sleeper Initiative Outreach Scheme

Basildon Mental Health Unit has won a national award

EPUT scoops regional NHS Parliamentary Award

Tendring roving support bus is a national award winner

Here For You shortlisted for national award

EPUT colleagues shortlisted in two Nursing Times Workforce Award categories

EPUT's COVID vaccination service for seafarers recognised as one of the best in the world

Dedicated Trust staff celebrate success at the Positive Practice in Mental Health Awards – CAMHS Inpatient Services winner of Addressing Inequalities in Mental Health

2021

Essex Partnership University hospital ward wins national award for outstanding palliative and end of life care

EPUT awarded gold accreditation from Employer Recognition Scheme

GLOSSARY OF TERMS

ADE: Adverse Drug Events

BSOG: Board Safety Oversight Group. A Executive and non-executive meeting chaired by a member of the Trust Board. Membership includes the ESOG members, the Trust Secretary, and two non-executive directors.

CAMHS: Children and adolescent mental health service

CAP: Clinical Associate in Psychology.

Care Units: The structure we have used in our Target Operating Model to organise and manage our services. Care Units have been established with dedicated leadership teams to own safety, quality and improvement at a local level

Co-production: When an individual influences the support and services they receive, or when groups of people get together to influence the way that services are designed, commissioned or delivered

CQC: Care and Quality Commission

ECOL: EPUT Culture of Learning

EMHII: Essex Mental Health Independent Inquiry

EPMA: Electronic Prescribing and Medicines Administration

EPR: Electronic Patient Record

ESOG: Executive Safety Oversight Group. An Executive meeting chaired by the Chief Executive with the remit to oversee safety improvement work and provide assurance the planning and delivery of the safety strategy.

HIE: Health Information Exchange. This enables care professionals to view shared care records

HPFT: Hertfordshire Partnership Foundation Trust

HSE: Health and Safety Executive

HSJ: Health Service Journal. An industry news service that covers policy and management in the NHS.

iWantGreatCare: An online platform for patients, service users and families to provide reviews and ratings on the services we provide. All feedback is anonymous.

KPI: Key Performance Indicator

L50: A meeting of the organisation's 50 senior leaders

LPC: Learning Collaborative Partnership Group

MaST: A management and supervision tool used across out community mental health teams to better manage data on patients to speed up decision making

MHUCD: Mental Health Urgent Care Department

OPEL 4: Operational Pressures Escalation Levels Framework

PHSO: Parliamentary and Health Service Ombudsman

Physical restraint: Any direct physical contact where the intention of the person intervening is to prevent, restrict or subdue movement of the body, or part of the body of another person

PSIRF: Patient Safety Incident Response Framework

Safety Summit: A meeting that brings together partners from across the system to jointly discuss safety, quality and improvement

SIP: Safety Improvement Plan

SOPs: Standard Operating Procedures

TASI: Trauma and self injury

Time to Care: A programme of projects being implemented across the Trust to increase time available of staff to deliver care to patients on our inpatient mental health wards

WDES: Workforce Disability Equality Standard

WRES: Workforce Race Equality Standard