Essex Partnership University
NHS Foundation Trust

EPUT QUALITY ACCOUNT 2018/19

Executive Summary

We provide a range of different services, in different geographic areas, resulting in a complex document. To help readers navigate our Quality Account, a summary of content and where you can find specific information that you may be looking for is provided below.

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PART 1

STATEMENT ON QUALITY FROM SALLY MORRIS, CHIEF EXECUTIVE OF EPUT

I am delighted to present this Quality Account for 2018/19, which shows how Essex Partnership University NHS Foundation Trust (EPUT) met our quality commitments for the past year – our second as a newly-merged organisation – and outlines our quality priorities in 2019/20.

Sally Morris,
Chief Executive

We identified five Quality Priorities for 2018/19. They were developed in line with the national quality goals; but, as a learning organisation, it was important to us that we took into account the issues raised with us directly. So we also included learning from complaints about our services, incidents, areas identified for improvement by the CQC and other feedback from people who use our services and their carers.

I am pleased to report that we achieved our quality priorities for last year. You can find more details about these and the work done to achieve them in this report. This is a testament to the skills and dedication of our staff; and, as Chief Executive, I am very proud of them. The improvements include:

- ensuring all mental health inpatients are also monitored for any deterioration in their physical health by using early warning scores;
- reducing the number of falls and avoidable pressure ulcers;
- improving good clinical recordkeeping by staff which is essential to support the delivery of high quality, evidence-based care;
- developing our innovative Trust Quality Academy by progressing established Quality Champions up to Gold Level so they can recruit and mentor new Quality Champions and by offering service users and carers Quality Champion training so they can help design and deliver quality improvement projects;
- working to ensure we identify all the significant learning from the statutory mortality review process and using this to improve services across the Trust.

When we merged in April 2017, we were clear that we are on a quality improvement journey. Our aim was to be rated as 'Good' in our first CQC comprehensive inspection, and to work towards being 'Outstanding' five years after merger. Our first CQC comprehensive inspection took place, unannounced, just a year after our merger. We were delighted that the Trust was rated as 'Good' overall, with our community health services and mental health services also achieving overall ratings of 'Good'. Fifteen of our core services were inspected and 11 of these achieved an overall rating of 'Good'. These are significant achievements for the Trust and our staff so soon after a major change process.

We also achieved 'Good' ratings in 59 of the 75 total domains inspected by the CQC and two 'Outstanding' ratings for 'Caring' in two core services. A 'Requires Improvement' rating was given overall for the Safe domain in mental health services and in 13 of the 75 total domains inspected, along with one 'Inadequate' rating for the Well-led domain in substance misuse services.

Inspectors were impressed by the extent to which the new values of the merged Trust had been embraced by everyone and displayed by all the staff they met. They also found that the Trust's senior managers were very visible in the core services and many members of staff told them that Board members were approachable, had visited their services and were willing to hear comments. As our aim is to be rated 'Outstanding' overall by 2022, it is particularly pleasing that the CQC found a number of examples of outstanding practice already across the Trust. This includes staff's interaction with patients, technology and innovation used to support patients and the preparation and support for patients to live successfully outside of hospital.

Rawreth Court and Clifton Lodge had their first inspections under the CQC's care home regime in 2018/19. While their overall ratings of 'Requires Improvement' is far from the outcome we would have wished, it is reassuring that both services are rated as 'Good' in regards to caring. The inspections identified several positive findings in both facilities and we were heartened that learning from the inspection at Rawreth Court was reflected in the Clifton Lodge inspection. We have a firm foundation to build on now to help ensure improved outcomes at the next inspections.

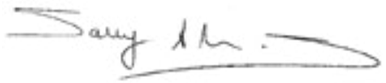
We know further work is required to raise quality in some areas of the Trust. We fully accept the CQC's findings in this regard and have used them to develop our quality priorities for 2019/20. But it's not all about what others tell us. I believe in checking personally, where possible and appropriate, that things are as they should be in the Trust. I make unannounced visits to services at any time of the day and night to see for myself the care being provided and hear directly from people using the services and the staff providing them. I hold regular open staff briefing sessions throughout the Trust and talk with our Members and other local people about their experiences of services at our 'Your Voice' meetings across Essex.

This report details many achievements of which the Trust and our staff can be justifiably proud. It also details our improvement plans for this current year. I hope you enjoy reading about them. I also hope you will understand how seriously we take our responsibility to provide quality services and how hard we work to continue to deliver services in a caring, compassionate and open way.

We have tried to make the report as easy to follow as possible. There are contact points at the end of the report – please do not hesitate to get in touch if you wish to know more about any of our quality improvements.

Statement of Accuracy

I confirm that to the best of my knowledge, the information in this document is accurate.



Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
23 May 2019

> *I'm really grateful to have been on a ward with such a good culture of care and concern for their patients. Thank you for keeping me in safe hands. I'm lucky to have had such a good team.* ***Kingswood Ward***

PART 2

OUR QUALITY PRIORITIES FOR IMPROVEMENT DURING 2018/19 AND STATEMENTS OF ASSURANCE FROM THE BOARD FOR 2018/19

What services did EPUT provide in 2018/19?

During 2018/2019, we provided hospital and community-based mental health and learning disability services across Essex as well as a small number of specialist mental health and/or learning disability secure services in Essex, Bedfordshire and Luton. We also provided community health services in South East Essex and West Essex as well as some specialist children's services Essex-wide.

How have we prepared this Quality Account?

This Quality Account has been prepared in accordance with the national legislation and guidance relating to the preparation of Quality Reports and Quality Accounts in the NHS. The legislation and national guidance on Quality Reports and Accounts specifies mandatory information that must be reported within the Quality Account and local information that the Trust can choose to include; as well as the process that Trusts must follow in terms of seeking comments from partner organisations (Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees) and the Council of Governors on their draft Quality Account as well as independent assurance from an external auditor.

This Quality Account has been collated from various sources and contains all the mandated information that is required nationally, as well as a significant amount of additional local information. It is set out in three sections in accordance with the national legislation and guidance. The report was considered in draft form by the EPUT Quality Committee and the Board of Directors. The draft report was also sent to Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees and they were given 30 days in which to consider the content and provide commentary for publication in the final version. Clinical Commissioning Groups are required to provide a statement whereas the other partners are given the opportunity to provide a statement for inclusion should they wish to do so. The resulting statements are included at Annexe A of this Quality Account. The draft document was also sent to Local Authority Health and Wellbeing Boards for consideration and comment should they wish. The Lead Governor for EPUT also provided a statement, on behalf of the EPUT Council of Governors, which is included in Annexe 1.

The document was sent in draft form to the Trust's external auditors in April 2019, in order to provide independent external assurance in accordance with national guidance. This process has been completed and the external auditor's report is included at Annexe 3 of this Quality Account.

The EPUT Board of Directors approved the final version of the Quality Account 2018/19 and their statement of responsibilities in this respect is included at Annexe 2 of this report.

2.1 Key actions to maintain and/or improve the quality of services delivered in 2019/20

Quality Account

How have we developed our priorities for the coming year?

This section of the report outlines the annual key Quality Priorities identified by the Trust to improve the quality of our services in 2019/20. We have developed our Quality Priorities in line with national quality goals, which are based on patient safety, service user and carer experience and clinical effectiveness. In addition, we have incorporated quality improvement ideas along with themes arising from complaints and incidents, areas for improvement identified by the Care Quality Commission (CQC) and feedback from people who use our services and their families and carers.

2.1.1 Priority 1 - Continued reduction in harm

The Trust will aim to achieve 95% harm free care as measured by the national Safety Thermometer data collection. We will continue our journey towards harm free care aiming to decrease harm by 50% against current levels in the following areas with an ambition to move towards zero harm.

- Pressure Ulcers
- Avoidable falls
- Medication omission
- Physical health of mental health patients
- Early warning systems for deteriorating patients.

To achieve this, we will establish a working group to drive forward all aims as follows:

AREA	ACTIONS
Pressure Ulcers AIMS: 1) Develop a trajectory for a reduction in category 2 pressure ulcers 2) Zero category 3 and 4 pressure ulcers acquired as a result of omissions in care	• By April 2019 develop and embed RCA Pressure Ulcer Guidelines across all clinical services • By June 2019 have in place revised training programme incorporating educational videos • By September 2019 review all skin/pressure ulcer related data/information packs and ensure appropriate distribution
Avoidable Falls AIMS: 1) Aim for a 15% reduction in all falls 2) Reduce the number of falls resulting in a serious incident by 10% 3) Reduce the number of falls as a result of omissions in care by 50% against current performance	• 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 • By July 2019 to introduce Falls: Supportive and Safe Observation Guidelines and measure outputs in relation to reduction in number of falls • By September 2019 implement a procedural guideline for Delirium • Continued participation in the National Audit of Inpatient Falls • By September 2019 to have Falls Champions in all inpatient areas • By October 2019 to review guidance in relation to the safe use of bedrails • By December 2019 hold a learning event for Falls Champions
Medication Omission AIMS: • To reduce the number of omitted doses by 50%	• Review the current data and develop an action plan to eliminate hotspots • Consider the use of ePMA and if appropriate develop a Business Case to support implementation
Physical health of mental health patients AIMS: • To support nursing and support staff in the development of physical health competencies • To implement the competency framework	• By June 2019 develop a Physical Health Training programme based on the competency framework and the management of diabetes and CVD • By June 2019 to review the physical health audit to incorporate qualitative outcome measures and develop a baseline • By June 2019 the Physical Health Action Implementation Group will be reviewed to incorporate The Deteriorating Patient and Pressure Ulcers
Early warning systems for deteriorating patients	• For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required Measures: • 100% of inpatient wards have implemented NWS 2 • 100% of inpatient wards have implemented the sepsis pathway • By September 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.

Preparing medication for ward round

2.1.2 Priority 2 – Restrictive Practices

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 has been shown to reduce conflict and restraint and associated work related sickness absence, with significant benefits for people using services and staff. Additionally, two wards have been selected to take part in a two year collaborative, working with Royal College 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.

- By April 2019 we will have a system in place across all wards to comply with the requirements of the new national data set.
- By June 2019 all wards will be using Safety Crosses to monitor any incident and the type of restrictive practice that has occurred.
- 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.
- By March 2020 we will implement the core strategies from the Reducing Restrictive Practice Guide across all inpatient areas. We will evaluate evidence of these strategies and their impact, and report to the Restrictive Practice Steering Group.
- By March 2020 we will reduce planned prone restraint (face down floor based restraint) by 20% as part of the longer term strategy to eliminate this practice completely.

2.1.3 Priority 3 – Suicide/Unexpected Deaths

We have identified the following priorities to ensure successful implementation and embedding of the Trust's Suicide Prevention Strategy within our services.

1) Suicide Prevention Safety Tools and communication
2) Suicide Prevention Learning Culture
3) Suicide Prevention Family and Carer Involvement.

The work programme for 2019/20 will incorporate the following.

- By August 2019 we will put in place a suicide prevention dashboard to track and monitor progress on the ten key parameters for safer mental health services.
- By September 2019 a rolling programme of training will be available to support our workforce to develop key competencies.
- By December 2019 we will produce a report on the effectiveness of the dashboard as a performance improvement tool, to support clinical decisions.
- By October 2019 our Suicide and Self-harm policy will be updated.
- During 2019/20 we will work to develop a strong integrated suicide plan with local stakeholders
- By December 2019 work in relation to developing a 'zero suicide app' will be in place and mechanisms agreed for evaluation.

2.1.4 Priority 4 – Collective Leadership

In order to operate as an outstanding organisation, we must work collectively with our staff, the people who use our services and our system partners to plan, deliver and evaluate the quality of care we provide, and the associated outcomes. Developing a just and learning culture and making continuous improvement everyone's business will support this. We have also identified the following priorities:

- 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
- Locality hubs will be developed for system partners to collectively drive forward the transformation agenda
- All staff will be given the opportunity to undertake, develop and to work collectively with colleagues to implement quality improvements.
- We will embed collective leadership into organisational development frameworks to develop our teams

2.1.5 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 our services. To support this priority the work programme for 2019/20 will incorporate the following actions:

- By March 2020 all members of the Trust Board will undertake NHSI's Board level quality improvement programme
- We will develop quality improvement hubs across all Directorates to drive continuous improvement at a local level
- We will provide training to our Quality Champions, aiming to train a further 120 staff in quality improvement methodology
- We will develop 30 Gold level Quality Champions to provide coaching/mentorship to new recruits
- We will provide quality improvement awareness sessions and provide opportunities for service users and carers to take part in continuous improvement initiatives
- By September 2019 we will have in place a dashboard against all quality priorities.

2.1.6 Priority 6 – Effective Use of Technology

We will use technology effectively to better acquire, review, understand, analyse and exchange patient safety data and knowledge through the following work plan.

- Developing a dashboard for all quality priorities incorporating data from the new Patient Safety Incident Management System.
- Introducing the Perfect Ward app that makes quality inspections easy and more efficient (www.perfectward.com) and developing systems to respond to real time data alerts.
- Using ESR, safer staffing and safe care systems to gain assurance that staffing levels can support the delivery of organisational priorities.

2.1.7 Priority 7 – A Just and Learning Culture

We will develop a just and learning culture to embed our approach in responding to incidents and errors to protect staff and people that use our services. The following actions have been identified for 2019/20.

- By June 2019 we will embed elements of a just and learning culture into induction, leadership and quality champion training
- From July 2019, within one week of a serious incident, a copy of its 72 hour review will be shared with all members of the relevant teams
- We will publish good practice stories 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.

2.1.8 Priority 8 – End of Life Care

We are committed to providing 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. All those identified as being at the end of their lives should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death.

> *You were an amazing, motivating and supportive carer, who was worth her weight in gold throughout. Not just to the patient concerned, but to family members also supporting the situation*

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

- implement a competency framework for staff, regardless of their grade, to enhance knowledge and skills for end of life care and care in the last days of life;
- work with systems and partners to create best approaches with regard to advanced care planning and individualised care plans;
- convene an End of Life Forum for clinical staff;
- expand the number of End of Life Care Champions.

2.2 Progress against the quality priorities we set for 2018/19

The Board of Directors considered the strategic context, their knowledge of the Trust and the feedback from staff and stakeholders during the planning cycle and identified five Quality Priorities for 2018/19.

RAG (Red Amber Green) ratings have been applied to provide an accessible method of understanding the levels of performance. RAG ratings should be used in conjunction with the actual levels of performance which are also quantified in the charts that follow.

RAG rated **RED** to indicate that performance has not met the target by a significant margin.

RAG rated **AMBER** to indicate that performance is close to target.

RAG rated **GREEN** to indicate that performance has met or exceeded the target %.

2.2.1 Safety

Quality priority: We will continue our journey towards our ambition of achieving harm free care in the following areas.

- Pressure Ulcers
- Falls
- Restrictive Practice
- Medication Omissions
- Early detection of Deteriorating Patient
- Unexpected death.

Data source: Datix

National Definition applied: Yes

Within this Quality Priority eight targets were set.

Why did we set this priority?

■ Pressure Ulcers

Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers with the most vulnerable people being those aged 75+. Pressure ulcers are more likely to occur in people who are seriously ill, have limited mobility, cognitive impairment and nutritional deficiency. Pressure ulcers occur when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair blood supply. The presence of a pressure ulcer creates a number of significant difficulties psychologically, physically and clinically to patients, their families and their carers. They have a profound impact on a person's overall wellbeing and can be both painful and debilitating. Pressure ulcers can be serious and lead to life-threatening complications.

■ Falls

Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals. They are the most commonly reported type of incident in community hospitals and the third most commonly reported type of incident in mental health hospitals.

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Hip fracture is the most common serious injury related to falls in older people. Thirty per cent of people who fracture their hip as a result of a fall will die within 12 months of the injury. Thirty per cent will not return to their pre-fracture level of function.

■ Omitted Doses

In 2007 a review of medication incidents by the National Patient Safety Agency (NPSA) identified that omitted and delayed medicines was the second largest cause of medication incidents reported to the National Reporting and Learning System (NRLS). The data highlighted that if delayed or omitted some medicines, such as anti-infectives, anticoagulants and insulin, could have serious or even fatal consequences. As a result, in 2010 the NPSA issued a Rapid Response Report aimed at reducing harm from omitted and delayed medicines in hospital.

Doses of medicines may be omitted for a variety of reasons, including:

- a valid clinical reason for not giving the medicine;
- the intention to prescribe a new or regular medicine is not carried through;
- the medication is not available on the ward or in the patient's home;
- the route of administration is not available (e.g. nil by mouth, loss of patency of an IV line);
- the patient is away from the ward or out when visited at home;
- poor communication between or within teams about the patient's needs;
- the patient refuses the medication.

■ No Force First

'No Force First' was originally an initiative within mental health in-patient units in the United States to dramatically reduce the number of, and ultimately eliminate dangerous restraint and seclusion events. It has a proven record of success in transforming healthcare environments and enhancing safety for service users and staff.

The key priorities for delivery are:

- developing leadership competencies towards organisational change;
- developing data to inform practice;
- building workforce competencies;
- implementing restraint restriction tools;
- developing patient roles within inpatient settings;
- reviewing debriefing techniques.

A 10% reduction was agreed across all work streams

During 2018/19 we have taken the following actions:

- We have strengthened membership of the Sign up to Safety Pressure Ulcer work stream with participation of tissue viability nurses and matrons from south east Essex and west Essex community health services to further support shared learning across the Trust.
- There is weekly reporting to the Executive Team on pressure ulcer prevalence including identifying any trends or themes and actions being taken forward to embed learning.
- Action plans for avoidable pressure ulcers are presented at Skin Matters meetings and monitored through the local quality and safety groups.
- Learning from root cause analysis undertaken for category three and four pressure ulcers is shared with teams.
- On-line pressure ulcer training has been reviewed and revised to reflect NHSI recommendations and is now mandatory.
- We participated in the National Stop the Pressure Day, holding events to engage the public
- Training on falls prevention has been strengthened.
- Work on falls prevention has been taken forward as part of the NHSI Falls Collaborative.
- We held a dedicated Falls Week in October.
- The Falls Guideline has been harmonised across the Trust.
- Standardised Falls Risk Assessment Tools are in use across all older adults wards.

2.2.1 Safety

- Communication of medication errors by service area via ward managers and matrons through Quality and Safety meetings and via the pharmacy weekly checklist.
- We implemented a system of checking all that all the medication charts have been signed before the staff on each shift leave.
- We introduced support through supervision where medication errors are repeated.
- We took forward the 'No Force First' approach with regard to restraint.
- We reviewed restraint training and implemented TASI training across all relevant areas.
- We used service user stories within restraint training.
- We signed up to a two-year collaborative on restrictive practices with RCP and NHSI.
- Performance in each of the above categories has been monitored during 2018/19 with the following reduction achieved at the time of writing against the organisational baseline:
  - Omitted doses : 375 in 2018/19 compared to 827 in 2017/18;
  - Prone restraint : 382 in 2018/19 compared to 407 in 2017/18 (6% reduction);
  - Avoidable PU : Three in 2018/19 compared to five in 2017/18 ;
  - Avoidable Falls : 10 in 2018/19 compared to nine in 2017/18.
- The Trust has consistently achieved or surpassed 95% harm free care from the 'Safety Thermometer' every month throughout the year.

Stop The Pressure information for Pressure Ulcer Week

2.2.1 Safety

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Achieve 95% harm free care through the national Safety Thermometer data collection	To date Safety Thermometer data indicates 95% or above for harm free care.	**98.1%**
2	Reduce the number of avoidable category three and four pressure ulcers acquired in our care	YTD there have been three avoidable three/four pressure ulcers compared to five in 17/18.	**3**
3	Reduce the number of avoidable falls that result in moderate or severe harm and a 15% overall reduction in falls	YTD there have been 13 falls resulting in a serious incident, of which five were avoidable. The figure for 2017/18 was 19, of which four were avoidable	**13** **5 avoidable** **15% reduction achieved**
4	Reduce the number of omitted doses of medication across our services	There were 375 omitted doses recorded up to end of March. If rates continue; EPUT (excluding Bedfordshire Community Services) has seen a 54.7% reduction in the number of omitted doses (2017/ 18 outturn = 827)	**375**
5	Implement 'No Force First' to reduce the number of restrictive practices including restraints	There is a plan to take this forward as part of the two-year Restrictive Practice collaborative.	
6	Roll out suicide prevention training to community mental health teams	Current training already open to community mental health teams - consideration to be given on increasing the uptake from this group.	**Complete**
7	Ensure that all staff working in adult inpatient services, crisis services, access and assessment, prison and IAPT receive recognised, appropriate suicide prevention training including those risks associated with physical health	Agreement secured for two part time dedicated trainers. As of January 2019, 452 colleagues have completed the Connecting with People training. In total, 780 colleagues have completed some form of suicide awareness training e.g. STORM or CwP. Online suicide awareness training is available to everyone through the Zero Suicide Alliance	**Partially complete**
8	Undertake audits to ensure all inpatients are monitored for physical health deterioration using early warning scores	The audit was presented to the Physical Health Action Implementation Group in February.	**Complete**

2.2.2 Clinical Effectiveness

Quality priority: Up-to-date clinical risk assessment and care plans have been a theme identified from our serious incident investigations. As a Trust we therefore want to ensure all care plans are produced in collaboration with the person using the service to meet their needs, are regularly reviewed and contain up to date information.

Data source: Audit

National Definition applied: Yes

Within this Quality Priority two targets were set.

Why did we set this priority?

Clinical record keeping is integral to professional practice. Good record keeping is a vital part of communication for clinical staff and is integral to promoting safety and continuity of care for service users. Staff should be clear about their responsibilities for record keeping in whatever format records are kept. Clinical records provide an account of individual considerations and the reasons for decisions and the use of this information is essential to supporting delivery of high quality, evidence based care

During 2018/19 we have taken the following actions:

- The practice development team has undertaken face to face training.
- We have undertaken records audits across CAMHS & LD, the Mother & Baby Unit, Secure Services, Mental Health Adult Wards and Mental Health Older People's wards in Q1 with a target to achieve 90% compliance by Q4.

	Baseline compliance (Q1)	Re-audit compliance (Q4)
CAMHS	85%	85%
Mother & Baby	91%	98%
MH Adults	80%	88%
Secure Services	79%	95%
Mental Health Older Adults	86%	89%
Total	**84%**	**91%**

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Undertake record keeping audits and achieve improvement compared to results from audits carried out in Q4 2017/18	Record keeping audits undertaken for inpatients as part of Matron toolkit. Annual audit complete.	**Complete**
2	Gather feedback from service users and their families about engagement and collaboration with their care plan to meet their needs and use it to make improvements as necessary.	Work continues in regards to gathering feedback. Format being reviewed in an attempt to increase the number of feedbacks received. Work continues to review work plan in alignment with national work.	**Partially complete**

2.2.3 Clinical Effectiveness

Quality priority: We will embed mortality review processes developed during 2018/19 in order to identify learning and take action

Data source: Local Audit
National Definition applied: Yes

Within this Quality Priority we set four targets.

Why did we set this priority?

The effective review of mortality is an important element of our 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. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2018/19 we have taken the following actions:

- The Mortality Review Policy was approved and is available from EPUT's website.
- A full report was presented to the Board of Directors in accordance with national requirements.
- We have published three Learning from Deaths reports.
- We have established processes for reviewing deaths in scope.
- We have had a review of deaths in the elderly and a review of LD deaths.
- Our policy on Mortality Review and Learning from Deaths was approved by the Board of Directors in September 2017, to be implemented from October 2017. We will undertake an audit on compliance with the policy after 12 months of its implementation at the end of Q3 2018/19.

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Provide quarterly reports on mortality to the Board of Directors	Reports are presented to the Board on a quarterly basis. The Q1 report was presented to September Board.	Complete
2	Complete thematic reviews of deaths in line with our Mortality Policy	Thematic reviews in progress with further ones being commissioned.	Complete
3	Identify trends and themes from case note reviews for action	Case note reviews currently being undertaken	Partially complete
4	Undertake audit of serious incident action plan implementation to ensure learning is embedded into practice	Audits of action plans continue following sign off of SI RCA's. The reports are submitted to Learning Oversight Subcommittee.	Complete

2.2.4 Patient Experience

Quality priority: We will strengthen engagement and involvement with service users, families and carers in relation to the mortality review process and the new clinical model (transforming services year 2)

Data source: Local Audit/Data Collection
National Definition applied: N/A

Within this Quality Priority we set three targets.

■ Quality Priority

We will strengthen engagement and involvement with service users, families and carers in relation to the mortality review process and the new clinical model (Transforming Services Year Two).

Milestones:

- Collate and analyse data collected from bereaved families and carers taken each quarter in respect of the Trust's level of engagement and involvement with them, to inform our processes and training for staff
- Have a protocol in place by end of Q3 for all co-production work with service users, families and carers including an evaluation method to inform our future processes in respect of the new clinical model
- Have trained a cohort of service users and carers to be Trust Quality Champions by the end of Q3

Why did we set this priority?

- To further achieve our commitment to encourage people to engage with us, feedback on our services and feel able to raise concerns.
- To further support the delivery of our strategic objective 'co-design and co-produce service improvement plans with system partners, including commissioners and service users' by involving service users and carers more to play a meaningful role not only in current services but also the future of Trust services.
- To enable us to monitor how effectively we involve bereaved families and carers by seeking their feedback appropriately so we can take action to improve processes.
- In recognition of the fact that every interaction we have is an engagement opportunity, and an opportunity to live our values of compassionate, empowering and open.

During 2018/19 we have taken the following actions:

- We have put in place questions to allow us to gain feedback from bereaved families at the conclusion of the serious incident process. This information is collated and used to inform our processes and training for staff.
- We have drafted a protocol for all co-production/engagement work with service users, families and carers including an evaluation form to gain feedback from the person with lived experience to help inform our future processes.
- We have implemented a training programme for service users and carers to become Trust Quality Champions.

2.2.4 Patient Experience

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Collate and analyse data collected from bereaved families and carers taken each quarter in respect of the Trust's level of engagement and involvement with them to inform our processes and training for staff	Mechanisms are in place for the collation and analysis of data. Family Liaison Officers are reminded of the need to pose the questions formulated by the Trust to families post meeting to present the final report with them.	Complete
2	Have a protocol in place by end of Q3 for all co-production work with service users, families and carers including an evaluation method to inform our future processes in respect of the new clinical model.	A protocol has been drafted ready for implementation when co-production projects are going to be taken forward. An evaluation form is also in place to gain feedback at the end of a project.	Complete
3	Have trained a cohort of service users and carers to be Trust Quality Champions by the end of Q3	Training has been run with some service users and carers. Some participants have expressed an interested in completing the Quality Champion Training. This will be scheduled in 2019/20.	Partially complete

2.2.5 Effectiveness

Quality priority: We will increase the number of staff and service users trained in quality improvement methodologies and involved in the implementation of quality improvement initiatives.

Within this Quality Priority four targets have been set.

Data source: Local Data Collection
National Definition applied: N/A

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Provide Quality Champion training in all localities of the Trust with the aim to train a further 120 Quality Champions	Quality Champions training continues across all localities with an additional 50 Quality Champions undergoing training. A further four cohorts commenced in November 2019.	Complete
2	Develop 30 Gold level Quality Champions to provide coaching/ mentorship to new recruits	30 Gold level Quality Champions have been identified. The Quality team is working with the OD team to deliver both coaching and mentorship programmes in the autumn.	Complete
3	Provide quality improvement awareness sessions and provide the opportunity for service users and their carers to take part in training and quality improvement initiatives	Quality improvement has been incorporated into induction from August 2018. Access to quality academy awareness sessions circulated through communication systems. Service user / carer forums have commenced with individuals accessing training, forming part of current project teams.	Complete
4	Develop directorate quality improvement hubs to drive quality improvement at a local level	Forensic quality improvement hub under development with nine projects identified. Intention is to review in two months and roll out to other directorates.	Partially complete

2.3 Learning from Deaths

2.3.1 Background and context

The effective review of mortality is an important element of our approach to learning and ensuring the quality of our services continually improves. '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' was published by the NHS National Quality Board in March 2017 and set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2018/19 we have strengthened our approaches to mortality review in line with the national guidance. We take every death of people in our care very seriously. We expect our staff to be compassionate and caring at all times. The aim of reviewing the care provided to people who have died is to help improve care for all our patients by identifying whether there were any problems, understanding how and why these occurred and taking meaningful action to implement any learning. The reporting of mortality data is part of this review process. It is an evolving process across the whole NHS and continues to be challenging, both nationally and locally, to gather and analyse the data. The review of mortality and reporting of data will, therefore, continue to evolve over time to become more meaningful as we learn from our own experiences of doing this and those of other NHS Trusts.

As Trusts have been able to determine their own local approaches to undertaking mortality reviews and defining those deaths which should be in scope for review, mortality data is not comparable between Trusts. As such, we are using data locally to monitor the review of mortality and to assist in the ultimate aim of learning from deaths and improving the quality of services. Due to the nature of the services we provide, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss, and we have strengthened our processes to support people who have been bereaved by a death of someone in our care. We have undertaken a review of a sample of these 'expected' deaths to identify any learning in terms of the quality of the care we provide to people at the end of their lives.

2.3.2 Explanatory notes

**** Please note, all figures stated in the section below relate to deaths 'in scope' for mortality review. Deaths 'in scope' are defined in the Trust's Mortality Review Policy as:***

- all deaths that have occurred within our inpatient services (this includes mental health, community health, learning disability and prison inpatient facilities);
- all deaths in a community setting of patients with recorded learning disabilities;
- all deaths meeting the criteria for a serious incident, either within our inpatient services or in a community setting;
- any other deaths of patients in receipt of our services, not covered by the above that meet the criteria for consideration for a Grade 2 case note review. These are identified on a case-by-case basis and include:
  - any patient deaths in a community setting which has been the subject of a formal complaint and/or claim by bereaved families and carers;
  - any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision;
  - any deaths of patients deemed to have a severe mental illness in a community setting. For the purposes of this policy, this is deemed to be any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems that are recorded as having been under the care of the Trust for over two years.
- any deaths identified for thematic review by the Mortality Review Sub-Committee (including a random sample of 20 expected inpatient deaths per annum).

Figures are only stated for Q1 – Q3 of 2018/19. Q4 information will not be reported to the Board of Directors until June 2019. Information in relation to Q4 2018/19 will, therefore, be reported in the Trust's Quality Account for 2019/20. The reporting schedule was the same last year; and, therefore, information relating to Q4 2017/18 is also reported in this Quality Account.

At the time of preparing this Quality Account, the thematic reviews and expected inpatient death review sample for 2018/19 are in the process of being defined and commissioned and figures are therefore not included within the data below. Information in relation to thematic reviews of deaths occurring in 2018/19, including the random sample of 20 expected inpatient deaths, will therefore be reported in the Trust's Quality Account for 2019/20.

The figures contained in this section of the Quality Account are consistent with the agreed approach for reporting quarterly information to the Board of Directors and are reported as at 4 March 2019.

2.3.3 National Guidance Ref 27.1 - Number of deaths in scope for mortality review

2018/19 Q1 – Q3:
During 2018/19 (Q1 – Q3), * 172 of EPUT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Q1 = 59
Q2 = 53
Q3 = 60

****Figures for the fourth quarter are not yet available at the date of preparing this Quality Account and will be reported in the EPUT Quality Account 2019/20.***

2017/18 Q4:
The number of deaths within scope for mortality review in Q4 2017/18 was 76.

National Guidance Ref 27.2 Number of these deaths subjected to case record review/investigation

2018/19 Q1 – Q3:
By 4 March 2019, one Grade 2 case record review and 29 Grade 4 Serious Incident investigations have been carried out in relation to 30 of the Q1 – Q3 2018/19 deaths included above.
Note: in addition to the above, four case record reviews and 24 Serious Incident investigations are in progress.

The number of deaths in each quarter 2018/19 for which a case record review or an investigation was carried out (including those in progress) was:
Q1 = 14
Q2 = 21
Q3 = 23

The grade of review for 46 of the 172 deaths is under determination.

Figures for the fourth quarter are not yet available at the date of preparing this Quality Account and will be reported in the EPUT Quality Account 2019/20.

Explanatory note:
- **68** closed reviews at Grade 1 (do not fall within the category of case note reviews/investigations)
- **30** closed reviews at Grade 2 - 4 (case note review/investigation)
- **28** reviews in progress at Grade 2 - 4 (case note review/investigation)
- **46** final grade of review still under determination

Total = 172

2017/18 Q4:
By 4 March 2019, zero Grade 2 case note reviews and 23 Grade 4 Serious Incident investigations have been carried out in relation to 23 of the Q4 2017/18 deaths.

Note: in addition to the above, three case record reviews and zero Serious Incident investigations are in progress.

For the full year 2017/18, by 4 March 2010 five Grade 2 case note reviews and 88 Grade 3 Critical Incident Review / Grade 4 Serious Incident investigations have been carried out in relation to 92 of the total of 248 2017/18 deaths.

Note: in addition to the above, four case record reviews and zero Serious Incident investigations are in progress.

2.3.4 National Guidance Ref 27.3 - Deaths judged more likely than not to have been due to problems in care

2018/19 Q1 – Q3:
Five, representing 2.9%, of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
- **2** representing 3% for the first quarter
- **3** representing 5.6% for the second quarter
- **0** representing 0% for the third quarter

Please note, 80 reviews are still in progress or a judgement in terms of problems in care is still to be made at the date of preparing this information.

Figures for the fourth quarter are not yet available at the date of preparing this Quality Account and will be reported in the EPUT Quality Account 2019/20.

2017/18 Q4:
Zero, representing 0%, of the patient deaths during Q4 2017/18 are judged more likely than not to have been due to problems in the care provided to the patient.

Please note, four reviews are still in progress/ a judgement in terms of problems in care is still to be made at the date of preparing this information.

The above judgements have been estimated using a tool designed locally by the Trust, based on the Royal College of Physicians Structured Judgement Review tool and methodology as there was no national methodology for mental health deaths. This tool is not based in any evidence based research. The Trust has recently devised an amended pro forma based on the methodology published by the Royal College of Psychiatrists in November 2018 and future judgements will use this tool.

2.3.5 National Guidance Ref 27.4 - Examples of learning derived from the review/investigation of deaths judged more likely than not to have been due to problems in care

The following are examples of learning derived from the investigation of deaths judged more likely than not to have been due to problems in care provided to the patient.
- Community Mental Health Teams should ensure continued communication from the team to the family about the progress of an Associated Mental Health Practitioner (AMHP) referral.
- Alerts to the Emergency Duty Service on Friday afternoons should be reinforced.
- Care plans and risk assessments should be updated taking in to consideration new risk factors identified.
- 48-hour follow-up calls should be completed according to patient risks and care plan and should:
  - address areas relevant to identified risk and should include a mental state examination unless contraindicated;
  - be documented by staff with access to the electronic records;
  - be documented contemporaneously.
- All contact with families should be recorded and information to be relayed in sensitive and appropriate language.
- Once a patient with the prison service has been assessed and discussed in the multi-disciplinary team meeting as requiring mental health support, they should have an identified key worker allocated within seven days and be followed up by the mental health team.

2.3.6 National Guidance ref 27.5 - action taken in consequence of the learning detailed above

We have taken the following actions as a result of the examples of learning detailed above.
- We have reviewed team processes for communicating with families about the progress of an AMHP referral.
- We have put in place processes for all Associated Mental Health Practitioner hubs to refer all outstanding work to the Emergency Duty Service at the end of each working day, including Fridays – categorising all into either high risk or non-urgent referrals.
- Staff attended Care Programme Approach (CPA) and clinical risk assessment training and monthly care plan audits were implemented.
- We reviewed the seven-day follow up procedure, reminded staff of the 48 hour protocol and implemented a 48 hour follow up template evidencing associated risk and care plan.
- A teaching session was delivered by a Consultant Psychotherapist to the Recovery and Wellbeing team on delivering sad news to families or carers.
- We developed a written procedure for the allocation of an identified key worker to patients within the prison service within seven days.

2.3.7 National Guidance Ref 27.6 – Impact of the actions described above:

The impact of the example actions described above is as follows.
- We strengthened our processes for keeping families informed of progress of AMHP referrals.
- We strengthened our processes for referral from AMHP hubs to the Emergency Duty Service at the end of each working day, including Fridays.
- We strengthened our care plan and risk assessment processes.
- We strengthened our 48 hour follow up processes.
- We enhanced our employee's skills in delivering sad news to families.
- We strengthened our processes for the allocating of identified key workers to patients within the prison service.

2.3.8 Learning from other deaths subjected to mortality review/investigation

We identify any appropriate learning from all mortality reviews undertaken and agree actions irrespective of whether the death has been judged as being more likely than not to have been due to problems in care provided to the patient. Examples of such learning include.

- Here must be clear recording of medical reviews with records of medication prescribed or changes to doses.
- All medical records must be available on the electronic patient record.
- All relevant previous mental health episodes should be sought and considered within the assessment to inform care and treatment planning.
- We should put in place contingency risk management plans where possible.
- We should put in place a process for communication sharing when a service user is under the care of more than one community team.
- If a patient cancels a clinical appointment, we should try to contact them in order to form a view on the clinical risk and develop an appropriate plan.
- Where consent is given for families/carers to be contacted, we should make contact with them regularly where appropriate.

In addition to the individual mortality reviews outlined in the sections above, during 2018/19 we undertook the following thematic reviews of deaths occurring in 2017/18

- expected inpatient deaths (10 in community health services and 10 in older peoples mental health services);
- deaths of clients receiving substance misuse services;
- deaths of clients receiving learning disability services;
- deaths classified as serious incidents.

The above reviews have resulted in a total of 169 deaths being subjected to overarching thematic review. We have also undertaken an audit of a random sample of seven deaths closed at Grade 1 review (desktop review).

We have shared the learning from these reviews with teams and our Mortality Review Sub-Committee overseeing its implementation. Examples of learning and actions taken as a result include.

- The principles of Advanced care planning, person centred care planning and discussions around preferred priorities of care should be actively applied in order to provide excellent end of life care to patients with advanced Dementia. The End of Life Care Plan template was reviewed to take account of the learning.
- We should develop proactive and collaborative partnerships between substance misuse services and physical and mental healthcare providers, including GPs, hospitals and CMHT, to ensure the sharing of all relevant information throughout an episode of care, for the benefit of individual patients and to improve integration of care.
- Review of Dual Diagnosis Policy and procedures and strengthening of processes to ensure high quality of care for dual diagnosis patients.
- We should consider ways of continuing to improve access to multi-disciplinary and multi-agency records, in order to reduce time spent retrieving Clinical and Medical records.
- We should continue our excellent work on the training of the Mental Capacity Act (MCA) for staff.
- We should consider a process of review for clients who have not been in contact with the service for a period of nine months or more. Consultants should be encouraged to complete the discharge process if they feel the client does not require any more medical intervention or support. A key element of the new Learning Disability (LD) Service Model is that there will be link workers who will provide 'soft contacts' for individuals who are not in regular contact with the local LD Service but who will require contact to ensure their safety.

2.3.9 National Guidance ref 27.7 – 27.9 - Mandated information that will be reported in 2019/20 Quality Account

We are unable to report on the following mandated information in the Quality Account 2018/19 and will report on this in the Quality Account 2019/20.

- The number of case record reviews or investigations finished in 2019/20 which related to deaths during 2018/19 but were not included in the Quality Account for that previous reporting period (i.e. Q4 information).
- An estimate of the number of deaths included above which we judge as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this (i.e. Q4 information).
- A revised estimate of the number of deaths during the previous reporting period taking account of the deaths referred to in the point above (i.e. Q4 information).

2.4 Whistleblowing

We hope to create an environment where our staff are able to speak up and raise concerns about poor practice without fear of victimisation. We want to encourage staff to express any concerns in a constructive way and to put forward suggestions in order to contribute towards the delivery of care and services to patients, service users and carers.

Our 'Raising Concerns policy and procedure' does not replace existing policies and procedures regarding grievance or complaints, or dealing with patient events as described in the 'Being Open and Duty of Candour policy' nor is it intended to replace the normal lines of communication between staff and their managers. Matters of concern should still be dealt with through normal management and/or clinical advisory channels, A 'standard' integrated policy was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS aimed at improving the experience of whistleblowing in the NHS. It is expected that the policy (produced by NHS Improvement and NHS England) is adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients and service users. Our approach and local process has, therefore, been integrated into the policy and provides more detail about how we will look into a concern.

If an individual raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully an individual into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided an individual is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

We are committed to the principles of the 'Freedom to Speak up' review and its vision for raising concerns, and will respond in line with them.

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and the individual will receive an acknowledgement within two working days. We will tell the individual who will be handling the matter, how to contact them, and what further assistance required. If required, we will write summarising the concern and setting out how we propose to handle it and provide a timeframe for feedback.

Individuals can raise concerns about risk, malpractice or wrongdoing in connection to any harm to the service we deliver. Just a few examples of this might include,but are by no means restricted to:

- unsafe patient care;
- unsafe working conditions;
- inadequate induction or training to staff;
- lack of, or poor, response to reported patient safety incident;
- suspicions of fraud (which can also be reported to our local counter fraud team);
- a bullying culture (across a team or organisation rather than individual instances of bullying).

How does the Freedom to Speak Up agenda support staff?

Freedom to Speak Up is a national agenda and an elected Principal Guardian is in place for EPUT. We have a number of mechanisms in place to enable staff to raise issues, for example the 'I'm Worried About' facility on the intranet and the 'Raising Concerns' policy and procedure. The Freedom to Speak Up Principal Guardian facilitates discussions between staff and management. Local Guardians are in place to support the Principal Guardian.

2.5 Annual Report on Safe Working of Junior Doctors 2018/19

2.5.1 Introduction

This section provides assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract.

2.5.2 Doctors in Training Data:

In north Essex the data for doctors in training is as follows:

Number of doctors in training (total inclusive of GP and Foundation)	71
Number of doctors in psychiatry training on 2016 terms and conditions	28
Total number of vacancies (average over reporting period)	19.5
Total vacancies covered by Locum Appointment for Service (LAS) and Medical Training initiative (MTI) (average)	10.5

In south Essex the data for doctors in training is as follows:

Number of doctors in training (total inclusive of GP and Foundation)	46
Number of doctors in psychiatry training on 2016 Terms and Conditions	28
Total number of vacancies (average over reporting period)	7
Total vacancies covered by LAS and MTI	3.25

2.5.3 Annual data summary:

In north Essex the data for doctors in training is as follows:

Trainees within the Trust								
Specialty	Grade	Q1	Q 2	Q 3	Q 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	30	32	32	33	**13**	880 hrs.	17 hrs.
Psychiatry	ST4-6	23	24	24	22	**13**	4120 hrs.	79 hrs.
Total		**53**	**56**	**56**	**55**	**26**	**5000 hrs.**	**96 hrs.**

Trainees outside the Trust overseen by the LET guardian								
Specialty	Grade	Q1	Q 2	Q 3	Q 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
GP trainees	ST1	13	14	14	15	**4**	see note 1	see note 1
Foundation	FY1	12	10	12	12	**2**	see note 1	see note 1
Foundation	FY2	14	15	15	15	**1**	see note 1	see note 1

Note 1: There is a mixture of Foundation and GP trainees who work either four or six months rotation, so it is difficult to calculate hours uncovered as we do not have an electronic rostering system to capture data.

2.5.4 Agency Usage

We avoid using agency and rely on the medical workforce to cover at internal locum rates. We have only booked one locum to cover one overnight shift in this reporting period. The total number of shifts covered in reporting period:

North Essex Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness	217	217	1	2263.5	2263.5
Total	**217**	**217**	**1**	**2263.5**	**2263.5**

South Essex Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness	84	84	0	1087.5	1087.5
Total	**84**	**84**	**0**	**1087.5.5**	**1087.5**

2.5.5 Issues Arising

There are vacancies at Core Trainee (CT) and Specialty Trainee (ST) level that has resulted in rota gaps throughout the year.

- **April 2018 – July 2018** - Three gaps at CT and 10 gaps at ST level
- **August – October 2018** - Seven gaps at ST level
- **November 2018 – January 2019** - Eight gaps at ST level
- **February – March 2019** - Five gaps at CT and nine at ST level

The gaps at CT level on the on-call rota are usually filled with existing doctors who are paid a locum rate. We generally avoid agency locums but used one, once during this reporting period. The gaps at ST level are usually left unfilled. There are no particular reasons or patterns observed for these gaps and recruitment is a national issue.

2.5.6 Actions taken to resolve issues

- We have advertised for LAS (Locum appointment for Service) doctors and currently there are 14 LAS and MTI (Medical Training Initiative) doctors who have filled the rota gap and gaps in service successfully.
- The CT doctors have been willing to fill the rota gap at NHS agency rate provided their working hours are still compliant as stated in the Junior Doctors Contract.
- Consultants while on call have stepped down to help with service provision duties if there are gaps at ST level.
- The Director of Medical Education (DME) and Clinical Tutors have attended BMJ career fairs in order to provide career advice to steer medical students towards psychiatry.

2.5.7 Key issues from host organisations and actions taken

There are no specific key issues within the Trust with regard to vacancy rates.

Junior Doctors have raised concerns about high work load at the Peter Bruff Assessment Unit at Colchester. This is being investigated by the Clinical Tutors and DME.

2.6 Statements of Assurance from the Board relating to EPUT 2018/19

2.6.1 Review of services

During 2018/19, EPUT provided and/or sub-contracted 149 relevant health services.

EPUT has reviewed all the data available to them on the quality of care in 149 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 94% of the total income generated from the provision of relevant health services by EPUT for 2018/19.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2018/19 monthly data quality reports were produced in a consistent format across all services. These reports monitor timeliness of data entry and data completeness. There has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information about data quality is included in the data quality section below.

2.6.2 Participation in clinical audits and national confidential enquiries

Clinical audit is a quality improvement process undertaken by doctors, nurses, therapists and support staff that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005). Clinical audit is a tool to assist in improving services; robust programmes of national and local clinical audit that result in clear actions being implemented to improve services are a key method of ensuring high quality. We participate in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes and additional national and locally defined clinical audits identified as being important for the people who use our services.

During 2018/19 14 national clinical audits and one national confidential enquiry covered relevant health services that EPUT provides.

During that period EPUT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EPUT was eligible to participate in during 2018/19 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Sentinel Stroke National Audit Programme Round 5 (SSNAP) 2018/19
- National Audit of Cardiac Rehabilitation (NACR)
- National Asthma and COPD Audit Programme (NACAP)
- National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)
- National Audit of Intermediate Care – NHS Benchmarking
- National Diabetes Foot Care Audit Round 4 (NDFA)2018/19
- POMHUK Topic 16b Rapid Tranquilisation
- POMH UK topic 18a : Use of Clozapine
- POMH UK Topic 6d : Assessment of the side effects of depot antipsychotics
- POMH UK Topic 7f : monitoring of patients prescribed Lithium
- National Clinical Audit of Anxiety and Depression (NCAAD)
- NCAP EIP Spotlight Audit 2018/19
- Psychological Therapies Spotlight Audit

National Confidential Enquiries:

- CAMHS

The national clinical audits and national confidential enquiries that EPUT participated in during 2018/19 are as above.

The national clinical audits and national confidential enquiries that EPUT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:	
Audit (POMH = Prescribing Observatory for Mental Health)	**No. of cases submitted as a % of the number of registered cases required by the terms of the audit/enquiry**
National Audit of Care at the End of Life (NACEL)	MH services, WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process
Sentinel Stroke National Audit Programme Round 5 (SSNAP) 2018/19	Data collection is on-going and continuous
National Audit of Cardiac Rehabilitation (NACR)	Data collection to be started from March 2019
National Asthma and COPD Audit Programme (NACAP)	Data collection to be started from March 2019
National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)	Data collection is on-going and continuous
National Audit of Intermediate Care – NHS Benchmarking	WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process

The national clinical audits and national confidential enquiries that EPUT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:	
Audit (POMH = Prescribing Observatory for Mental Health)	**No. of cases submitted as a % of the number of registered cases required by the terms of the audit/enquiry**
National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)	Data collection is on-going and continuous
National Audit of Intermediate Care – NHS Benchmarking	WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process
National Diabetes Foot Care Audit Round 4 (NDFA) 2018/19	Data collection is on-going and continuous
POMH UK Topic 16b Rapid Tranquilisation	100% of required cases had information provided to national organisers
POMH UK topic 18a : Use of Clozapine	100% of required cases had information provided to national organisers
POMH UK Topic 6d : Assessment of the side effects of depot antipsychotics	100% of required cases had information provided to national organisers.
POMH UK Topic 7f : monitoring of patients prescribed Lithium	Data collection in progress.

The reports of eight national clinical audits were reviewed by EPUT in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

SSNAP
- Team to ensure timely submission of complete data set to SSNAP as soon as possible
- Project Group to contact SSNAP regarding incorrect patient data allocation

NDFA
- Liaise with Podiatry team to send back the patient details to be entered to system.
- Use reminder email to collect data in a timely fashion to get back patient details
- To implement robust processes to record 12 and 24 week outcome.
- Look into appointment redesign for urgent referrals
- Review pending pilot of the Hot Foot tool currently being piloted via two GPs.

NCAP
- Mandatory annual checks in place for all patients with a diagnosis of psychosis
- Improvement in the compliance for the recording of physical health parameters

POMH
- Harmonise the depot practices and procedures in the Trust
- Medical staff to clearly describe the clinical reasoning at the basis of the decision initiating a long acting antipsychotic.
- Implementation of specific prompt to ward round template to improve adherence
- Implementation of side effect pro forma in Mobius (currently used in Remedy)
- Improve documentation of a care plan around the management of future episodes of disturbed behaviour within one week of administering RT
- Ensure a recent ECG (within the previous 12 months) has been undertaken & recorded prior to administering IM Haloperidol

EIP
- Options around setting up physical health clinics being explored, already in place in the east and now starting in the west. ECG and additional scales and BP machines now available to both teams Consideration being given to linking this in more with the medical review and how it can work in tandem
- All clinicians to use Dialog & QPR as outcome measures for all patients regardless of FEP. FEP clients to have this reviewed at CPA meeting after six months and following that at least yearly
- Care Coordinators to ensure patients are engaged with Psychology Department and Employment Advisors. Psychology and Employment to be advised of new First Episode referrals and participate in First Episode Groups
- Family Interventions training refresher to be held for care coordinators and system developed to capture interventions delivered
- Physical Health checks DNA'd to be offered a home visit
- Two psychologists to complete CBTp top-up training following funding by Health Education England.
- New EIP referrals are offered ABI clinic (Assessment Brief Intervention), where indicated for CBTp informed work
- Staff members to be trained in BFT when this becomes available

(Note: All national clinical audit reports are presented to relevant Quality and Safety Groups at a local level for consideration of local action to be taken in response to the national findings.)

The reports of 25 local clinical audits were reviewed by EPUT in 2018/19, and we have taken or intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

- All inpatient areas complete physical health assessments including MUST and Waterlow as stated in session 4.0 (Assessment of all New Patients) of Clinical guideline on Physical Healthcare CG55
- Clinical leads should continue to monitor the completion of risk assessments and their content within clinical supervision in order to support staff to develop skills in the management of risk and to identify cases which may require escalation
- Ensure the actions taken box within the referral is completed in full, with the comments box to record the reasons behind a decision made that supports the rejection or allocation details recorded
- Admin staff to be asked to manage the appointments/arrange for new dates and referral letters to be sent if patient's current hospital is out of the local area
  - Feedback to groups to inform essential Trust work streams
  - Restrictive practices
  - Physical Health
  - Deteriorating patient
  - Falls
  - End of Life
  - Suicide Prevention

2.6.3 Clinical Research

We developed our priority clinical audit programme for 2018/19 following consultation with senior mental health and community health service managers to focus on agendas required to provide assurance that our services are safe and of high quality. A centralised Clinical Audit Department oversees all priority clinical audits, to facilitate clinicians to ensure high quality, robust audits and monitor and report on implementation of action plans post audit to ensure that, where necessary, work is undertaken to improve services. Learning from audits takes place internally via reports that are provided to individual senior and local managers, operational quality groups and centralised senior committees. The Trust also reports regularly to stakeholders such as Clinical Commissioning Groups about outcomes of audits relevant to services in their portfolios.

We offer opportunities for people using our services and staff alike to take part in research studies relevant to them which enables us to support the NHS to improve the current and future health of the population together with providing an evidence base for ongoing better healthcare. We are committed to being a research active organisation providing a balanced portfolio of interventional, observational, commercial and non-commercial studies across our specialty service areas delivered in Essex.

The total number of patients receiving and staff delivering relevant health services provided or sub-contracted by EPUT in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee and the Health Research Authority (HRA) was 924.
This number of recruits was from participation in 33 research studies opened at the Trust in 2018/19, including the National Confidentiality Inquiry into Suicide and Homicide and Sudden Unexplained Death, by People with Mental illness (NCISH) which has recruited 79 participants in 2018/19.

We are aligned with the National Institute for Health Research (NIHR) Clinical Research Network (CRN) North Thames (NT), which provides regional support for researchers and funds a number of research delivery staff at the Trust to run studies on the NIHR CRN portfolio, a database of high quality peer reviewed clinical research studies meeting CRN eligibility criteria and expected to lead to significant changes in the NHS within five years. We were ranked nationally by the NIHR CRN as 29/70th highest recruiting Mental Health and Community Trust to portfolio studies for 2018/19.

We collaborate locally with Anglia Ruskin University, University of Essex, University of Hertfordshire, University of East Anglia and acute Trusts through University College London Partners (UCLP), the Eastern Academic Health Science Network (EAHSN) and the NIHR Collaborations for Leadership in Applied Health Research and Care North Thames (CLAHRC North Thames).

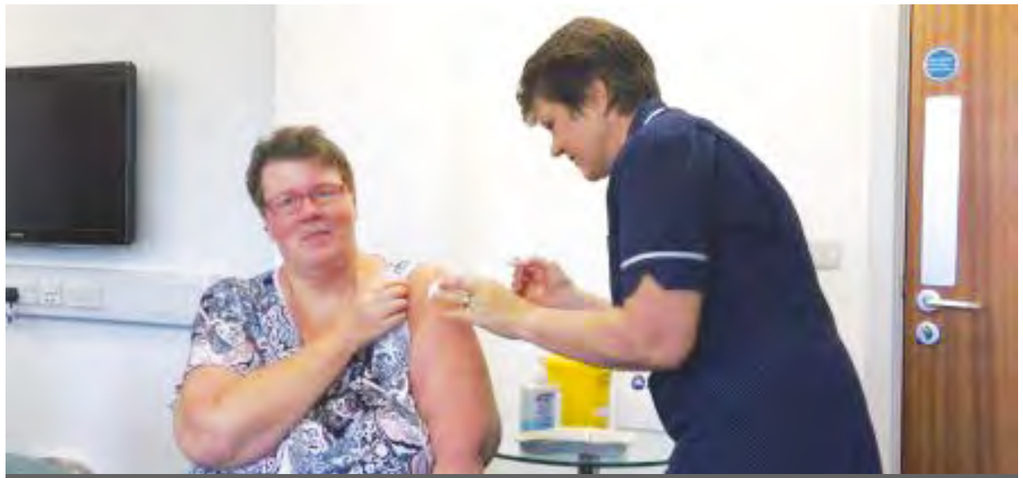
In late 2018 we took part in the NIHR CRN Patient Research Experience Survey (PRES), respondents rated their experience of taking part in research at EPUT at 4.32 out of 5 and 100% would consider participating in research again in the future.

The number of patients receiving relevant health services provided or sub-contracted by EPUT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 293. [Overall recruitment including staff who participated was 924]

2.6.4 Goals agreed with commissioners for 2018/19

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support a cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations. It makes a proportion of the provider's income dependent on locally agreed quality and innovation goals.

A proportion of EPUT's income (2.5% of contract value) in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between EPUT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.



Chief Executive, Sally Morris, leads the flu campaign 2018

Our CQUIN programme for 2018/19 included schemes negotiated with commissioners across the areas in which we were commissioned to operate services. The CQUIN programme included a mix of local and national schemes and was valued at just under £6 million which represents 2.5% of contract value for the Trust. This compares to the 2017/18 CQUIN programme which represented 2.5% of contract value equating to £6.7 million. The current forecast achievement is £5,544,198.82.

Our CQUIN programme included
- staff health and wellbeing - staff survey;
- staff health and wellbeing - healthy food choices for staff;
- staff health and wellbeing - flu immunisations;
- improving the assessment of wounds;
- personalised care and support planning;
- physical health – cardio metabolic assessments;
- physical health part B - collaborating with primary care clinicians;
- improving services for people with mental health needs who present to A&E;
- transitions out of CYPMHS (Children and Young Persons Mental Health Services);
- preventing ill health by risky behaviours;
- community immunisation service (CIS);
- recovery college in secure services;
- reducing restrictive practices in secure services;
- discharge and resettlement;
- CAMHS inpatient transitions.

Our dedication to continually improving services endures; and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the national CQUINs that have been set by commissioners in previous years as well as locally negotiated schemes. We anticipate teams will continue to ably meet the challenges for the coming year.

2.6.5 Stretching goals for quality improvement – 2019/20 CQUIN Programme (Commissioning for Quality and Innovation) for EPUT

Commissioners have incentivised us to undertake 12 CQUIN projects in 2019/20.

The value of our 2019/20 CQUIN scheme is £2,921,216 which equates to 1.25% of Actual Annual Contract Value, as defined in the 2019/20 NHS Standard Contract. In contrast to previous years, all are national CQUIN schemes.

The schemes agreed for 2019/20 are:
- staff flu vaccinations;
- alcohol and tobacco screening;
- alcohol and tobacco - tobacco brief advice;
- alcohol and tobacco - alcohol brief advice;
- 72hr follow up post discharge;
- mental health data quality - quality maturity index;
- mental health data quality – interventions;
- use of anxiety disorder specific measure IAPT;
- three high impact actions to prevent hospital falls;
- six month review for stroke survivors;
- healthy weight in adult secure mental health services;
- tier four CAMHS staff training.

Although these CQUINs are nationally mandated, the quarterly milestones Trusts are expected to meet on the journey to achieving the final CQUIN requirement are agreed locally.

This will support the need for different Trusts to work in different ways over the duration of the CQUIN, while working towards a common goal.

Essex Partnership University NHS Foundation Trust (EPUT) is required to register with the Care Quality Commission and its current registration status is registered with conditions. EPUT has the following conditions on registration in relation to Clifton Lodge and Rawreth Court (Nursing Homes):

- a requirement to have Registered Managers;
- a limitation on the number of beds provided by the services.

The Care Quality Commission issued EPUT with a Section 29A Warning Notice during 2018 in relation to healthcare services provided at HMP Chelmsford. The Warning Notice expired on 28 September 2018 following action taken by EPUT. Healthcare services at HMP Chelmsford were transferred to a new provider on 31 March 2019.

Essex Partnership University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2018/19

2.6.6 What others say about the provider?

The Care Quality Commission completed five inspections during 2018/19:

Comprehensive Inspection (April – May 2018)

The CQC completed a comprehensive Inspection of our services in April and May 2018. The inspection was unannounced and was to review the quality of our services and to provide an initial rating following registration as a new provider in April 2017.

The final report confirmed we had achieved an overall rating of 'good' along with both community health services and mental health services also achieving an overall rating of 'good'. In addition, of the 15 core services inspected, 11 achieved an overall rating of 'good'. We achieved 'good' ratings in 59 of the 75 total domains inspected and a further two 'outstanding' ratings for 'caring' in two core services.

A 'requires improvement' rating was given overall for 'safe' in mental health services; in addition, we received 'requires improvement' ratings in 13 of the 75 total domains inspected and one 'inadequate' rating for the 'well-led' domain in substance misuse services.

The grid below shows our full ratings including the significant number of 'good' ratings as well as the areas which required further action to be taken:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Mental health	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health services for children and young people	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health inpatient services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community end of life care	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Requires Improvement Jul 2018	Good Jul 2018	Requires Improvement Jul 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires Improvement Jul 2018	Requires Improvement Jul 2018
Forensic inpatient or secure wards	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Child and adolescent mental health wards	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Wards for older people with mental health problems	Good Jul 2018	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Wards for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for adults of working age	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Mental health crisis services and health-based places of safety	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for older people	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community mental health services for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Substance misuse services	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Inadequate Jul 2018	Requires Improvement Jul 2018
Overall	Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

The CQC report confirmed that inspectors found a number of examples of outstanding practice across the Trust. This included staff's interaction with patients, technology and innovation used to support patients and the preparation and support for patients to live successfully outside of hospital.

The report described a number of positive areas and themes found in the inspection, including the following:

- Inspectors were impressed by the extent that our values had been embraced by everyone and were shown and modelled by all the staff met.
- We had worked at pace to harmonise policies and procedures to support staff following the merger. Senior staff saw leadership as fundamental to their role and the CQC saw that we embraced leadership values as being important at all levels of the organisation.
- Senior Managers were very visible in core services and many members of staff told the CQC that the Board members were approachable, had visited their services and were willing to hear comments.
- We had a robust governance framework and structure.
- We had taken significant steps to improve patient experience following previous CQC inspections.
- We ensured that actions had been prioritised based on risk, and the CQC saw significant work had been undertaken in the CAMHS inpatient and learning disability inpatient services; this had dramatically improved the environments for people using services.
- Leaders had oversight of safeguarding and incident reporting and shared lessons learnt.
- Compliance with mandatory training, supervision and appraisal was good.
- Staff and leaders cared for and supported each other.
- Staff felt listened to and supported.

The inspection report identified a number of issues which we needed to address. The key areas of concern that the CQC identified were:

- managing ligature risk;
- bed management;
- oversight of smaller services;
- deprivation of liberty;
- clinic room management.

As at the end of March 2019, a total of 300 individual actions have been reported as completed (97%) which confirms that we continue to make progress with the actions agreed to address the findings of the inspection.

HMP Chelmsford (June 2018 and October 2018)

The CQC completed an inspection of healthcare services provided at HMP Chelmsford by the Trust in week commencing 4 June 2018. The CQC undertook the inspection jointly as part of the overall inspection of the prison by HM Inspectorate of Prisons. The CQC noted improvements had been made with the Enhanced Nursing Service and Integrated Drug Treatment Service (IDTS), however, there were still a number of concerns we needed to address and as such the CQC issued the Trust with a Section 29A Warning Notice on the 27 July 2018.

In October 2018 the CQC undertook an unannounced focused inspection to review improvements made as a result of the Section 29A Warning Notice. This was to determine if the healthcare services we provided were meeting the legal requirements and regulations and that patients in the prison service were receiving safe care and treatment.

The CQC published a report on 6 February 2019 which confirmed that we had taken action in the majority of areas from the Warning Notice; however, there were three areas which required additional action to be taken to resolve. Overall the CQC acknowledged that a lot of progress had been made and commented that "it felt like a different place since the last inspection".

We completed a testing exercise at the end of March 2019 against the action plan developed as a result of the CQC inspection completed in June 2018 and the subsequent Section 29A Warning Notice. The testing was undertaken to confirm if the action taken had led to an improvement and had been maintained. The results of the testing confirmed the majority of actions tested had led to an improvement and had been maintained.

The contract to provide the healthcare aspect of the service ended on the 31 March 2019 and the commissioner appointed a new organisation to provide this service from the 1 April 2019. We continue to provide the IDTS service within the prison.

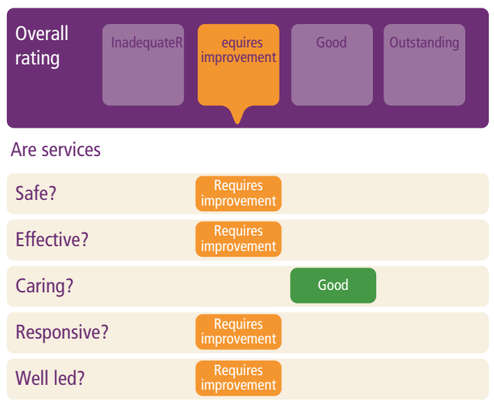
Nursing Homes (November 2018 and January 2019)

The CQC completed an inspection of our two nursing homes, Rawreth Court and Clifton Lodge. The purpose of the inspections was to provide the nursing homes with an initial rating following registration as nursing homes with the CQC in November 2017.

The CQC completed the inspection of our Rawreth Court in November 2018 and the final report provided the service with an initial rating of 'requires improvement'. We developed an action plan to address the concerns identified, and as of the end of March 2019 57% of the internal actions identified to address the requirement notice actions have been reported as completed. There are no actions which have passed the internally agreed timescales.

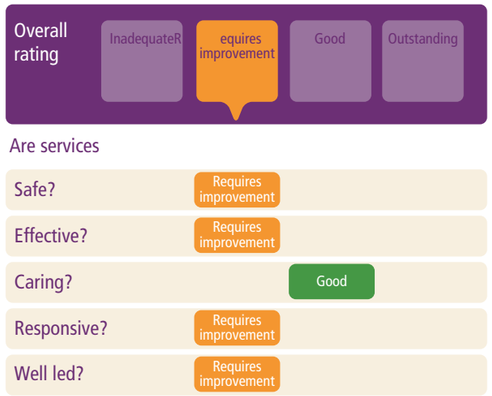
The CQC completed an inspection of Clifton Lodge in January 2019 which provided the service with an initial rating of 'requires improvement'. We developed an action plan to address the concerns identified and as of the end of March 2019 a total of 46% of the internal actions identified to address the requirement notice actions have been reported as completed. There are no actions which have passed internally agreed timescales.

Clifton Lodge



Thank you for all your kindness and understanding and for the unlimited care that you gave my dad at Clifton Lodge. You were all helpful and welcoming at any time of day. Some would say this is my job, but it takes a special person to be able to do the job you all do. Thank you.

Rawreth Court



We were so impressed with the unit and the staff there. The little touches like the street names, vintage style posters on the walls, door decorations (which I loved) and personalised boxes outside of the rooms really made it feel less like a nursing home and more like a community. I also have to say, the unit is absolutely spotless! I just wanted on behalf of my family, to let you know how pleased we all are with the care and environment at Rawreth Court and say thank you

2.6.7 Data Quality

Our ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and enables services to be alerted to any deviation from expected trends.

We have systems and processes in place for the collection, recording, analysis and reporting of data. Information systems have built in controls to minimise scope for human error or manipulation. There are corporate security and recovery arrangements in place. Roles and responsibilities in relation to service and data quality are clearly defined and where appropriate incorporated into job descriptions.

2018/19 has been a challenging year with the ongoing use of two mental health information systems inherited from the two former organisations (SEPT and NEP). We have undertaken considerable work to align data reporting across the organisation and to ensure that data definitions are interpreted and applied consistently. During 2018/19 Trust-wide reporting has been implemented to ensure that national data submissions accurately reflect our position.

Internal audit carried out a data quality audit on randomly selected KPIs across the Trust during February 2018 and advised there was 'satisfactory assurance' on the controls that were in place. Internal audit completed a further audit in Q3 2018/19 which has provided positive assurance on the controls in place.

We have assessed internal and external reporting requirements and reviewed data provision to ensure it is aligned to these needs. Data used for reporting is used for day to day management of the Trust's business. We use data to support decision making and take management action is address service delivery issues identified by reporting. Data used for external reporting is subject to verification prior to submission. We prepare and submit data returns on a timely basis and these are supported by an audit trail.

We have sought external independent assurance on the content of the Quality Account and of the quality of data that supported reporting of performance against three of the KPIs reported within it.

In addition to the changes above, the following key developments have taken place.

- The Information Assurance Framework has been revised to focus on the performance indicators outlined within the Single Oversight Framework. The assurance framework reflects the changes that were made to the Single Oversight Framework in November 2017.
- During 2018/19, a new IM&T strategy has been approved, which acknowledges the primacy of data quality and proposes practical steps to consolidate and improve it.
- Continued monthly monitoring of data quality across mental health and community health services patient data by Senior Management Teams, Executive Team and Finance and Performance Committee.
- Presentation of a regular Data Quality Report to the Information Governance Steering Sub Committee.
- In March 2019, a revised Data Quality Policy and Procedure was approved for use throughout the Trust.

EPUT achieved a Data Quality Maturity Index score of 98.9% for Q1 and 98.8% for Q2 compared to the NHSI Single Oversight Framework target of 95%.

EPUT's Information Governance Data Security and Protection Toolkit (DSPT) overall score for 2018/19 was compliant across all assertions.

Essex Partnership University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Essex Partnership University NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 99.4% for admitted patient care
- 100% for outpatient care
- N/A for accident and emergency care

The percentage of records in published data, which included the patient's valid General Medical Practice Code was:

- 99.2% for admitted patient care
- 99.9% for outpatient care
- N/A for accident and emergency care

We will be taking the following actions to improve data quality.

- Submission of additional fields within the Mental Health Services Dataset. As part of the implementation of new national datasets the Trust is undertaking intensive monitoring of all the data fields to ensure a high level of data quality is achieved.
- Increased number of Data Quality Audits to be undertaken by the Internal Audit function.

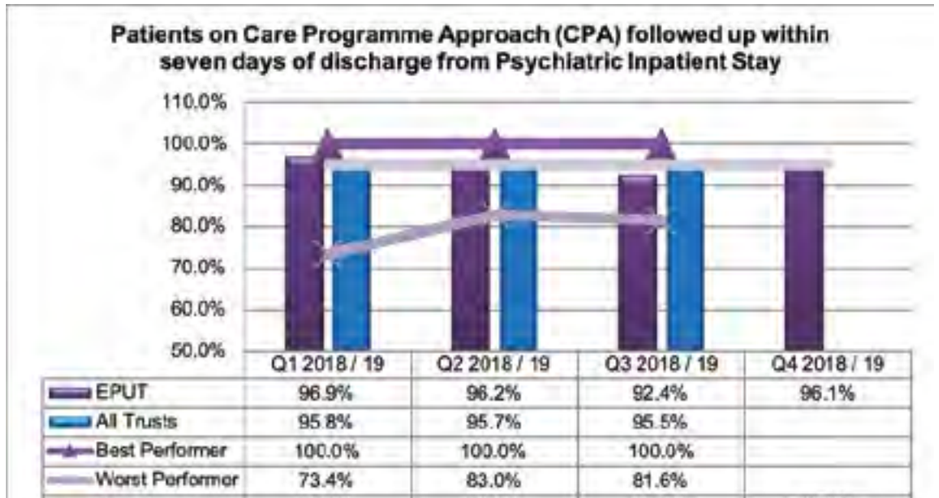
2.7 National Mandated Indicators of Quality

A letter from NHS Improvement dated 17 December 2018 accompanied by detailed guidance outlined the reporting and recommended audit arrangements for Quality Accounts for 2018/19. The National Health Service (Quality Accounts) Regulations 2010 had been previously amended to include changes of the mandatory reporting of a core set of quality indicators.

Those indicators relevant to the services we provided during 2018/19 are detailed below, including a comparison of our performance with the national average and the lowest and highest performers. The information presented for the four mandated indicators has been extracted from nationally specified datasets, and as a result, only available at a Trust-wide level.

2.7.1 Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay

Our ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and enables services to be alerted to any deviation from expected trends.



	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT	96.9%	96.2%	92.4%	96.1%
All Trusts	95.8%	95.7%	95.5%	
Best Performer	100.0%	100.0%	100.0%	
Worst Performer	73.4%	83.0%	81.6%	
Target	95.0%	95.0%	95.0%	95.0%

This indicator measures the percentage of patients that were followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit.

This target has been met for quarters one and two, but we failed to meet the target in quarter three.

We investigated the dip in performance and found that in some cases staff were contacting the person who was discharged on the day of discharge. Under the national construct contact on the day of discharge is not counted as a seven day follow up.

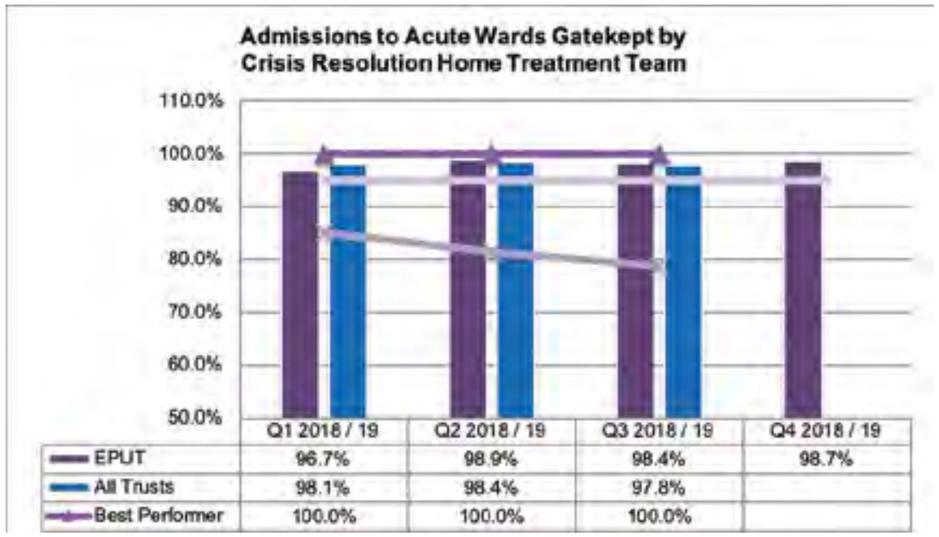
During Q4, we followed up 373 discharges within seven days out of a total 388 discharges, equating to a rate of 96.1%. The Q4 position is based on local data and will be updated upon receipt of the national data. The Q4 data for other organisations is not currently available but will be updated upon receipt.

We have taken the following actions to improve this indicator, and so the quality of our services.

- routinely monitoring compliance on a monthly basis including through use of dashboards
- disseminating identified learning across relevant services

Data Source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition applied: Yes

2.7.2 Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team



	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT	96.7%	98.9%	98.4%	98.7%
All Trusts	98.1%	98.4%	97.8%	
Best Performer	100.0%	100.0%	100.0%	

This indicator measures the percentage of adult admissions which are gate kept by a crisis resolution and home treatment team.

This target has been met consistently during 2018/19.

During Q4, we gate kept 466 out of a total 472 admissions, equating to a rate of 98.7%. The Q4 position is based on local data and will be updated upon receipt of the national data in early May 2019. The Q4 data for other organisations is not currently available but will be updated upon receipt.

Data Source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition applied: Yes

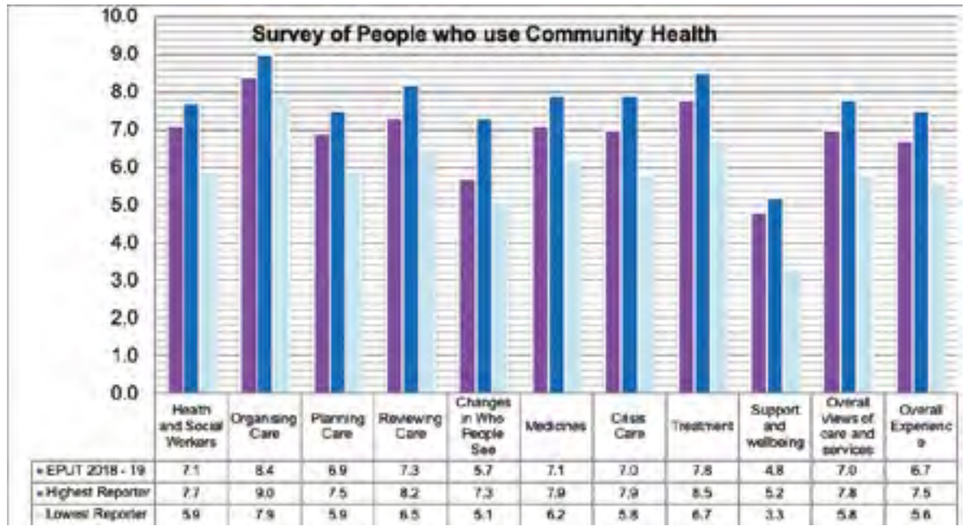
Thank you so much for all of your help and support during my admission, the nursing team always gave space to think and the number of coping strategies that I have learnt I will keep using and hopefully help to keep me out of hospital best wishes. ***Galleywood Ward***

2.7.3 Patient experience of community mental health services

The Community Mental Health Patient Survey 2018 was sent to patients who received treatment from us. The 2018 survey of people who use community mental health services involved 56 providers of NHS mental health services in England (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services). The survey is commissioned by the CQC and received responses from 12,796 people, a response rate of 28%.

Our 2018 report shows how we scored for each evaluative question in the survey, compared with other trusts. It uses an analysis technique called the 'expected range' to determine if the Trust is performing 'about the same', 'better' or 'worse' compared with most other trusts.

The questions are split into different domains and a summary of results is provided in the graph below:



	Health and Social Workers	Organising Care	Planning Care	Reviewing Care	Changes in Who People See	Medicines	Crisis Care	Treatment	Support and wellbeing	Overall views of care and services	Overall Experience
EPUT 2018 - 19	7.1	8.4	6.9	7.3	5.7	7.1	7.0	7.8	4.8	7.0	6.7
Highest Reporter	7.7	9.0	7.5	8.2	7.3	7.9	7.9	8.5	5.2	7.8	7.5
Lowest Reporter	5.9	7.9	5.9	6.5	5.1	6.2	5.8	6.7	3.3	5.8	5.6

The results of the 2018 Community Mental Health Patient Survey show that EPUT have scored 'about the same' as the England average across all sections in the graph above.

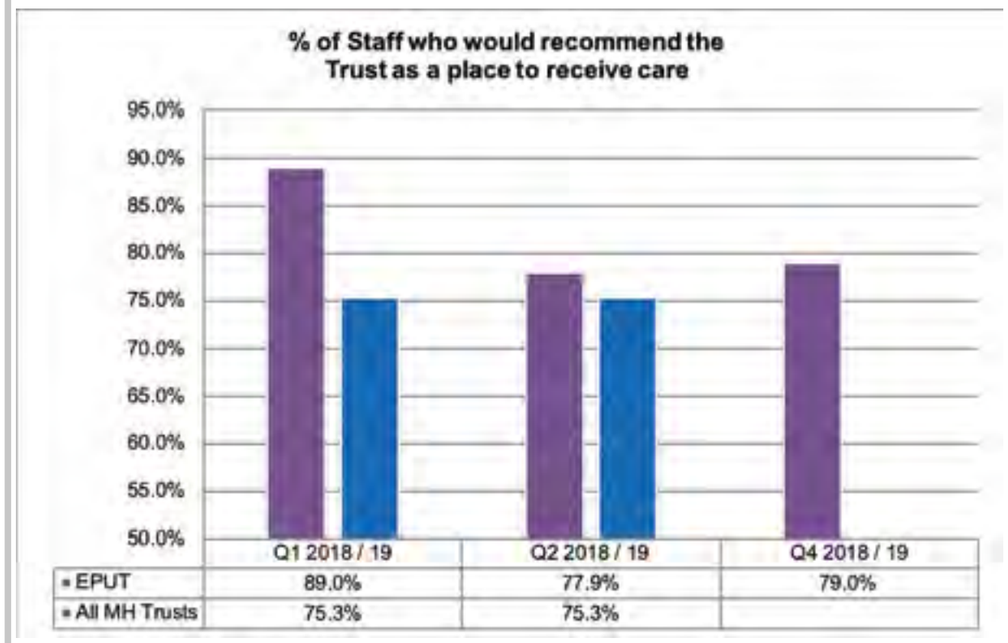
For one question we scored worse than average, 'Q17 Changes in who people see, what impact has this had on the care you receive?' An action plan has been developed and is in the process of being implemented.

Data Source: CQC Community Mental Health Services Survey
National Definition applied: Yes

2.7.4 Staff recommended score of the Trust as a place to receive treatment

The Friends and Family Test is available to staff to record whether they would recommend the Trust to their family or friends, either as a place to work or as a place to receive care.

Our staff were able to record their views from 1 April 2018 to 31 March 2019, although responses are not reported for Q3 as this coincides with the national NHS Staff Survey.



	Q1 2018 / 19	Q2 2018 / 19	Q4 2018 / 19
EPUT	89.0%	77.9%	79.0%
All MH Trusts	75.3%	75.3%	

The results of the 2018/19 SFFT show us as above average for the percentage of staff who would recommend the Trust as a place to receive care. We have taken the following actions to further improve this indicator, and so the quality of our services.

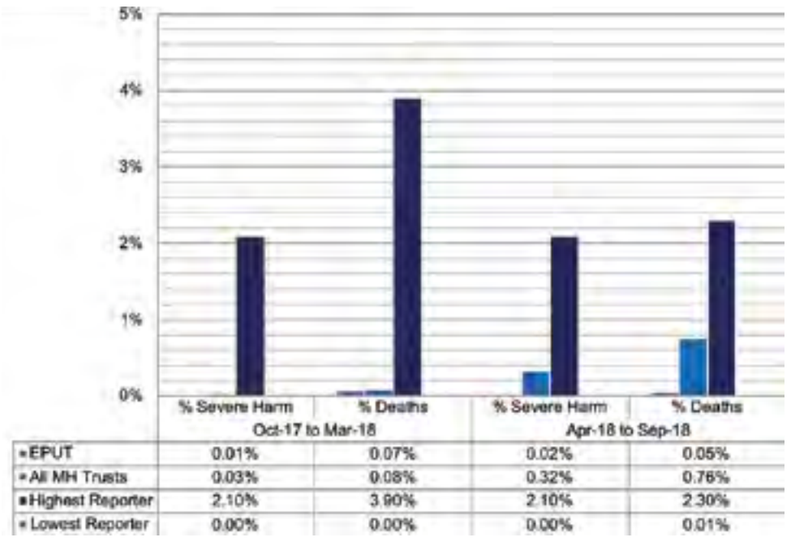
- SFFT link is regularly sent out to staff with an invitation to complete.
- SFFT is referred to as one of the key channels through which staff can report anonymously and confidentially.
- Paper versions of SFFT are taken to events and staff are asked to take them back to staff rooms and receptions.
- SFFT page has been created on the intranet for staff to access which has a link to the survey on it, the summary reports for Q1 and Q2, and further information/supporting publications regarding SFFT.
- SFFT link is also included on all staff engagement pages on the intranet so it is clearly visible and staff can access it easily when they want to give feedback.

Data Source: Staff Friends and Family Test (FFT) survey
National Definition applied: Yes

2.7.5 Patient safety incidents and the percentage that resulted in severe harm or death

Reporting Dates	1st October 2017 – 31st March 2018			1st April 2018 – 30th September 2018		
	All incidents	Severe harm	Deaths	All incidents	Severe harm	Deaths
EPUT	6,965	8	48	7,025	14	37

The graph below shows the percentage of all incidents we reported to the NRLS that resulted in severe harm and those which resulted in death.



	Oct-17 to Mar-18		Apr-18 to Sep-18	
EPUT	0.01%	0.07%	0.02%	0.05%
All MH Trusts	0.03%	0.08%	0.32%	0.76%
Highest Reporter	2.10%	3.90%	2.10%	2.30%
Lowest Reporter	0.00%	0.00%	0.00%	0.01%

Patient safety data for period 1 April 2018 to 30 September 2018 was published in March 2019.

The national collection of patient safety incident data for period 1 October 2018 to 31 March 2019 is due to be completed by the end of May 2019 and reports are expected to be published in September 2019.

We consider that this data is as described for the following reasons
- nationally reviewed via the NRLS;
- benchmarking is against similar Trusts within our cluster group.

We have taken the following actions to improve this indicator, and so the quality of our services
- We have taken forward work to reduce the number of harms – details of some of this work are included throughout this report.
- We have agreed quality priorities for the coming year to specifically reduce incidents resulting in harm.
- There is close monitoring of quality improvement initiatives.
- Monthly Datix training for reporting staff and managers highlights the importance of reporting and to improve the quality of incident records.
- Closer monitoring of incidents is in place requiring manager approval to assist in reducing the length of time between the initial report and the data being uploaded to the NRLS.

Data Source: NRLS NPSA Submissions
National Definition applied: Yes

2.8 Implementing the Duty of Candour

The Duty of Candour is the requirement for all clinicians, managers and healthcare staff to inform patients (or, where appropriate, the patient's advocate, carer or family) of any actions which have resulted in, or could have resulted in, harm. It actively encourages transparency and openness and we have a legal and contractual obligation to ensure compliance with this standard. We have considered such openness and transparency to be vital in ensuring the safety and quality of our services and have continued to drive forward work in this area.

The Executive Directors have overall responsibility for ensuring the principles of Being Open: Duty of Candour policy and procedure and other associated policies are implemented across the organisation. Although Duty of Candour concentrates on incidents that are defined as causing moderate or severe harm, we are committed to being open with all patients and their families and carers in line with our Trust values. All our staff are encouraged to report all incidents based on our culture of a transparent, learning organisation and use the Datix Risk Management system to ensure a standardised approach.

All moderate, serious harm incidents and those identified for escalation are monitored on a weekly basis in a meeting held between the serious incident office and Clinical Risk Team with the Deputy Director of Nursing to review and ensure appropriate investigations are taken forward. For all moderate or severe harm, contact is made either with the patient or family members as appropriate and this is followed up in writing within 10 working days offering them the opportunity to participate in the investigation. This is monitored through the Serious Incident Office with weekly reporting to the Executive Operational Sub Committee as well as through performance reports.

Our Being Open: Duty of Candour Policy describes the process for acknowledging, apologising and explaining when things go wrong and outlines the professional, contractual and statutory Duty of Candour with which staff must comply to ensure that when cases of severe or moderate harm occur patients and relatives are fully informed and involved in the investigation process.

We have a mandatory Duty of Candour on-line course covering all staff with an overview course as a minimum for non-clinical staff, a more detailed course for clinical staff and even more detailed course for managers. The training provides staff with an understanding of the 'Being Open' process and the benefits of this. The aim is to support clinical staff to implement 'Being Open' knowledge within clinical practice and provides an overview of organisational and individual responsibilities as well as how to access and use Trust documentation. It emphasises that all staff have a responsibility to ensure that the principles contained with the policy and associated guidelines are followed in that they:

- must ensure that they report all patient safety events, complaints or claims to their line manager immediately;
- have responsibility to ensure that as part of continuing professional development they acquire, maintain and disseminate knowledge and skills to carry out where required the principles of 'Being Open';
- through clinical supervision and post event reviews, they can expect to receive support tailored to their individual need.

All the courses as a minimum cover:

- definitions;
- 10 key principles;
- process overview;
- benefits of 'Being Open'.
- responsibilities;
- level of response to different incident categories;
- documenting and recording;

This course is not required to be undertaken at regular intervals, but all moderate or severe harm incidents are monitored and further sessions can be given to individuals or teams via the serious incident office as well as advice to staff.

PART 3

REVIEW OF EPUT QUALITY PERFORMANCE DURING 2018/19

This part of the Quality Account is divided into four sections.

Section	Content	Page
3.1	Some examples of local service quality improvements and Trust workforce development initiatives delivered during 2018/19	51
3.2	Performance against EPUT Trust wide and service specific quality indicators • Trust wide quality indicators • Mental health services quality indicators	73
3.3	Performance against key national indicators and thresholds mandated nationally which are relevant to EPUT from the NHS Improvement Single Oversight Framework (as specified in the NHS Improvement Quality Reports Guidance for 2018/19)	85
3.4	Listening to our patients / service users. This section details some of the work the Trust has undertaken to capture patient experience and use this to help improve the quality of services	89

To enable readers to get an understanding of the Trust's performance in local areas, performance against indicators is detailed by locality area where it is possible to do so.

3.1 Examples of Quality Initiatives

Outlined below are some examples of quality improvements that have been achieved by EPUT services during 2018/19 to provide a flavour of the diversity of initiatives we are working on and the progress we are making in improving the quality of care we provide to our patients and users. Due to the diversity and capacity of services we provide, we only have room to include very brief details in this report - please do get in touch with us (contact details are at the end of this report) if you would like further details about any of the initiatives listed.

3.1.1 Mental Health Services

Specialist Services

Forensic Services

- Collaborative co-production with service users on Aurora Ward to reduce restrictive practice and sharing of risk management practices leading to greater choice for patients and fewer interventions from staff. This was recognised at the Trust's 2019 Quality Awards where service users attended to receive their award.
- Under the 'Fair Deal' Quality Initiative service users are participating in the delivery of training to staff, service groups and forums and delivering courses within our Recovery College. This both improves their vocational skills, confidence and self-esteem as part of their recovery pathway and provides an opportunity to be compensated for their expertise through an incentive programme.
- The service prioritises physical health care and has a diabetic lead nurse providing clinics to all patients with immediate needs, reducing the need for attendance at acute hospitals as well as providing advice on diet, lifestyle and self-management of medication. In addition all patients with long term conditions are placed on a register and monitored to ensure they are receiving rapid and appropriate support when required and screening at or above the level they would expect to receive in the community.
- To support and improve service user contact with their friends and family whilst in hospital, all patients are provided with mobile phones which can be used by them throughout the ward as a low cost alternative to traditional payphones increasing their sense of independence and choice. The removal of payphones also eliminates a known ligature risk.

Recovery College Graduation

Learning Disabilities Services

- The Health Facilitation Service supports the inpatient unit by assisting with appointments in acute facilities during inpatient stays and also visiting the unit every week to provide education to service users based on individual need, supported by inpatient staff and therapists.
- The Health Facilitation Service has continued to support mainstream health providers to make their services accessible to people with LD and this year have been involved in the development of a webinar to educate dental practices about the needs of people with LD and how to make reasonable adjustments. They have also worked alongside the diabetes service to develop a group tailored to the needs of people with LD and this has now been run successfully on two occasions.
- There are also plans for a Big Health Day to be run in the local area during LD Awareness Week where a whole day will be given to showing people with LD how to be healthy. This day will be fully interactive with events throughout the day promoting the benefits of staying healthy.

Health & Justice Service

- A female pathway has been developed within the Health and Justice Service, in order to be able to refer females to female only services, to offer female workers when requested and for females to be seen in family friendly environments. The anticipated benefits are greater engagement from females in treatment services, the ability to offer female support staff when requested and an increase in partnership working.
- A female Health and Justice Service flowchart has been produced and a directory of female specific services has been collated to further enhance the service offer for females.

> *With regards to the process of LeDeR and the issues faced with completing the reviews. He said he has been involved with the reviews since the programme started and feels that our health facilitation service do a brilliant job and he is very impressed with us all!*

Sally Morris cuts the ribbon to open the new De-escalation Suite at Byron Court

In-Patient Perinatal Service

- Rainbow Unit has a recovery corner within the activity room on the ward which has a 'handprint wall' where patients on the day of discharge have the opportunity to add their handprint; this has proven to be a very powerful source of support and instils hope in newly admitted patients. There is also a recovery board which houses notes, stories, poems or messages from patients to patients to demonstrate that recovery is possible.
- The therapy programme incorporates partner/carer invite and involvement as well as supporting 1:1 interactive therapy sessions between families such as dad's attendance at baby yoga classes.
- Each patient is given a welcome pack at the point of admission which they can add to throughout their stay with written outcomes from care reviews and care plans. The ward has now created a discharge pack which is created for each patient with a focus on non-clinical support and activities in their local area. These include group activities that they have enjoyed while on the unit or an area of interest they had discussed with a member of staff during their stay.

Child and Adolescent Mental Health Services

- Daily risk huddles have been initiated, which provide an opportunity for de-brief, reflection and open discussion in regards to risk. These huddles also incorporate the involvement of young people in regards to managing and maintaining safety on the wards.
- Young person led groups on the ward, in which they develop, lead and facilitate peer activities, developing confidence, sharing experience, and identifying skills.
- The use of Twitter to share practice and demonstrate safe and effective use of social media for young people. This allows the wards to connect with other CAMHS services and to learn and grow with the support of other services.

Perinatal Mental Health Service received Highly Commended in the national Positive Practice Awards

Drug & Alcohol Services (STaRS)

- STaRS have introduced a quality assurance tool across all sites providing weekly assurance and feedback relating to our key areas of activity.
- STaRS have led the redesign of the alcohol treatment pathway leading to clarity regarding the care co-ordination of these service users.

> *Thank you, really doesn't cut it, because what you have done for me has been life changing and you have given me the best present of all, the gift of being able to enjoy my daughter and give me the skills to be a good mum. It's still a long road, but I feel far better equipped to travel the ups and downs. I hope you all know the difference you made not just to individuals but families on a daily basis. So I hope you see now why thank you just doesn't cut it.*

Inpatient Mental Health Services

Adult Inpatients

- Mental Health Liaison Teams were developed towards Core 24 (Nice). Basildon and Southend acute hospitals are compliant following wave 1 funding. Colchester, Broomfield and Princess Alexandra acute hospitals are now ready for wave 2 funding.
- As part of the transformation work stream, there is now 24/7 Emergency/Urgent Response & Intensive Home Treatment provided. Any person experiencing a mental health crisis should receive a response from the liaison mental health service within a maximum of one hour of the service receiving a referral. Within four hours of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence based care package (informed by NICE) in place.
- High Intensity User Group was developed, working in partnership with ECC & MIND using ECC winter pressure funding. This is aimed at helping health and social care systems identify and support some of the most vulnerable people in our society by providing them with community based 1:1 coaching and mentoring to empower them to self-manage.
- In north east the Home First/Homelessness Project now has a part-time Band 7 post funded by Colchester Housing Borough Council. The national plan to end homelessness is aimed at ending rough sleeping, getting everyone housed, and preventing homelessness.
- An RTMS (repetitive transcranial magnetic stimulation) treatment for depression has been developed. This treatment was approved by NICE in 2015.
- ECT (electroconvulsive therapy) has been developed as a service to the private sector. This treatment is known to make changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses.

Older Adult Inpatients

Older Adult Inpatient Dementia/Functional Care Pathway (includes acute care decision making and gate keeping record prior to admission)

- Whilst home would always be the first option, mental health admission may not be avoidable. Prior to any admission it would be expected that there had been an assessment by the DISS team who would provide a clear rationale for admission including a clear and mutually agreed outcome. This ensures admissions are planned and purposeful. The inpatient services have developed clear assessment and treatment processes with timelines and there is an estimated date of discharge within 24 hours of admission. Length of stay is reduced and flows through the service improved.

Falls Prevention

- A Falls Focus Group has been established to look at a number of areas such as:
  - improving the ward environment by undertaking environmental audits with action plans and recommendations;
  - identifying falls champions for each ward with defined roles (both registered and unregistered staff);
  - planning falls champion training for the coming year;
  - eight staff training places identified and agreed through workforce development team on chair based exercise programmes in the summer of 2019, as a specifically targeted falls prevention programme;
  - increasing the high-low bed stock in the Trust.

Community Mental Health Services

Open Dialogue

- In Thurrock we are excited to have commenced a four week residential training in Peer Open Dialogue (POD). This is also associated with a year's research trial, which will consider how POD compares to 'Treatment as usual'. The trial is due to commence at the end of April 2019 and will last a year. This is closely associated with UCL, who will oversee the process.
- POD is seen as one of the new service user led and focused approaches to treatment for people suffering from severe and enduring mental health problems. It is also seen as an approach within Family Therapy. Professionals' focus is on facilitating family/significant others network meetings with the service user and whoever they identify as significant in their lives. In addition, the fidelity measurement criteria centres on continuity, responsiveness and minimising professional hierarchy, offering natural reflections from professionals to the network meeting.
- Research in Finland, where it originated has shown that patients who were under POD, needed significantly fewer admissions and in some cases; for example: patients with Psychosis, came off their medication and remained stable.

Thurrock First

- The Thurrock First service is an integrated community mental health, community health and social care service provided jointly by EPUT, North East London NHS Foundation Trust (NELFT) and Thurrock Council. It is recognised that people accessing services can present with complex conditions that cross the divide between healthcare (both mental and physical), and social care. The aim is to offer a single point of entry for each person to meet all their needs.
- Thurrock First strives to provide a high quality integrated adult health and social care information, advice and assessment service focused on prevention and signposting. In particular, it is the first point of telephone contact for adults living in Thurrock who want to talk to someone about adult social care, mental health, health problems that have been diagnosed and for which on-going care is needed, where to get help with other health problems and care that is available in the community.

> *I am writing this letter on behalf of our family to say a massive thank you to all the doctors, nurses and staff involved in our mother's treatment, care and recovery. From the top, the doctor and her team, through to the night staff, canteen staff and cleaners and particularly the nurses, all gave our mother the most amazing care, compassion and attention to bring our mum back to her old self. Sadly we only hear the bad bits from within the NHS, but the care and service our mum received from the NHS, on Beech Ward, was a shining example of the NHS at its very best.*

SIM (Serenity Integrated Mentoring) Mid Essex Project

- This model of care combines the best clinical care with compassionate but consistent behavioural boundary setting to reduce harm, promote healthier futures and reduce repetitive patterns of crisis from impacting 999 and other emergency care teams. Commencing in May 2018, SIM Mid Essex is a new programme, part of the national accelerator programme, led by a Project lead from Hampshire Constabulary. A trained police officer and mental health care co-ordinators work with the patient regularly to develop a shared care and response plan.
- The patient may have been referred to the programme to help find ways of coping that cause less risk to themselves and/or others. They may have been regularly detained by the police under Section 136 of the Mental Health Act, or frequently called 999 for an ambulance, attended A&E, or been admitted to a mental health ward on multiple occasions. The decision to offer the specific patient mentoring is made by the team consisting of representatives from mental health services, police, ambulance and the accident and emergency department. Mentoring can help the patient find new ways of coping so they are better able to manage their mental health. People who have used this programme have found it has improved their self-esteem, wellbeing and quality of life by addressing practical, social and emotional issues that can contribute to a mental health crisis. Frequency of detention under Section 136 is also reduced.
- A police mentor is an officer who is trained in mental health. The police mentor will meet with the patient and care co-ordinator (along with carers and/or family member, if the patient wishes) to help the patient reduce the risks they may be causing for themselves and/or others. Together they will take account of the patient's specific and individual needs particularly when responding if the patient is in crisis and help the patient stay safe and within the law. The police mentor and care co-ordinator work closely with the patient to better understand their personal needs when they are in crisis and co-produce their unique care and response plan. The police officer working with the patient will not to wear uniform but is a member of the NHS staff with an NHS identity badge, a police identity badge and full access to NHS buildings and patient's clinical records, meeting all governance requirements.

Sally Morris and Essex Police' Steve Worron pictured at launch of SIM (Serenity Integrated Mentoring)

Older people and dementia services

Accessible and responsive services

- Development of the West Essex Integrated Single Point of Access for all community and MH older people's and dementia services.
- North East Essex multi-agency dementia primary care pilot based around a cohort of four surgeries.
- EPUT older people's and dementia services aligned to primary care hubs/networks as part of locality integration initiatives.

> *My lovely dad who spent many weeks with you in your excellent care has sadly passed away. He is finally at rest from that terrible disease called dementia. You will remember how much he loved to sing and dance so the angels are set for one big party now. Thanks to every one of you for helping him in his last tormented months and helping him so much to get through each day without hurting anyone. Keep doing what Angels do on earth.*

Essex Dementia Team celebrate National Dementia Day 2019

SWIFT team

Enhanced integrated services to support care and treatment at home

- South East Essex Dementia Intensive Support Service and SWIFT admission avoidance collaborative.
- The Mid Essex Dementia Intensive Support Service is fully operational across the Mid system providing alternatives to admission. The service has continued to improve through this full implement stage reflecting the feedback from stakeholders.

End of life care for those with dementia

- The North East Essex Dementia services have been working with the St Helena's Hospice in their quality improvement initiative to deliver the gold standard framework for End of Life care for those with dementia.

North East Community Mental Health

Enhanced Mental Health Liaison Team

- The Mental Health Liaison Team received funding for additional staff to focus on periods of high activity and include an unregistered clinician to support the patient and carer in the referral experience. A steering group is ongoing involving a number of providers to consider improvement and governance of the service.

> *I would like to say a big thank you to the Swift Team who have attended me this week during a really horrible bout of illness. The nurses were excellent in every way and were so kind which gives one a lot of comfort when it's most needed. I think this is a wonderful scheme and keeps us oldies out of hospital, which is wonderful. Thank you all again for everything.*

GP Primary Care Pilot

- EPUT was approached to support a one day a week pilot in a local GP surgery in the NE which identified it required additional support with mental health referrals. A Band 7 Advanced Nurse Practitioner was mobilised to work with challenging cases within the surgery to support their GP colleagues. EPUT initiated a multi-disciplinary team meeting once a week where cases were discussed and subsequently seen by the primary care mental health worker. The pilot was so successful in terms on patient and GP feedback that a full time post was commissioned and now in post in Tendring and Colchester.

Social Care Leadership (Adult Mental Health)

Care Planning Scrutiny Panel

- This panel meets on a weekly basis to ensure there are fewer delays in provision of funded care and scrutinises all applications due to be submitted to Essex County Council's Social Care Funding Forum and the S117 Panels. The aim of the Scrutiny Panel is to ensure that all paperwork submitted to Essex County Council and the S117 panels is of the highest quality. It also ensures as far as possible that the applications are likely to be accepted and taken forward, thereby reducing delays in the provision of care. The Scrutiny Panel also provides very clear learning for staff via a robust feedback process.

Review and Recovery Team

- During 2018/19 the new Review and Recovery Team was launched in the north east of Essex, led by a Social Work Consultant in partnership with Peabody Housing, a local charity. The aim of this team is to ensure that high level support is provided to service users in this area when it is deemed appropriate for them to move on. The team is able to work with individuals intensively to ensure that their move from residential care into supported housing or their own tenancy is smooth and successful.

HeadsUp Service

The Trust successfully delivered the launch of the new HeadsUp Service, in partnership with Enable East and funded by the Big Lottery Fund and European Social Fund. HeadsUp works with people across Essex who have common mental health problems, such as anxiety and depression, and who are going through a period of unemployment. More than 90 people have already made the most of the project's free support, advice, practical tips and experiences to help with employability. A team of peer support workers give one-to-one support, while practical interactive workshops help to build skills and confidence. HeadsUp are assisted by a network of Essex-based businesses and organisations who share their guidance and expertise. Where relevant, they also help to secure employment or training for participants enrolled on the programme. HeadsUp has been shortlisted as a finalist in the 'Primary Care Initiative of the Year' category at the national HSJ Value Awards for its work supporting people back into employment.

Performance management of Section 117

- This process covers close monitoring of EPUT's performance in managing Section 117, by contacting all care co-ordinators and clinical managers on a monthly basis to let them know of all S117 reviews required to take place within the next three months as well as reminding them of any that are overdue. The aim of this process is to ensure that the Trust maintains a high performance in this area, thereby ensuring that service users receive a high level of care.

Partnering with Think Ahead

- EPUT has been supporting a second cohort of Think Ahead students. There are four Think Ahead social worker students based in north Essex, supported by two consultant social workers. Working in partnership with the Essex County Council, the Think Ahead students undertake placements in their children and family teams. EPUT also provides training on the national Think Ahead programme on Family Group Conferencing which has proved to be very successful over the last two years. This partnership will continue into its fourth year.

Connecting People

- Connecting People is an evidence-informed social intervention developed and evaluated in a series of studies led by the University of York that is taught on the National Think Ahead training programme for mental health social workers.
- Connecting People is underpinned by social capital theory and the recognition of positive social connections for the enhancement of physical and mental wellbeing. The primary aim of this intervention is to enhance the quality and diversity of service users' social networks. It adopts a logical, eight-step method of non-prescriptive and individualised care to facilitate movement towards improved social networks and social inclusion.
- EPUT have been taking part in a research study based on the psychosis service pathways working with the University of York, in collaboration with the McPin Foundation, University of Central Lancashire and the London School of Economics.
- The work undertaken within this pathway is highlighted by the National Collaborating Centre for Mental Health (NCCMH) as a positive practice example on the 'Positive Practice in Mental Health (PPiMH)' directory website.

Chaplaincy Volunteers

- Chaplaincy volunteers are active in Clacton and Colchester, Basildon and Epping. Recent trained volunteers have commenced visiting in the Derwent centre, Harlow, the first chaplaincy input at the Derwent Centre for almost two years and have been well received. The Linden Centre and Crystal Unit continue to be covered via the current service level agreement.
- Chaplaincy Volunteer training has continued to be provided. The latest course was held in the west at St. Margaret's Hospital, Epping. A waiting list is now being built up for the next training and it is hoped it can be held in south or the east.

Volunteer Chaplains celebrate their graduation

Psychological services

Dementia and Frailty Services (DFS)

- More individualised feedback has been developed with post diagnostic support (PDS), including an innovative PDS day workshop for all newly diagnosed people with dementia and their carers. These provide support and identify those families needing more complex support.
- A specialised group is provided for people with Mild Cognitive Impairment and a complex psychological therapy service for people with complex trauma and personality disturbance as expressed in later life.
- Intervention and supervision is provided to the UCL directed Pathfinder study for psychological therapy for people with cognitive impairment.
- A Tree of Life group exists to assist older people in both areas with complex psychological histories and current issues. In addition there is involvement in the EPUT Equality and Diversity programme with one psychologist seconded into the WRES initiative and one appointed as an equality champion.

Primary Care Interface and Integration

- Integration of Psychology and IAPT providers has been piloted in identified neighbourhoods in line with the development of a primary care facing mental health service. Collaborative care models of service delivery are being reviewed and scoped for local viability. Interventions include ACT and the Trauma Stabilisation Groups. This will enable the most accessible offer of interventions, with assigned governance, for those patients that typically represent the interface between primary and secondary care provision.

Knightswick Psychosis Project

- Having identified a low referral rate to psychological services for patients presenting with needs associated with psychosis, a locality psychologist has invested in developing a pathway to enhance access for this patient group. A scoping of unmet needs identified a need for interventions associated with paranoid delusional belief systems.
- Staff completed specialist training for a psychological programme targeting paranoid delusions. The 'Feeling Safe' programme offers potential for the upskilling of multidisciplinary team (MDT) staff to offer increased coping and resilience skills to patients with psychosis who have historically accessed a predominantly medically driven care plan. With the stabilisation of distress associated with delusions, there can be increased opportunities for the care plan to include social prescribing and goal attainment.

> *I would like to say a big thank you my IAPT counsellor who has been most helpful and supportive, the regular telephone therapy sessions have been a life line for me to talk through a lot of my health issues and difficult family challenges over the last 6 months. I am very appreciative of the support and guidance, I still have a few hurdles to get over, however, I do feel a lot more confident than I did six months ago.*

Secure Services

Sally Morris congratulates the Recovery College graduates

- An Understanding Risk Group has been implemented at Fuji (female medium secure ward) and Wood Lea Clinic (male LD low secure ward). This involved providing patients with psychoeducation around their risk and the risk factors associated with them reoffending. This supports patients to develop insight into their own offending behaviour, as well as empowering them to take greater responsibility of managing the risk they may present to others.
- Following the identification of the most effective interventions available for patients who have offended, psychologists have now attended Life Minus Violence (LMV) training. There is now an LMV programme underway at Brockfield House with patients attending two-hour group sessions three times a week.
- Psychologists within the team have attended training for the Fire-setters Intervention Programme for Mentally Disordered Offenders (FIP-MO). The FIP-MO programme has been run as two groups at Brockfield House (male and female groups) as well as in an individual format at Robin Pinto Unit. The group has found good outcomes so far as evidenced by pre- and post- standardised outcome measures.
- An Understanding Social Difficulties Group was implemented at Wood Lea Clinic to assist patients in understanding a diagnosis of autism and in supporting them to develop social skills.
- In response to the rehabilitation needs and difficulties reintegrating into the local community following lengthy hospital admissions, a Moving On group was designed and facilitated by psychology and OT on Forest Ward (male medium secure rehabilitation ward).
- Mindfulness Groups have been facilitated on wards for both patients and staff. This has been a means of staff learning techniques for their own wellbeing, as well as being able to use the techniques with patients. It has provided opportunities to model to patients the normality of anybody using mindfulness. This initiative has been launched on Robin Pinto Unit (male low secure ward) and Alpine and Lagoon (male medium secure wards).
- Mindfulness Based Cognitive Behavioural Therapy (MBCBT) has been implemented as a group on the male medium secure wards. This has been adapted to make it suitable for patients with severe and enduring mental health problems and is being facilitated jointly by psychology and OT.
- Rather than viewing DBT as an intervention to only be delivered to females with a diagnosis of EUPD, the wider implementations of the model were considered, including the use of DBT Skills Training to prisoners and young offenders. A DBT Skills Group was trialled with male low secure patients at Robin Pinto Unit. This new initiative had good outcomes in terms of reductions in anger, aggression and impulsivity.

The programme has also been adapted to enable patients to be referred to specific modules for skills training (taking two months each) instead of the full two-year programme, thereby enabling a wider pool of patients to access interventions most appropriate for their needs.

> *With love and thanks for your continued support and care for him.* ***Robin Pinto***

In-Patient Wards

- Assistant psychologists are now working under qualified supervision to provide activities, interventions and to improve observations after hours and on weekends.
- The pilot initiative planned to be established as a standard service offer, and should Clinical Associate Psychology apprenticeships become available, these will be considered suitable for evolving into apprenticeship training schemes to establish this as an ongoing offer. All groups have received extremely positive feedback from patients, with many ward staff also having commented on the positive impact their presence is having on the wards. In addition to this, the assistant psychologists also provided 'Visible and Available Psychology Times' (V&A) on the wards whereby patients or staff can seek informal psychological advice and support.
- Clinical Psychologists won a Quality Award for the innovative training they offered to Security Staff working on each Adult Inpatient Psychiatric Ward, on working with people with mental health problems.

Personality Disorder and Complex Needs (PD) developments

- A unique integrated and needs-led intervention service for people with Complex Needs (usually Personality Disorder, but also co-morbid conditions and trauma) has been piloted in South Essex as part of our Trust Service Transformation agenda.
- The PD lead for south east Essex has developed a project in conjunction with the CQUIN being led by the mental health liaison team. The project targets frequent attenders to A&E at Southend Hospital. High attenders are often identified as having a PD diagnosis and being care co-ordinated by a local RWT. The lead has worked up detailed case studies for this cohort, working with care co-ordinators to develop a psychological formulation that can offer insights into crisis profiles and the most appropriate whole system response across team provisions. In addition, they have delivered a focused skills training to identify care co-ordinators focusing on emotion regulation and distress tolerance.
- An Expert by Experience session was held to share the vision of the PD pathway developments, recruit opinions and engage consultation.
- An integrated Systems Training for Emotional Predictability and Problem Solving (STEPPS) initiative in south Essex has provided delivery as a partnership between IAPT providers and secondary care specialist mental health provision. This development will enhance access to psychological intervention for patients with a personality disorder, with the aim of reducing crisis presentations, reducing admissions and increasing recovery based goals and functioning.

GAS Goals outcome measure pilot

- In addition to standard outcome measures for specific symptoms and diagnoses, psychological services teams have piloted the use of Goal Attainment Scaling as an Outcome Measure. The GAS (Kirusek & Sherman, 1968) is a Clinician-Rated Outcome Measure (CROM), which measures the extent to which a patient's individual goals are achieved throughout the phase of an intervention.
- Psychological assessments inform a formulation of the presenting problem based on a clinical model framework. An intervention plan is then matched to patient needs, and personalised targets for intervention are set as goals. At the end of treatment, the extent of goal attainment is measured and used to provide feedback to the patient, to measure clinician progress and CPD needs, and to aggregate team outcome statistics. It assists in development and modification of intervention pathways and can be a behavioural and practical adjunct to quantitative clinical measures.
- Following a pilot, our commissioners have agreed to incorporate GAS into the care plan for every mental health service user, so outcomes will be established for every treatment episode. Service-specific outcomes (both qualitative, such as service user feedback sheets and quantitative, such as Patient-Rated measures), can easily be incorporated within the GAS framework. This way, services can still use any specific or specialist assessment and outcomes tools in conjunction with Goal Attainment Scaling, but the overall outcomes will be standardised using T-scores, and therefore be comparable from one service to another.

Specialist Psychotherapy Services

- Structured, time-limited group interventions have been introduced to reach more service users, including mentalisation-based and dialectic behavioural interventions over 18 months.
- Via joint assessment and discussion in the 'high intensity users' meeting, clients are identified as appropriate for more frequent psychodynamic psychotherapy. The increase in sessions is being monitored for value to the client and for the reduction on demands on other areas of the service. There is already some reduction in demands on the 'duty service' and care coordinators time.
- Psychotherapists provide training to multidisciplinary team staff, including 'Understanding our Patients' Behaviour' as well as topics such as: suicide, attachment, containment and trauma.
- A music therapist has introduced a 'Music Mirrors' project to enable memory links to embedded musical themes in patients with Dementia, amongst other innovative interventions on in-patient wards.

Team and staff support

- Team formulation forums provided by psychological services staff continue to be delivered across all MDT's. These include reflective practice sessions, case discussions and care plan development and identified training/teaching.

Staff support initiative following serious incidents or personal distress

Exposure to serious incidents (SIs) occurs for staff working in mental health services. Such experiences include the death of patients, serious patient injury, assaults on staff and patients causing harm to others. Any of these events can result in staff feeling overwhelmed by their emotional responses, which in turn can compromise resilience and performance and influence sickness absence.

- The Trust's psychological services developed a formal response plan for Psychological Services to take a lead in providing support to Trust employees affected by serious incidents. This is part of a strategic business plan targeting wellbeing and sustainability in conjunction with the NHS safety improvement and quality regime. A corresponding strategy is offered for consideration, embedded within the EPUT value system of being compassionate, empowering, and open. The proposal aligns to the EPUT investing in a safety culture that views openness as essential to better care, for both patients and staff.
- The identification and recruitment of psychological services designated clinicians who can step up in staff support roles, can provide governance and professional oversight to a robust workforce support strategy, is proposed. This clearly delineates staff support from investigatory processes and any HR procedures, promoting the propensity for openness and accessing assistance in a safe 'no blame' context. It hopes to be proactive in being workforce facing, to ensure team managers are also supported and enabled to respond to the support needs of their workforce in response to SI's.

ACT4NHS (Acceptance and Commitment Training) Staff Training

- EPUT has piloted Acceptance and Commitment Therapy-based training for staff, entitled ACT4NHS. The training aims to help staff identify and understand why they undertake certain tasks / functions during the process of their work, rather than just undertaking them in a task-orientated manner. It seeks to develop a level of psychological flexibility that enables staff to adapt to change, and manage the challenges of their daily work. By assisting staff to clarify their own individual life values, and measure the congruence of these against our organisational values, the aim is to enhance motivation and resilience, resulting in the provision of high quality care.
- ACT aims to:
  - highlight the ineffectiveness and costs of avoiding experiences that are difficult or unpleasant;
  - break down the literal content of thoughts and enable direct contact with difficult psychological content;
  - identify a sense of self that is distinct from and therefore not threatened by, psychological content;
  - promote contact with experiences in the here and now (thereby enhancing resilience and tolerance);
  - help clarify values which help to guide choices and emphasise what is important, and help distinguish them from goals and actions;
  - commit to actions that are linked to chosen values.

Allied Health Professions Mental Health

Closing the gap initiative

- This is an Allied Health Professions led initiative on managing the potential physical health risk to individuals on anti-psychotic medication and in particular in developing Type II diabetes by the engagement in a healthy lifestyle programme which incorporates education, exercise and meaningful activity & healthy eating. Initially developed on Cedar ward, this has been rolled out to other adult inpatient wards across Colchester, Chelmsford, Harlow and Basildon. The next phase is to introduce the initiative to community teams to sustain the progress made by service users once they are discharged from hospital and to support engagement with community resources.

Mindfulness

- Working in partnership with a range of professions and clinical groups, Trust leads have developed a broad range of mindfulness sessions and groups for both service users and staff. Staff sessions focusing of developing staff resilience also include brief sessions scheduled at lunch time which has proven popular with staff.

DBT

- Occupational therapists across adult community mental health teams in south Essex in partnership with psychological services have developed and facilitated a range of DBT focused skills training sessions to patients living in the geographic area. A systematic programme of training is being rolled out to ensure that occupational therapy staff across wider Essex and in particular, Colchester, Chelmsford and Harlow will also be delivering the same programmes to ensure parity.

Occupational Therapy Rotation for newly qualified staff

- Occupational therapy in mental health and learning disabilities has developed a robust and well-established rotational scheme of newly qualified Band 5 occupational therapists. The partnership includes Essex Partnership University NHS Foundation Trust (EPUT), Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and North East London NHS Foundation Trust to ensure that this includes acute care and specialities such as paediatrics. The scheme has been expanded to include Community health Services in EPUT, Essex County Council and acute hospitals in Colchester and Harlow.

Trust Occupational Therapists mark national OT Week

3.1.2 Community Health Services

West Essex Community Health Services

Integrated working with Essex County Council Adult Social Care

- West Essex Community Health Services are unique in terms of the operational leadership. The Director of Health and Care is responsible for both EPUT community services and Essex County Council Adult Social Care. The integrated leadership team work collaboratively to reduce hand offs and bureaucracy that delays and impacts on a patient's/carer's journey through the complex health and care system. It does this by:
  - supporting care home and domiciliary care providers to ensure that adults are able to remain in their own home environment wherever possible;
  - increasing understanding of both health and social care roles at the front line;
  - joint working across the collective occupational therapy workforce to avoid duplication;
  - collaborative joint decision-making to deliver person centred care, engaging with patients, family and carers to ensure the needs of the patents are achieved;
  - joint health and social care transfer of care planning for patients and carers from acute to community and home by reducing duplication of assessment;
  - reducing risk averse practice which increases length of stay by supporting effective safe discharge;
  - supporting difficult conversations with patients, family and carers regarding ongoing care and support.

Integration of Community Health and Specialist Dementia Frailty Services

- In 2018 the Harlow Specialist Dementia Frailty Team co-located with the Harlow Community Integrated Team based at Latton Bush. This first step with co-location has already supported improved communication and collaboration between clinicians which is a key enabler to support parity of esteem between physical and mental health needs for our patients.

Ongoing development of the Integrated Single Point of Access (SPA)

- Introduction of new telephone technology providing call waiting information for callers and recording of calls for audit and training purposes.
- Access to the EPUT contact centre for community nurses up to 23.00 hours 365 days per year and patients, and other health care professionals up to 24 hours.
- Therapists based in SPA to support effective triage of all therapy referrals, improving patient access to therapy support and preventing duplication.

Specialist Community Cardiac Team

- The team has expanded the heart failure service to include the provision of a dedicated Heart Failure Rehabilitation Exercise Programme. The aim of the programme is to empower patients with heart failure to self-manage their long term condition. The programme includes support to engage with physical exercise, management of medications, advice and guidance on diet and the impact of heart failure on everyday life.

The Trust marks Alzheimers Cupcake Day to raise awareness

Specialist Community Respiratory Team

Respiratory Clinician of the Day

- A clinician who will assess and review on the day referrals to the team, providing responsive and effective support to patients with respiratory conditions who are at high risk of an A&E attendance and/ or unplanned admission.

Respiratory Multidisciplinary (MDT) Team Co-ordinator

- MDT's have been established to support all patients discharged to ensure an appropriate care plan is developed with the patient to support self-management of their condition and prevent A&E and unplanned hospital admissions.
- The MDT Co-ordinator role requires effective system working across patient pathway with all respiratory clinicians, the patient and GP.
- Feedback from system partners and patients is very positive with other clinical pathways are considering a similar role.

> *I can honestly say the care and patient experience that was offered is beyond anything I have ever seen. All of the staff on the ward were fantastic and never once was anything too much trouble for them. There is no way I can repay the team except by saying thank you, thank you and thank you! They are an absolute credit to EPUT and the NHS!* ***Beech Ward, St Margaret's Hospital***

Empowering patients through technology

- My COPD App supports patients with Chronic Obstructive Pulmonary Disease with self-management of their condition.

West Essex Community Pain Service

- Provided by a multidisciplinary team (MDT) of professionals including specialist nurses, a psychologist, specialist physiotherapists, pharmacists and a pain consultant.
- Emphasis of the service is patient empowerment by supporting patients to gain the necessary skills to self-manage chronic pain.
- Provision of evidence based education and therapy sessions to support patients with shared decision making, development of personal goals.
- Supporting patients to understand the complexities of opioid medications. The service will support all patients who choose to reduce or discontinue their medications.

Harlow Integrated Community Team – development of a catheter clinic

The community nurses recognised the poor patient experience from current service provision and worked to:

- develop a community based clinic with appointment times for working age adults and non-housebound patients with in-dwelling catheters;
- provide a monthly service within an appropriate community clinic environment;
- improve the patient experience, effectiveness and efficiency of the service;
- extend the model of care across West Essex during 2019-20.

The service has to date received positive feedback from patients.

South East Essex Community Health Services

FNP (Family Nurse Partnership)

- The FNP team has continued to embed the use of the New Mums Star tool in personalising client care. The implementation of the Neglect clinical adaptation will enhance the work of the FNP team allowing testing and learning from new approaches. Both new and existing learning will be shared in knowledge and skills training with children's services partners. The team is committed to embedding team learning into their team meetings with a planned schedule for the year.

Speech and Language Therapy (SLT) – Paediatrics

- The continued rollout of the ABS delivery of a suite of programmes has been well received and extended the reach of the service in the target population. There is a positive impact on referral rates into the main service as a result of the preventative work undertaken by the ABS team.
- The use of Boardmaker Online (a subscription service) allows staff to upload general therapy resources via the account held for SLT on the Boardmaker Online website. Schools and parents can access the account with a unique username and password and print off as often as they like. This results in a saving on stationery and postage costs and can immediately make available items requested electronically. This is being extended into interactive activities which enables access when logging in via an iPad to target speech and language development over the coming year. The service will then be able to overview the amount of time these are accessed outside of direct therapy sessions to ensure that therapy targets are actually being practiced.

Palliative Care Service

- The Palliative Care Service supports patients and their relatives through the last year of life and provides care and support in the last days of life. The service maintains a Palliative Care Support Register, which is acknowledged as national best practice. The services also has a training arm to train front line staff (including those in care homes) to have confidence and better support patients in their last year of life. Additional developments have included new patient leaflets, undertaking carer surveys, an end of life competency framework and issuing a 'Red Folder' to all new patients with patient held information including advanced care plans.

> *Lovely to meet both of you yesterday, we really enjoyed it, very positive! Thank you so much for the idea sheets and activities, these are going to be very helpful.* ***SLT Paediatrics***

The Care Coordination Service

- In the last year the team has refined care plans which are now more personalised and goal based highlighting any areas which require support, showing the appropriate referrals that are made and states identified goals the patient wishes to achieve.
- The team have redesigned the way referrals are allocated, saving administration time. Internal referrals are now up and running, making the way in which SystmOne users refer easier and quicker.
- The care coordination team as a whole has unified paperwork and aligned working strategies/practices to provide the same quality service to the patient no matter the postcode.

The Castle Point and Rochford Team have two occupational therapists who are assessing and supporting frail patients who are frequent fallers.

South East Essex Care Coordination Service (Southend Team)

- The service works proactively with GPs within Southend to find patients who are vulnerable and at risk of decline and put in health and social care intervention before they hit crisis point.
- The service continues to maintain a strength base approach in developing an appropriate care package in a co-productive way. The team had expanded with 3.5 WTE Senior Health Care Assistants to support the service needs and ensure patients have continued support.

> *We lost both my husband's parents this year and the Palliative Care Team were involved on both occasions. My father-in-law died first and had quite a lot of involvement with your team member, who was excellent. My brother-in-law found it invaluable to have his help. Despite being out of area by the time my mother-in-law was also in need of palliative care. He stepped in to help. Once he became involved in her care, the contrast was incredible, thanks to him and all the team.*

Integrated Community Nursing Team

- Health Care Assistants (Band 3) were upskilled, trained and upgraded to deliver care to a Band 4 competency level. This has made our existing staff feel valued; feel supported into a nursing career pathway and helped the service respond better to the increasing district nursing demand.
- Quarterly staff development workshops saw over 150 staff from a variety of professional backgrounds participate in shared learning forums. Staff feedback from these workshops has been overwhelmingly positive, evidencing new learning and increased networking.
- A Practice Development Nurse position has supported district nurses in their day to day practice. The role supports newly qualified nurses to gain confidence working autonomously in the community and delivers tailored training to refresh or develop new nursing competencies.

The Leg Ulcer Service

- The Leg Ulcer Service provides holistic assessment and treatment for mobile patients with leg ulceration in clinic locations across the locality. Care is tailored to meet the individual's needs encouraging patient empowerment and involvement in their care to achieve desired outcomes.
- Assessment and on-going management is also provided through a 'well leg' monitoring service to help reduce risks of ulcer recurrence. All the nurses have extended knowledge and skills within the leg ulcer field.
- The Leg Ulcer Team continues to provide care at Southend Leg Club. This is a 'drop-in' centre held weekly with the support of volunteers to provide community-based treatment, health promotion, education and on-going care for people who are experiencing leg-related problems. Leg Club is held within a social setting to help foster peer support and tackle social isolation often linked to chronic health problems. Within the last year Southend Leg Club volunteers were recognised with an award from The Lindsay Leg Club Foundation for their continued work with Leg Club.

Workforce Development and Training – Quality Improvements 2018/19

Many of our quality improvements are concentrated on attracting a new workforce and creating development pathways for the existing staff.

Working with Schools and Colleges

- The Workforce Development and Training Department has been working closely with schools, colleges and Sustainability Transformation Partnerships (STPs) to increase engagement with school and college students. We are actively developing our talent pipeline by obtaining student details and offering work experience placements across the Trust and with our STP partners.

Further Development of Apprenticeship Programmes

- As part of the plan to develop our workforce, we have obtained Employer Provider Status enabling us to deliver health and care apprenticeships in-house. Whilst there are still many improvements to be made, we are very encouraged by the fact that the first learner to complete the programme and the End Point Assessment completed with a Merit. We feel that this demonstrates the quality of the training provided.

Application for approval to deliver as an Apprenticeship L4 L5 Higher National Diploma in Healthcare Practice England (Integrated Health and Social Care)

- This will enable in-house progression beyond the Level 3 programme mentioned above. This approval will enable us to deliver both L4 and L5 under Pearson's specifications in line with the Apprenticeship Standard for an Assistant Practitioner level 5. This will ensure high quality, consistent learning within the Trust, providing students with a clear line of development within the Trust and onward progression to a degree at Level 6. The delivery of the L4/5 course supports the Trust's 'grow your own' ethos and the recruitment and retention plan and is an exciting 'next step' for the Trust apprenticeship programme.

Development of Preceptorship Web media platform and Action Learning Sets

- As part of the Local Workforce Action Board, the Maximising Supply Group have been identifying ways in which to support, engage and reduce attrition in our newly qualified staff that are within their preceptorship year. As part of this we have the exciting development of a web-based media platform which is being created to allow for newly qualified practitioners across all areas to be able to access short experiential work placements in areas other than their own across the STP. This project has also identified the need for Action Learning Sets for the preceptees. The facilitators for which are currently being trained and venues identified. Action learning sets will also be supported with large scale seminar days on topics such as Quality Improvement and Leadership.

Improvements to Induction

- The aim of Corporate Induction is to introduce new starters to the Trust, providing information about its culture, values, policies, and essential information needed in daily work life. The impact of the information received is most effective if received in a timely manner, following starting with the Trust. The Induction and Mandatory Training Policy states that staff should attend Induction within two weeks of joining the Trust. In order to improve the relevance and usefulness of the content, and achieve the two week target, the training team have revised the programme so:
  - attendees are awarded seven competencies, which alleviate the need to complete e-learning for those subjects;
  - new starters are compulsorily booked on induction, and all mandatory training programmes;
  - the acquisition of the Linden Centre has enabled two Corporate Inductions per month, and further revision of programme will take place to improve the content.

Student Conference 2019

I have just done my TASI training. I am very impressed by the manner and way this training was provided. These gentlemen have been absolutely amazing, funny, professional and the wealth of experience they provided is beyond valuable. I have been with the Trust for a while and have often dreaded this five day course but they made every minute and second of it worthwhile for me and I know I cannot speak for others but they made sure that everyone gave all they could and I could feel this every single day of the training. They managed to make me see and evaluate my practice in a totally different way and as a registered professional not only have they provided me with the techniques to use but also a totally different way of thinking and engaging with my colleagues, patients and other staff.

Their conduct, passion, effort and professionalism should be a recognised standard of practice and it would be a travesty if this isn't recognised.

3.2 Overview of the quality of care offered in 2018/19 against selected indicators

As well as progress with implementing the quality priorities identified in our Quality Account last year, the Trust is required to provide an overview of the quality of care provided during 2018/19 based on performance against selected quality indicators. The Trust has selected the following indicators because they have been regularly monitored by the organisation. There is some degree of consistency of implementation across our range of services. They cover a range of different services and there is a balance between good and under-performance.

Patient Experience

3.2.1 Complaints

Data source: Datix
National Definition applied: only to K041-A submissions to the Department of Health

Complaints referred to the Parliamentary & Health Service Ombudsman

During 2018/19 a total of nine complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO). Of these nine referrals, the PHSO decided not to investigate in four cases. The remaining five referrals are ongoing. During this year two cases, one received in 2016 and one in 2017 were concluded. The first was partially upheld, the Trust and Council were asked to review their procedures for carers' assessments and each organisation was asked to pay £750 for the impact the failings had had on the complainant. The complainant disagreed with the amount and was given a deadline by the PHSO to accept payment. This was not met and no payment was made. The second referral was upheld and the Trust was asked to pay £3,520 for avoidable distress and part payment of legal fees. There were several recommendations made to the Trust, an action plan has been completed and implemented to address these.

Complaints closed within timescales

The 'Percentage of Complaints Resolved within agreed timescales' indicator is a measure of how well the complaints-handling process is operating. The agreement of a timescale for the resolution of a complaint is identified in the NHS Complaints Regulations, but these do not stipulate a % target to be achieved. The Trust believes that commitments to complainants should be adhered to and aims for 100% resolution of all complaints within the agreed timescale with the complainant. This year the Trust has achieved 88.10% for complaints closed within agreed timescale.

Non-Executive Director Reviews

An important part of the complaints process is the independent reviews of closed complaints by the Non-Executive Directors (NEDs). The complaints are selected at random each month. The reviewer will take into consideration the content and presentation of the response, whether they feel the Trust has done all it can to resolve the complaint and if they think anything else could have been done to achieve an appropriate outcome. During 2018/19, the NEDs reviewed 54 complaint responses. The majority received a good or very good rating for how the investigation was handled and the quality of the response.

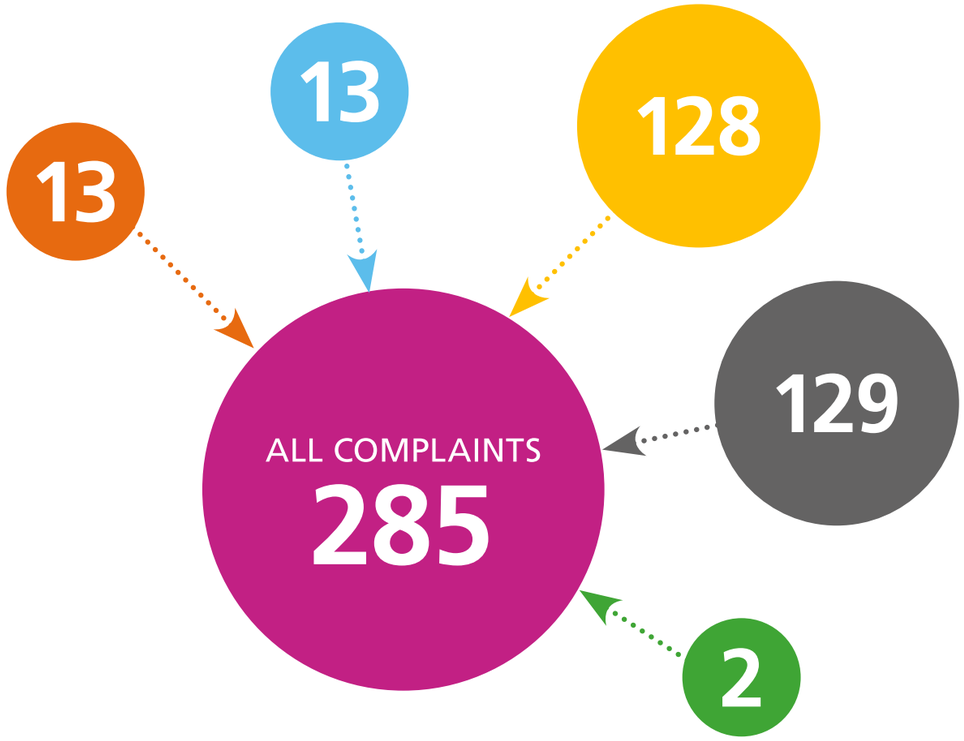
Number of formal complaints received:

Performance Indicator	2018/19
Number of formal complaints received	**285**
Comprising:	
Total received Mental Health Services	259
Total received Community Health Services	26
Number of complaints withdrawn	**12**

*Please note: The figures stated in this section of the report (and those reported in the Trust's Annual Complaints Report) do not correspond with the figures submitted by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Account and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within the period*

Patient Experience

Complaints Received by Locality



KEY:	
	EPUT TOTAL
	West Essex Community Health
	South East Essex Community Health
	South Essex Mental Health
	North Essex Mental Health
	Bedfordshire and Luton Forensic Mental Health

Patient Experience

Number of active complaints at year-end:

At year end, the number of active complaints was 55. All active complaints are on target to be responded to within their agreed timescale..

Number of complaints upheld / partially upheld:

A total of 300 complaints were closed during the year.

Performance Indicator	2018/19
Number of complaints upheld	24
Number of complaints partially upheld	201
Number of complaints not upheld	61
Totals	**286**

A total of 12 complaints were subsequently withdrawn by the complainant, one was not investigated due to consent being withheld and one was handled under Trust policy.

Patient Advice and Liaison Service queries and locally resolved concerns:

In addition, the Trust received a total of 956 Patient Advice and Liaison Service queries and 347 locally resolved concerns in 2018/19.

Nature of complaints received:

The top three themes for complaints for both mental health and community during 2018/2019 were dissatisfaction with treatment, staff attitude and communication. The top three themes for the Trust also apply nationally across the spectrum of health services. The table below shows the outcomes of the closed complaints for each of these three themes:

Top Three Complaint Themes 2018/19	Total Number of Complaints Received	Upheld	Partially Upheld	Total Upheld or Partially Upheld
Unhappy with treatment	42	2	28	30
Staff Attitude	53	6	34	40
Communication	39	5	29	34

The category 'unhappy with treatment' covers a wide spectrum. In some cases, complainants had certain expectations; however, this was contrary to their clinical need. The Trust was, therefore, limited in providing solutions to these complaints.

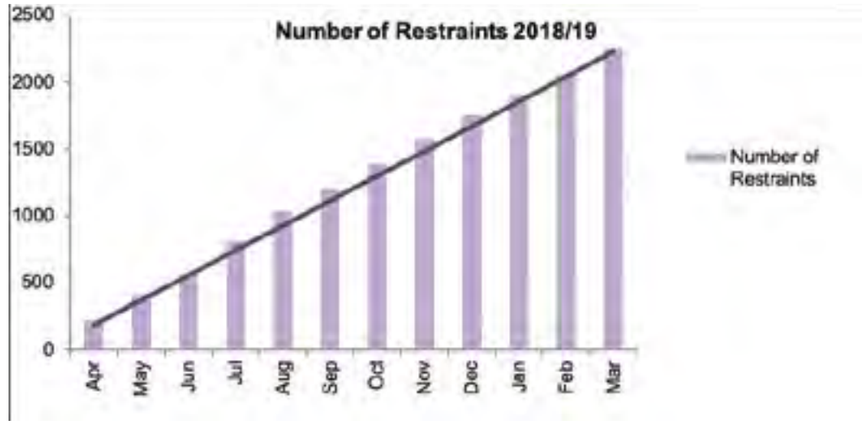
Patient Safety

3.2.2 Restraints

Restraints

EPUT monitors the use of restraints by inpatient ward on a monthly basis, including the reason for restraint and the type of restraint. The main reasons for restraint are self-harm, physical assault and anti-social behaviour. The most common types of restraint are patient standing and in a supine position. The use of prone position restraints are monitored in greater detail.

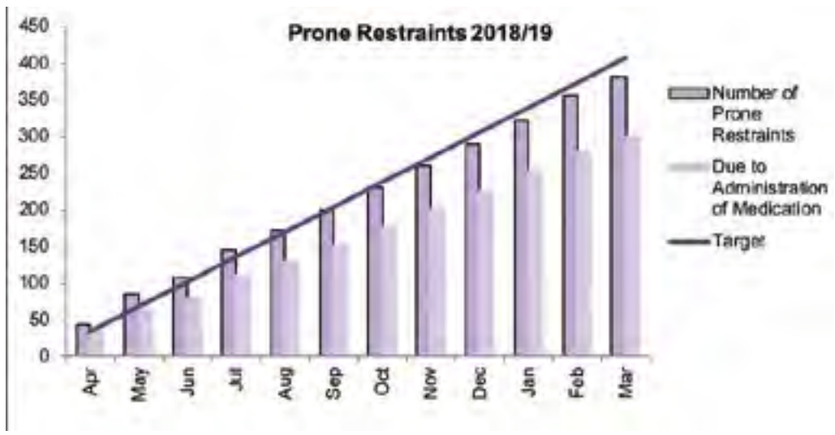
The total number of restraints in 2018/19 was 2251 this is a small increase compared to 2017/18 (2225). EPUT is also pleased to report that the rate of restraints per bed is lower than the national average but we did not achieve our internal stretch target of a 10% reduction.



Prone Restraints

The graph below shows the number of prone restraints undertaken by month and demonstrates that the majority of prone restraints take place to facilitate the administration of intra-muscular medication.

A reduction in the number of prone restraints is part of the Trust's Quality Priorities and is described in more detail in section 2.2.



3.2.3 Patient Environment

The Patient Led Assessment of the Care Environment (PLACE) Teams carried out assessments on the patient environment on 21sites from February – June 2018. No external validators accompanied the teams this year.

The Trust Board of Directors has ultimate responsibility for ensuring health services are provided within clean, safe and fit for purpose environments appropriate for health care.

EPUT achieved above the national average in four out of six categories. For Cleanliness we were +1.09%; for Facilities 1.46%; Dementia 0.12% and Disability 1.63%.

Although there are some areas of improvement and investment identified, overall the results must be considered as an improvement on the previous year.

	EPUT	England average (MH and LD trusts)	England average (All MH trusts)
Cleanliness	99.73%	98.64%	98.59%
Privacy, dignity and well being	89.18%	90.42%	90.08%
Food	90.03%	91.04%	91.29%
Facilities	96.70%	95.24%	95.26%
Dementia	87.46%	87.34%	87.20%
Disability	90.42%	88.49%	88.31%

3.2.4 Safer Staffing

The Trust monitors the actual levels of staffing compared to the established levels on a shift by shift basis across all its inpatient wards. The Trust has been above target all year. Twice daily sit rep calls are undertaken with all wards to review current staffing levels and risks.

3.2.5 Serious Incidents

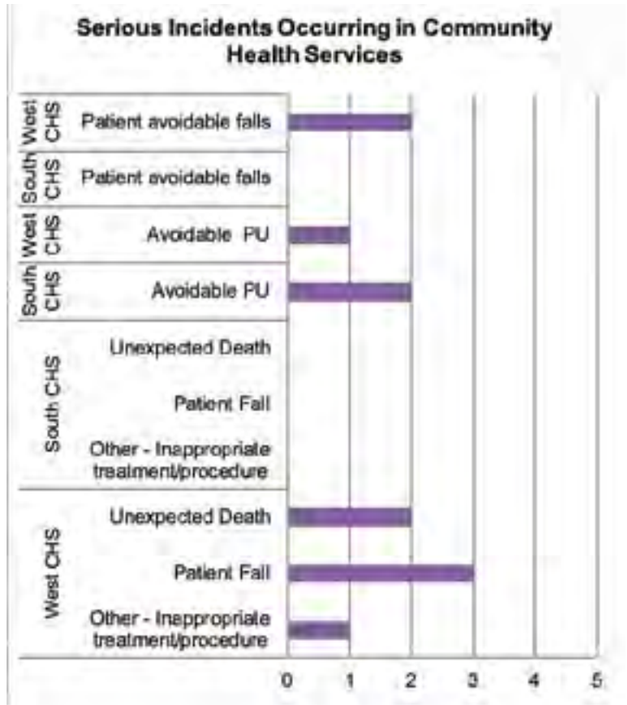
Data source: Datix
National Definition applied: EoE and Midland's definition applied

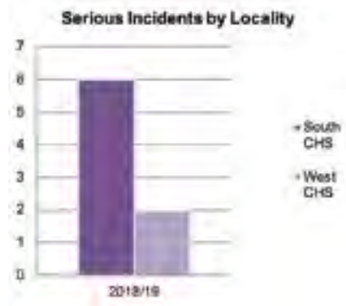
Monitoring of the number and nature of serious incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety systems.

The Trust reported six serious incidents in Community Health Services in 2018/19 compared to three during 2017/18 (excluding pressure ulcers).

Three of these incidents were falls leading to fractures. This is a slight increase compared to two last year. One of these incidents resulted in serious harm requiring surgical intervention. This is an increase compared to zero last year. Two of these incidents were unexpected deaths. This is an increase compared to one last year.

There were three avoidable pressure ulcers reported in 2018/19 and two avoidable patient falls.





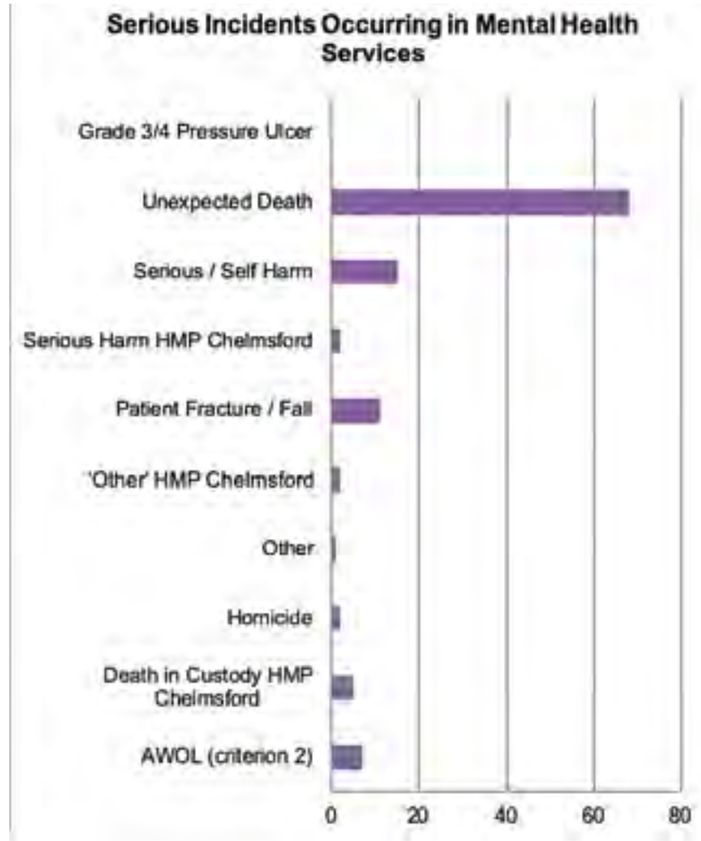
3.2.6 Serious Incidents

Data source: Datix
National Definition applied: EoE and Midland's definition applied

Monitoring of the number and nature of serious incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety. The Trust reported 113 serious incidents (SIs) in Mental Health Services in 2018/19 this is comparable to 112 reported in 2017/18.

The most common type of serious incident is an unexpected death. The Trust has unexpected death as a key priority for 2019/20. A commitment to suicide prevention training, implementing the Trust's suicide prevention strategy and learning from deaths are key to improvement. In addition to this, the Trust is strengthening their approach to family and care involvement and coproduction. Further details of suicide reduction can be found in the Quality Priorities section of this report.

The graph below shows that serious / self-harm and patient falls/fractures (occur mainly on older adult inpatient wards) are the two other most common form of serious incident.



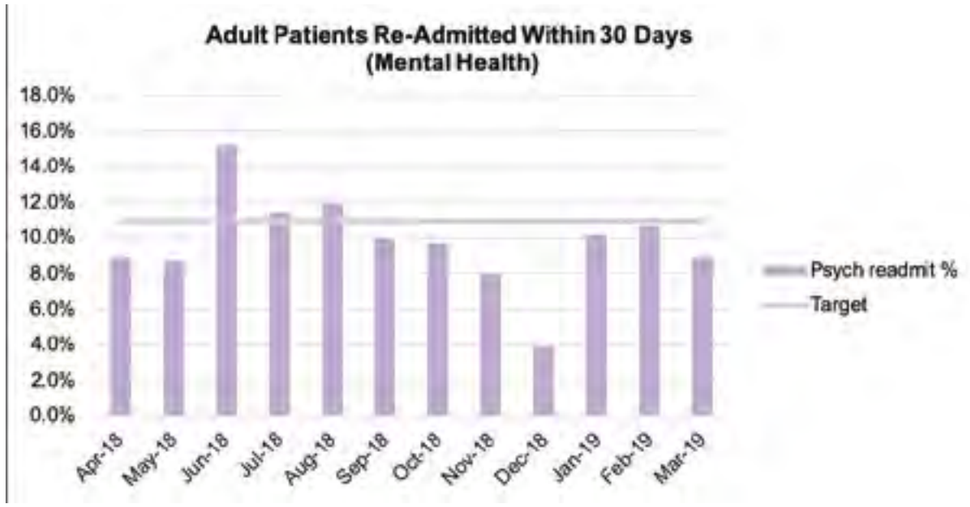
3.2.7 Readmissions

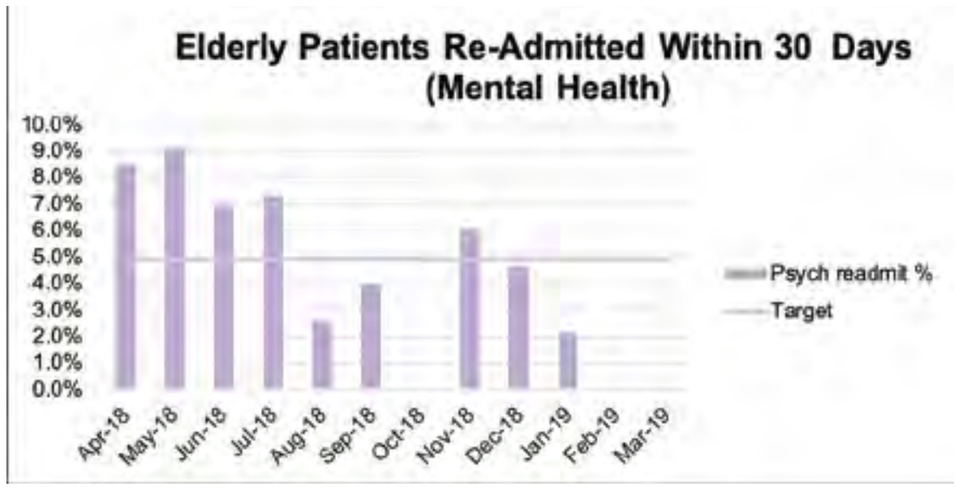
Data source: EPUT systems (IPM and Paris)
National Definition applied: Yes

The target % of Adults re-admitted within 30 days has been achieved for most months of the year with a slight spike in June 2018.

The target % of older people re-admitted within 30 days has not been achieved consistently during the course of 2018/19. Considerable improvement has been made since August 2018 ending the year with no re-admissions for February or March 2019.

In the graphs below, good performance is illustrated by levels of activity below the target line.

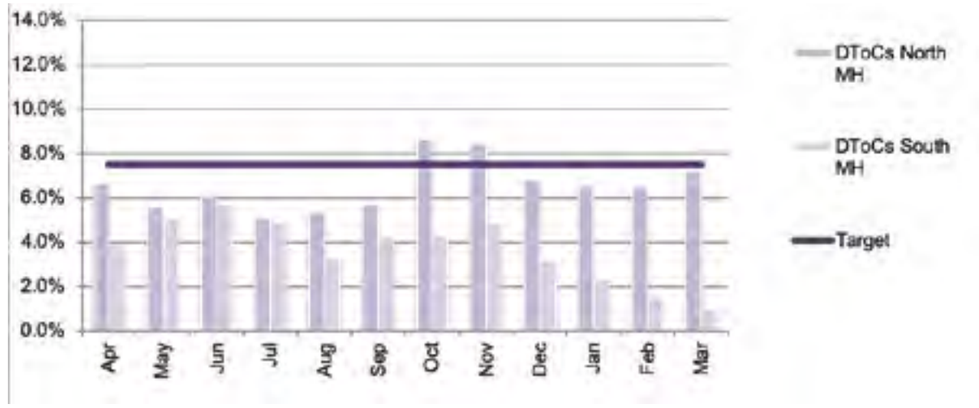




3.2.8 Delayed transfers of care

Data source: EPUT systems (IPM and Paris)
National Definition applied: Yes

Overall EPUT have been below benchmark across 2018/19. North MH Services were slightly above target in October and November.



Sheila Salmon and Sally Morris join the team for the official opening of the new Peter Bruff Mental Health Assessment Unit

3.3 Performance against key national priorities

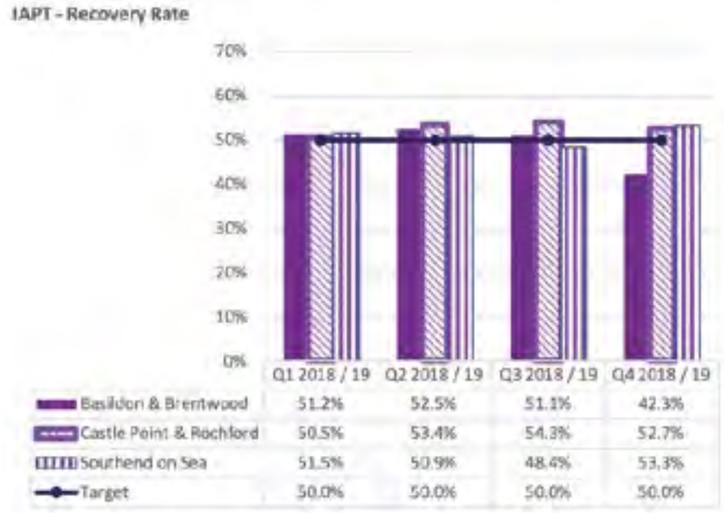
In this section we have provided an overview of performance in 2018/19 against key national targets relevant to EPUT's services contained in NHS Improvement's (NHSI) Single Oversight Framework in accordance with the national guidance issued by NHSI for Quality Reports. Data for two indicators, 'Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay' and 'Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team', have been reported in the mandatory indicator section (2.7) of this report.

3.3.1 Out of Area Placements

This indicator was introduced in the November 2017 update to NHS Improvement's Single Oversight Framework. The indicator measures the number of days that patients have spent in in-patient facilities out of area. This has been proactively addressed in 2018/19, and there has been a significant reduction seen compared to 2017/18.

3.3.2 Improving Access to Psychological Therapy Services – Recovery Rates

This indicator measures the percentage of patients discharged from IAPT services who have moved to recovery. The NHSI compliance threshold is 50%. IAPT services are commissioned from EPUT by three CCG's. Basildon and Brentwood fell below target in Q4. Q4 figures are local / provisional and will be updated with nationally published data when available.

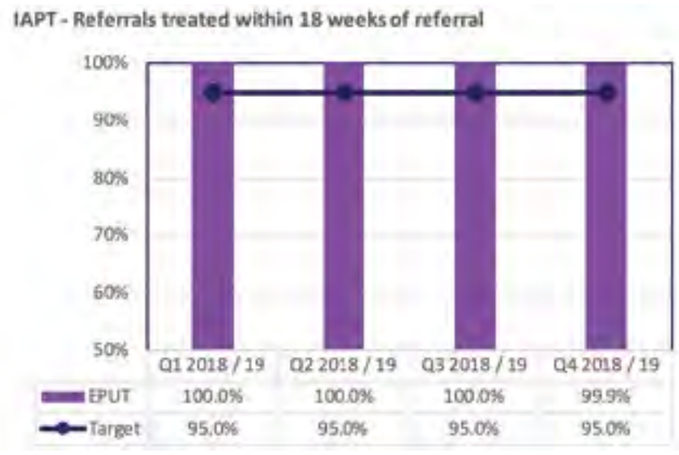


This indicator measures the percentage of referrals to IAPT services whose treatment commences within:

a) six weeks

b) 18 weeks

Compliance with both of these targets has been consistently achieved throughout 2018/19

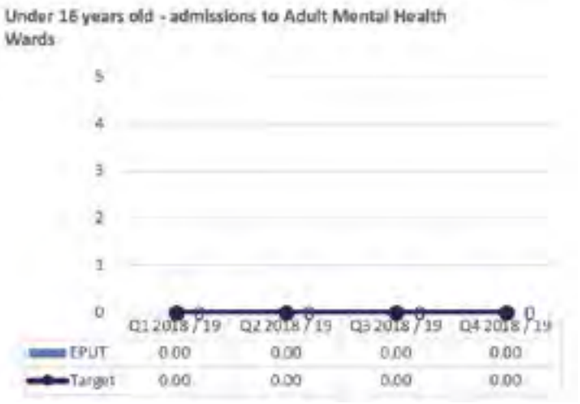


3.3.3 Early Intervention in Psychosis: Referrals treated within two weeks

This indicator measures the percentage of referrals for people with a first episode of psychosis treated within two weeks. Compliance with this target has been achieved consistently in 2018/19.

3.3.4 U16 Admissions to Adult Wards

This indicator measures the number of admissions of patients aged less than 16 years old to Adult Mental Health Wards. EPUT is pleased to report that no patients under 16 years old have been admitted to any of its Adult Wards



3.3.5 Cardio Metabolic Assessments

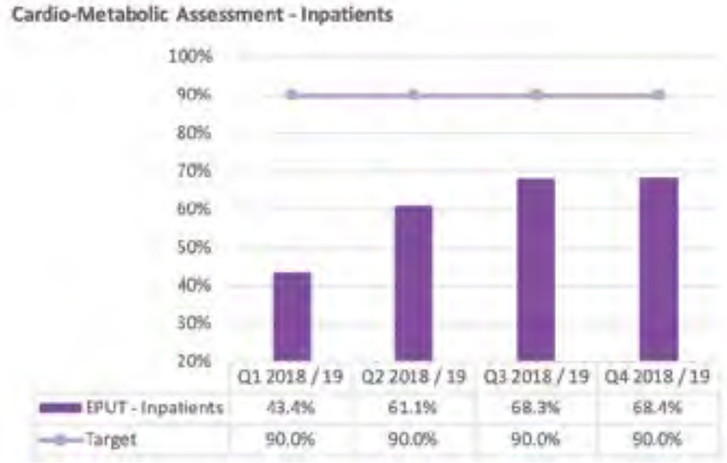
These indicators measure the percentage of adults with psychosis who have had a cardio-metabolic assessment, within three different settings

a) Inpatient wards

b) Early Intervention in Psychosis Service

c) Community services

The Service Improvement Team is currently working with relevant internal and external stakeholders to ensure that EPUT is working towards achieving the target levels of performance.



3.4 Listening to our patients and service users

We believe that receiving and acting on feedback from our service users is crucial to maintain the high quality standards we have set ourselves and work continues to increase the feedback received. This section of our Quality Account outlines some of the ways in which we capture feedback from people who use our services together with some examples of changes we have made and outcomes resulting from that feedback. Information in terms of the results of the Friends and Family Test (FFT) is included in Section 3.2 of this report (local quality indicators).

■ Patient Survey Feedback

The Trust has in place a unified patient survey. This draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. Surveys are sent to all patients who have recently been discharged, either from inpatient services or community caseloads as well as some patients who have chronic long term conditions to ensure they continue to receive a good service. Carers are also asked to complete the survey for those unable to fill it in themselves.

The Patient Experience Team provides services with regular reports which detail the results from the surveys for their teams. Managers review the content of these reports and discuss the feedback with their team or individual where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey.

Question	EPUT Scores 2018/19
To what extent did you feel you were listened to?	9.3
To what extent did you feel you understood what was said?	9.3
To what extent were staff kind and caring?	9.6
To what extent did you have confidence in staff?	9.4
To what extent were you treated with dignity and respect?	9.6
To what extent did you feel you were given enough information?	9.4
How happy were you with the timing of your appointments?	9.3
How would you rate the food?	7.3
To what extent would you say the ward/clinic was comfortable?	8.8
To what extent would you say the ward/clinic was clean?	9.3

A total of 5,451 responses were received to the Survey in 2018/19. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).
The lowest scoring area with an average of 7.3 was food. The Patient Experience Team attends open inpatient meetings in order to listen to concerns from service users. An item that does feature in some meetings is food. When this occurs the Team contacts the Facilities department to discuss any issues brought forward. This has led to menu changes in some areas. In addition, the Facilities Department undertakes their own surveys and audits in relation to food to try and improve the patient's/service user's experience.

Thank you event for the Trust Volunteers

As outlined in section 2.7 the Trust also participates in the National Community Mental Health Survey. The Community Mental Health Patient Survey 2018 was sent to patients who received treatment from the Trust in September to November 2017 to complete and return. Full details of the responses can be located in section 2.7.

■ Other Key Patient Experience Engagement Activities

Your Voice:
The aim of these events is to give service users, carers, members of the Trust and Governors as well as the public a chance to speak directly to the Chief Executive about the services provided by EPUT. They are held across all localities and include different presentations from teams relevant to the locality. The events also provide an opportunity to update everyone on the Trust's planning process. Feedback from these events is generally positive although attendance does vary considerably from locality to locality.

Stakeholder Forums:
The purpose of these forums is to provide the opportunity for service users, carers and staff to discuss services in their area and share feedback with the Trust. Forums are chaired by a locality lead for the Trust who is supported by operational staff. In 2018/19 the Trust extended these forums to mid and west Essex. The forums have been well received by members of the public and attendance continues to grow. Some smaller forums were also held more as discussion groups, which included patients, carers and local voluntary organisations.

Service User Reference Group:
One of the Trust's strategic objectives is to involve service users and carers more to play a meaningful role not only in current services but also the future of Trust services. The service user and carer reference group set up to discuss the merger and engage on the mental health transformation work remains in place with the group receiving updates on developments from the leads. Many of the attendees continue to attend smaller working groups looking at specific service areas of the transformation. The Stakeholder Reference Group offers the opportunity for attendees to feedback to others on the discussion topics in the smaller working groups.

Training:
The Trust continues to involve both carers and service users at induction when they are invited to present with a member of the Patient Experience Team to share their lived experiences. This session is positively received by both attendees and volunteers. In addition, service users give talks at the mental health first aid training, service users and carers take part in some clinical staff interview panels. Service users also share their lived experiences with EPUT Health and Social Care Apprentices in the form of a workshop.

Co-production:
The Patient Experience Team is responsible for driving the Trust's work to support co-produced projects. One example is the creation of the Health and Social Care Apprentices Workshop which was co-produced with service users.

Open Inpatient Meetings:
As noted Open Inpatient Meetings are in place in a number of our inpatient wards. These meetings allow managers the opportunity to gather feedback from patients and service users to improve services. Good practice is also recorded in order that it can be cascaded as learning throughout the Trust. As much as possible we encourage patients/service users to lead the meetings.

Buddy Scheme:
The scheme seeks to empower both service users and our future healthcare workers by increasing understanding of mental health through true partnership-based work and education. It gives mental health nursing students an opportunity to engage with an identified service user who acts as a 'Buddy' in a series of structured meetings and provides an opportunity to learn from carers, gaining insight into their experience. The scheme encourages students to enquire with sensitivity and respect about service user and carer experiences of living with mental illness within the context of family, work and the wider community. The Buddy Scheme was expanded to include allied health professional students in 2018.

Outpatient Surveying:
These are conducted in order to increase FFT returns by service users who attend community based outpatient clinics and appointments. A member of the Patient Experience Team together with a volunteer, where appropriate, will proactively hand out FFT surveys for service users to complete on arrival or leaving the outpatient centres. The presence of a volunteer assists this as they can often engage with service users who may not wish to engage with someone from the Trust and are more comfortable talking to a person with lived experience.

Examples of actions we have taken/outcomes from service user feedback we have received

The table below details some examples of the 'You Said, We Did' feedback gathered by the services. These are actions we have taken / outcomes that have been achieved as a result of listening to feedback from our patients, service users and carers over the past year. The Patient Experience Team collects this information on a bi-monthly basis.

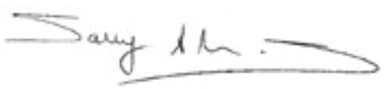
You Said	We Did
You requested that you had access to hot drinks all day not just at set times	We abolished the tea and coffee schedule and ensure that there is fresh hot water available to make drinks whenever you would like one
Patients felt the general environment was not very welcoming, cold or hot when in review appointments	In response we have redecorated, carpeted, supplied plants and have more visible information available. We are monitoring the centre temperature to ensure service user comfort
The Ladies Lounge could be more homely	We installed a television, painted the walls, took out the large tables and put in soft furnishings
We would like the garden to be tidier	An application for a volunteer gardener has been submitted to the Trust. As the weather improves garden projects will be offered as part of the OT programme
Refreshments in family room would be nice	Cold drinks and squash available in family room

CLOSING STATEMENT FROM SALLY MORRIS, CHIEF EXECUTIVE

I am proud to present our second Quality Account as EPUT. I am grateful to you for taking the time to read this report, and I hope it has been presented in a clear and useful way for you. I hope to be able to meet some of you at the Trust's open meetings in the forthcoming year and take forward any improvement suggestions you may have into next year's report.

In the meantime, if you have any questions or comments about this Quality Account please contact:

Faye Swanson
Director of Compliance and Assurance
Email: **faye.swanson@nhs.net**
Post: Essex Partnership University NHS Foundation Trust
The Lodge, Lodge Approach
Runwell, Wickford
Essex SS11 7XX



Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
23 May 2019

ANNEXE 1 – Comments on the Quality Account

We sent the EPUT Quality Account to various external partners to seek their views on the content of the report. The responses received are outlined below for information – we thank them for taking the time to consider the information and for providing their comments.

EPUT Council of Governors' Statement on the Quality Account 2018/19

We have been invited to review the draft Quality Report/Account for 2018/19. This has been undertaken by the Lead Governor co-ordinating thoughts and ideas from colleagues. This provides Governors with an opportunity to assure members of our Trust, via the Annual Report to Members that quality is at the heart of what EPUT does and will not be compromised. We have to ensure that the priorities which were set for 2018/19 have been met and are continuing to be taken forward.

The Board has identified patient safety, clinical effectiveness and patient experience as its priorities. The Governors take the view that without the highest level of patient safety, clinical effectiveness and patient experience these are not achievable. We have looked at what evidence there is to support the premise that patient safety is improving.

There are many measures for this and in general the Trust has shown that there have been significant improvements in most areas.

Omitted doses are down and the target set has been achieved. Avoidable pressure ulcers are also down with a significant reduction.

While overall falls are also down (by more than the 15% target set), avoidable falls are up slightly. We realise that this increase is probably not statistically significant but will be watching during this coming year that the downward trend is resumed.

We note that the number of prone restraints is now falling slightly by 6% (382 in 2018/19 from 407 in 2017/18). This is in line with national guidance and the 2015 Mental Health Act Code of Practice but, as was noted in our Statement last year, this still has some way to go to achieve the 'zero' target set by the Board. We note that most prone restraints are due to administration of medication. We raised the question last year as to whether there is a better way to persuade those who need this medication to take it voluntarily. We are hoping for more positive action in this area as probably the most likely route to reduce the prone restraint figures by a more significant amount.

The reduction in out of area placements continues, and we congratulate staff for achieving this. It has shown a significant improvement during the year and is recognised as being a major factor in a patient's recovery journey as well as reducing the cost to the Trust.

The Governors hold the view that the Trust Board engages in the processes relating to quality in the Trust, and treats quality as a top priority. We have attended the Trust stakeholder events, alongside service users and their carers, members of staff and senior staff from Local Authorities and Clinical Commissioning Groups, when time was spent considering the priorities for the coming year.

We also note that the Care Quality Commission undertook a full inspection following the first year of the new Trust's existence and congratulate the staff on achieving a remarkable score of 'Good' overall. This very helpful inspection provides an independent overview that the Trust continues to provide services of high quality.

We appreciate the good working relationship which exists between the Board (both Executive and Non-Executive Directors) and the Council and the regular attendance and input which we have received from Directors, whose standard of reports continues to be generally very high. We are also pleased that the Chief Executive, Sally Morris, uses the occasion of each of the Council meetings to address the Governors on an issue of interest. Her close involvement with the Council is much appreciated.

We have been pleased to continue, on your behalf, to undertake Quality Visits to a wide range of Trust facilities. These have enabled us to talk to staff as well as patients and to listen to any concerns there may be about quality. We can report that when these have been raised they have been immediately addressed.

A basic tenet for any NHS Foundation Trust is that a service user's physical condition should not be worsened by being in its care. We can give an assurance that the Quality Account is an honest commentary on the last year which shows a Trust which continues to be high performing, and the Board of EPUT have agreed a set of priorities which will continue to support the essential requirement that safety and quality comes first.

John Jones
Lead Governor
May 2019

EPUT Quality Account 2018/19

The draft Quality Account has been shared with the Chair, Councillors and co-opted members of the People Scrutiny Committee at Southend-on-Sea Borough Council, which is the health scrutiny committee. No comments were received. This should in no way be taken as a negative response.

Officers from the Trust attended the Scrutiny Committee meeting in October 2018 and Councillors scrutinised the issues concerning the relocation of the intermediate care beds to facilitate the St Luke's Primary Care Centre development and the recommendations relating to adult mental health beds. The Committee did not reach a specific conclusion and a number of concerns were raised which were addressed in the report considered at the Full Council meeting on 18th October 2018. At that meeting the Council resolved to support:-

(a) the creation of an additional 15-20 adult inpatient beds, to reduce the need for Southend residents having to be placed out of area;

(b) the request from Southend Clinical Commissioning Group (SCCG) and Essex Partnership University NHS Foundation Trust (EPUT) to defer consultation due to patient and staff safety issues, until the point of determining permanent moves;

(c) the establishment of a clinical group with the appropriate staff side representation to review and lead changes to enhance inpatient and community treatment, care and support going forward. This will include reviewing the options to bringing the Older People Organic Assessment beds back into South East Essex, with recommendations being completed by August 2019.

The Scrutiny Committee looks forward to the continued discussions with the Trust on this matter and will scrutinise the options and recommendations at the appropriate juncture.

Fiona Abbott
Principal Democratic Services Officer, Health Scrutiny Lead Officer & Statutory Scrutiny Officer
Legal & Democratic Services, Southend-on-Sea Borough Council

NHS
Southend
Clinical Commissioning Group

NHS Southend CCG
Southend-on Sea Borough Council
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Tel: 01702 215050
Email: southend.ccg@nhs.net
www.southendccg.nhs.uk

17th May 2019

For the Attention of Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
Via email: sally.morris4@nhs.net

Dear Sally

NHS Southend Clinical Commissioning Group welcome the opportunity to make comment on the annual Quality Account 2018/2019 prepared by Essex Partnership University Trust.

The CCG is pleased to see the Trust's commitment to an open and honest dialogue with the public regarding the quality of care delivered.

NHS Southend CCG note the following:

Quality Priorities
The CCG supports the five Quality Priorities for 2018/19, and that they were developed in line with the national quality goals and support the approach that as a learning organisation how you took into account the issues directly affecting the organisation.

The CCG were pleased to see that the 2018/2019 quality priorities were achieved. The areas relating to EPUT Community Health Services were discussed at the Quality Performance and Quality Meetings held between the CCG and Trust. The CCG where assured of the progress made.

The CCG also noted the improvements made within reducing the number of falls and avoidable pressure ulcers and can confirm that for this reporting period only one serious incident relating to pressure ulcers was reported during this period. The CCG was pleased to see the improvement made within management of falls which has resulted in reduction of incidents reported externally to the CCG.

The on-going work in developing Trust Quality Academy by progressing established Quality Champions up to Gold Level is recognised by the CCG as a good innovation and wish to commend the Trust on this development.

The on-going work the Trust has undertaken in management of complaints and incident including working to ensure significant learning from the statutory mortality review process is

embedded back into the organisation and using this to improve services across the Trust was seen as a good achievement and welcome progression for the coming year.

Care Quality Commission
The Trust first CQC comprehensive inspection took place, unannounced, and reported in July 2018. The CCG was pleased to see that the Trust was rated as 'Good' overall, with community health services and mental health services also achieving overall ratings of 'Good'.
The CCG supports the forward view the Trust has identified in terms of the aim to work towards being rated as 'Outstanding' five years after the merger.

Rawreth Court and Clifton Lodge
The CCG noted that Rawreth Court and Clifton Lodge had their first inspections under the CQC's care home regime in 2018/19. Whilst the overall ratings for both sites were 'Requires Improvement' the CCG also supports the Trust view that this is far from the outcome wanted, and were also reassured that both services were rated as 'Good' in regards to caring.
The CCG are looking forward to working with the Trust during 2019/2010 to support further quality improvement within these facilities following the hand over from a commissioning perspective on April 1st 2019 from NHS Thurrock CCG (who were the incumbent Commissioning Lead for this service) to NHS Southend CCG.

End of Life
The CCG was pleased to see the work implemented regarding end of life care following the findings of the CQC report July 2018. The Trust is committed to the provision of the very highest quality of care for people with advanced life threatening illnesses. The actions highlighted which include:

- 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
- Work with systems and partners to create best approaches with regard to advanced care planning and individualised care plans
- Convene an End of Life Forum for clinical staff
- Expand the number of End of Life Care Champions

The CCG acknowledges this is a large piece of work and welcomes seeing further improvement in this area once the above initiatives are embedded.

The CCG are able to confirm that throughout 2018-2019 the Trust continued development of integrated working has supported patients, family, carers and staff through:

- Increased understanding of both health and social care roles and taking opportunities to implement joint roles where this is delivers benefits.
- Joined up working across the collective occupational therapy workforce
- Collaborative approach to supporting our care home and domiciliary care providers to ensure that adults are able to remain in their own home environment wherever possible
- Joint decision making to deliver person centred care, engaging with patients, family and carers to ensure the needs of the patents are achieved
- Reduction in risk adverse practice which increases length of stay with safe discharge
- Supporting difficult conversations with patients, family and cares regarding ongoing care and support

The CCG supports that the Trust has reviewed the Integrated Single Point of Access but acknowledges that further work is needed to ensure that this service interfaces further with all services provided within the locality as more services become on line.

In regards to respiratory services the CCG welcomes the work taking place but recognises some of the challenges in sustaining this service. The CCG looks forward to reviewing the service in partnership as part of the integrated work stream.

Paediatric Speech and Language Therapist.
The CCG recognises the development work that is in place to further meet the needs of individuals within the geographical patch. Further work is needed to understand the potential gaps within this service and how this potentially affecting the patient. The CCG is committed to supporting improvement.

Community Nursing Services and Integrated Care
The CCG was pleased to see the training put in place to develop Health Care Assistants (Band 3) to deliver care to a Band 4 competency level, which has resulted in the workforce feeling, valued and also supported the District Nursing workload.

The support provided to GP practices and partners to promote a healthy walks programme in West Southend locality was also noted.

The CCG recognises the workforce challenges faced within Community and Integrated Care Services. It also supports the identified challenges highlighted within the account since the removal of national nurse training bursaries which have been highlighted as having some impact on workforce within some of the community nursing teams.

The CCG noted on reviewing the document that the following areas were not included within this year's accounts and would welcome consideration of these areas of work in the near future.

- The further development of the directory of services
- Further work on the activity data that evident the quality elements of the services provided.
- The positive and effective transition of its CICC services into their new premises which was felt to improve the quality outcomes and experience of the patient
- There was very little discussed in terms of the Trust work stream within safeguarding children and Adults. It would be helpful to understand the developments taking place in terms of the vulnerable groups.
- Infection control has some mention in the accounts but would welcome some further insight into the interventions and associated incidents.

In conclusion NHS Southend CCG has reviewed and endorses Essex Partnership University Trust Quality Account for 2018/19 as providing an accurate and balanced picture of the reporting period.

Yours sincerely

Dr Jose Garcia-Lobera
Chair

Tricia D'Orsi
Chief Nurse

NHS
Castle Point and Rochford
Clinical Commissioning Group

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17th May 2019

For the Attention of Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
Via email: sally.morris4@nhs.net

Dear Sally

NHS Castle Point and Rochford Clinical Commissioning Group welcome the opportunity to make comment on the annual Quality Account 2018/2019 prepared by Essex Partnership University Trust.

The CCG is pleased to see the Trust's commitment to an open and honest dialogue with the public regarding the quality of care delivered.

NHS Castle Point and Rochford CCG note the following:

Quality Priorities
The CCG supports the five Quality Priorities for 2018/19, and that they were developed in line with the national quality goals and support the approach that as a learning organisation how you took into account the issues directly affecting the organisation.

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The on-going work in developing Trust Quality Academy by progressing established Quality Champions up to Gold Level is recognised by the CCG as a good innovation and wish to commend the Trust on this development.

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- Infection control has some mention in the accounts but would welcome some furthe insight into the interventions and associated incidents.

In conclusion NHS Castle Point Rochford CCG has reviewed and endorses Essex Partnership University Trust Quality Account for 2018/19 as providing an accurate and balanced picture of the reporting period.

Yours sincerely

Dr Sunil Gupta
Chair

Tricia D'Orsi
Chief Nurse

NHS
North East Essex
Clinical Commissioning Group

Response to the Quality Account for Essex Partnership University NHS Foundation Trust 2018-2019

North East Essex Clinical Commissioning Group (NEECCG) welcomes this Quality Account as a commitment to an open and honest dialogue with the public regarding the quality of care provided by Essex Partnership University NHS Foundation Trust for 2018-2019 and its quality improvement plans for the forthcoming year.

NEECCG is commenting on this Quality Account by virtue of its role as commissioner for mental health services for North East Essex. Assurance from the CCG is required to ensure that the information in this Quality Account is accurate, fairly interpreted and representative of the range of services delivered.

Though the CCG is commenting on a final draft version of the Quality Account, we are pleased to be able to assure accuracy of the content of the report in general. We have fed back our comments on accuracy on the draft report and anticipate that these changes will be made to the final published version.

The Trust's remit has predominantly been the provision of both hospital and community based mental health services; as well as learning disability; general community nursing; a community hospital in south Essex and services in Bedford and Suffolk. This heralded real opportunity to enhance and develop the implementation and sustainability of further quality improvements through the sharing of good practice and the alignment of quality standards for the benefit of patients.

It is pertinent you have used learning from previous years, including relevant feedback from staff and stakeholders to develop your key priorities for the forthcoming year relating to patient safety, clinical effectiveness and patient experience.

The introduction of 'National Guidance on Learning from Deaths' published in March 2017 saw new guidance relating to mortality review processes. In addition to good governance processes, underpinned by a new policy; to maximise opportunities for learning and improve services you have continued to strengthen local approaches in line with the mortality review guidance into 18/19.

You have participated in 14 national clinical audits and 1 national confidential enquiry. Data collections for NACR and NACAP commenced in March 2019 and POMH UK Topic 7f. We note that 8 national clinical audit reports have been reviewed with actions identified. In addition, 25 local audits were completed and identified some intended actions to improve quality of care to service users.

Your support for research has led to you joining the Clinical Research Network-North Thames and 924 people enrolled in 33 research studies, including the National Confidentiality inquiry into Suicide and Homicide and Sudden Unexplained death, by people with Mental Illness.

It is pleasing to note the level of success you have achieved with the commissioning for quality and innovation schemes (CQUINs). You have worked collaboratively with a variety of acute providers and the community Emotional Health and Well Being Service (EWMHS). This collaboration has led to the implementation of processes to improve patient experience and reduce attendances at Accident and Emergency Departments.

You received a number of unannounced visits by the Care Quality Commission which reviewed specific services. The inspection reports have been largely rated good, although they did identify some concerns relating to safe care and treatment, which remains 'requires improvement' and actions are ongoing.

The Trust narrowly missed the core quality indicator standard required by the regulatory framework for exceeding the 95% threshold for 7 day follow up of discharged patients with a dip in Quarter 3 to 92.3%. Local data suggest a recovery to 96.1% in Quarter 4 however to be confirmed once the national data is received. The 95% standard was exceeded however, for gate keeping of patients requiring admission by access and assessment teams.

It is particularly pleasing to see strengthened duty of candour responsibilities include mandatory Duty of Candour on-line training for all staff; improved governance processes; and the appointment of a Family Liaison Officer/Duty of Candour Lead.

The conclusion of the NHS North East Essex CCG is that Essex Partnership Trust's Quality Account 2018-19 provides a clear picture of your performance, improvements and future ambitions for improving quality and safety in your services. The CCG looks forward to working collaboratively with you as an integral partner in providing high quality healthcare services to the population of north Essex.

Lisa Llewelyn

Lisa Llewelyn
Director of Nursing and Clinical Quality
NHS North East Essex Clinical Commissioning Group.

NHS
West Essex
Clinical Commissioning Group

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for the commissioning of community and mental health services from Essex Partnership NHS Foundation Trust (EPUT) for the citizens of west Essex.

From October 2018 the mental health component of the contract (which had been managed by a different CCG on behalf of west Essex) returned to the direct administration of West Essex CCG.

EPUT provide services across Essex including community and mental health services. Where possible the information in the Quality Account has been divided by locality and type of care, this has helped us to identify elements of the account that are specific to west Essex patients.

The Quality Account for this year is a review of EPUTs performance in 2018/19. This is the second Quality Account of the merged organisation.

There is a significant section in the account explaining how the Trust is implementing and managing the National Guidance on Learning from Deaths. All the data which is now part of the requirement for quality accounts has been included. This section includes robust actions which EPUT are taking in relation to deaths "more likely than not to have been due to problems in care".

EPUT achieved the majority of sub elements within their quality priorities from last year. The elements which were partially complete at year end are either part of a 2 year plan or being maintained as a priority for 2019/20. We would like to congratulate the Trust on their work with bereaved families and their process for ensuring that co-production work with families and carers is carried out according to an agreed process.

In west Essex, EPUT have taken a key role in developing and delivering the Mental Health Liaison Service in the Emergency Department at The Princess Alexandra Hospital and have been instrumental in integrated care work for people with respiratory disease.

The Trust is working to embed quality improvement methodologies across the workforce. The inclusion of quality improvement as an essential element of induction for new staff demonstrates the Trusts clear commitment to the effective use of improvement science.

The CCG fully support EPUTs quality priorities for 2019/20, particularly their on-going commitment to reduction in harm and the suicide prevention strategy.

We are grateful that the Trust has included the governance arrangements for producing the quality account; this makes it clear to patients and families how this complex document has been created.

We confirm that we have reviewed the information contained within the Account and checked this against data sources where these are available; it is accurate in relation to the services provided.

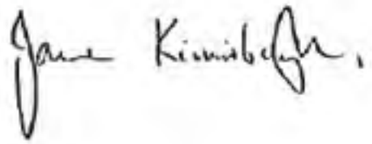
The explanation by the Trust of why certain data sets are as they are has been fully explained.

We have reviewed the content of the Account: it complies with the prescribed information as set out in legislation, by the Department of Health and additional requirements identified for this year's account

for example information on how staff can access a Freedom to Speak Out Guardian and the annual report on safe working of junior doctors.

Whilst the element of care that EPUT deliver for west Essex is only a proportion of their overall care provision, the account demonstrates clearly how care has been delivered by locality for both mental and community health. The account also shows how valuable local collaboration with EPUT continues to be for the west Essex system.

We believe that the Account is a fair, representative and balanced overview of the quality of care at the Trust.



Jane Kinniburgh
Director of Nursing and Quality
West Essex Clinical Commissioning Group.

May 2019

NHS
Thurrock
Clinical Commissioning Group

ESSEX PARTNERSHIP UNIVERSITY TRUST MID AND SOUTH ESSEX MENTAL HEALTH

CCG QUALITY ACCOUNT

MANDATED SUMMARY STATEMENT

Mid and South Essex Sustainability and Transformation Partnership Response

The Clinical Commissioning Groups contracting with Essex Partnership University Trust for the provision of Community and Inpatient Mental Health Services welcomed the opportunity to review and comment on the Quality Account for Essex Partnership University Trust 2018/19. Thurrock Clinical Commissioning Group co-ordinated the response on behalf of Mid and South Essex Sustainability and Transformation Partnership (STP) who aim to commission safe, effective and responsive services that provides a positive experience for patients and carers.

Thurrock Clinical Commissioning Group received contractual transfer in February 2018 and has established a robust contractual relationship and vigorous governance arrangements to monitor quality and drive service improvement through the Clinical Quality Review Group and the Mental Health Partnership Board. These structures provide valuable forums through which organisational check and challenge can be undertaken. The organisations have the ambition to work collaboratively and gain assurances that ultimately drive enhancements to the quality systems and processes and improve treatment and care delivery for our CCG populations.

The Quality Account summaries EPUT achievements against the 2018/19 Trust quality priorities and identifies the 2019/20 priorities. It is notable that Essex Partnership University Trust is a relatively new organisation following the merger of South Essex Partnership Trust and North Essex Partnership Trust in April 2017. The Clinical Commissioning Groups would endorse that the Quality Account has been prepared in accordance with National Legislation and requirements. Essex Partnership University Trust is required to include in their Quality Accounts the Trusts performance against National quality indicators. The Quality Account demonstrates this data has been included.

National Mandated Indicators of Quality (Mental Health Specific)

The National Mandated Indicators of Quality for 2018/19 are reported at a Trust wide level, which is wider than this STP contract.

The Trust achieved Q1 and Q2 performance for Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay. The performance dipped slightly in Q3 2.6% below the target of 95%. Commissioner note that local data for Q4 indicates the trajectory has returned to an above target position. In the key domain of `Admissions to Acute Wards gate kept by Crisis Resolution and Home Treatment Team` the Trust reported above average concordance for this indicator and achievement in all four quarters and would reflect reporting throughout the year.

Commissioners acknowledge the results of the Survey of People who use Community Mental Health Services and the profile of `about the same` average score in most sections (between highest and lowest reporter). In the one section that was worse than average Commissioners note that EPUT has developed and is in the process of implementing an action plan.
The National Indicator for Staff Friends and Family Survey reports that EPUT are above Q1 and Q2 position for all Mental Health Trusts in the % of `Staff who would recommend the Trust as a place to receive care`. In order to provide transparency it would be helpful to include the actual data on number of responses from staff and a graph reflecting the response % to question would `staff recommend as a place to work`.

QUALITY PRIORITIES 2018/19

The Trust reported that they have performed well against the majority of their 2018/19 quality priorities and demonstrated strong performance in reducing the omitted doses of medication from 827 in 2017/18 outturn to 375 in 2018/19 data outturn which may reduce the potential and actual harm for patients and improve treatment outcomes. EPUT have acknowledged in the report that their internal ambition to achieve a 10% reduction in restraints was not achieved. EPUT are engaged with a National work stream to continue work on this patient safety initiative. The STP recognises the Trust performance in the delivery of quality priorities for 2018/19 and the positive reported effect this has had on delivery of safe and effective services.

We share the Trust's reported view that there are some key areas of work that require action to ensure that service users experience the best possible care and treatment promptly and in the most appropriate setting and the STP will continue to monitor progress, contractually review and take any required assurance action in 2019/20 to sustain safe, effective and responsive service delivery for the future.

Of the five Quality Priorities set by the Trust for 2018/19 the reported status is five quality priorities rag rated green with a range of ambitions partially complete. The Clinical Effectiveness – record keeping risk assessment and care plan priority for 2018/19 overall achieved the target of 90% against the audit criteria. Some of the practice areas did not achieve 90%, but it is noted that all practice areas either maintained or improved on their Q1 performance.

The Quality Priority section for 2018/19 identifies the following harm free work streams:

- Pressure Ulcers
- Falls
- Restrictive Practice
- Medication Omissions
- Early Detection of Deteriorating Patient
- Unexpected Death

A baseline for the above safety indicators are set out in the report on page 11 but this summary does not include the data for unexpected deaths. In the section reporting Serious Incidents (page 72/73) the unexpected death bar on the graph represents circa 70 unexpected deaths. As a safety priority domain commissioners would expect this data to be included in the report to qualify reporting against the 10% reduction set by EPUT for all work streams.

EPUT have included unexpected deaths as a key priority for 2019/20 and we support this commitment. Key to this work stream will be EPUT implementing the Suicide Reduction Plan on page 8. This reflects the Trust commitment to engage from Board to floor and with wider stakeholders in forging ahead with this crucial area of work. The Connecting With People evidenced-informed social intervention training programme underpinned by social capital theory is in the process of being rolled out in the Trust and it is positive to note that 452 staff have completed this training that is linked to suicide reduction.

Commissioners are cognisant of the progress that EPUT have achieved with embedding the Mortality Review process and adopting and adapting the Royal College of Psychiatrist Structured Review tool and methodology as best available evidence to support practice and decision making. The thematic reviews of deaths undertaken in 2017/18 demonstrate the Trusts engagement in learning from Deaths Culture and practice methodology.

The Clinical Commissioning Group would like to congratulate the Trust on the overall outcome of the comprehensive Care Quality Commission (CQC) inspection in April / May 2018. As a newly merged organisation the achievement of "Good" overall evidences a significant achievement by the Trust. We are satisfied that action plans were developed in response to the CQC inspection recommendations and that the Trust has continued work in year to raise the quality standards in the identified areas. Furthermore, the amalgamation of the CQC recommendations into developing the 19/20 quality priorities is warmly welcomed by commissioners.

The STP would like to commend the Trust on the results for the DQMI that achieved a Data Maturity Index score of 98.9% for Q1 and 98.8% for Q2 and evidences an excellent standard against the NHSI Single Oversight Framework target of 95%.

The STP have worked with Providers to implement a range of the Local Service Quality Improvements and Workforce Developments detailed in the Quality Account and view this section of the report as a reflection of the progress of EPUT as a relatively newly formed organisation of a journey of continuous quality improvement.

CQUIN

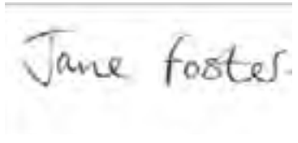
All South Essex Mental Health CQUINs were part of the contractual relationship for a minimum of the 2 year National CQUIN programme. The CQUINs were incentivised to provide system wide engagement and transformation. EPUT have worked with commissioners and other providers to undertake the ambitious transformations and build coalitions with key partners to deliver the Sustainability and Transformation Plans that are woven through the CQUIN programme. The CQUIN programme in 2018/19 did not attain the totality of the milestones. In order to achieve the full CQUIN programme in 2019/20 the pace of change, implementation and alliance building will need to be consistent and focused over the life of the delivery of the CQUIN schemes.

Essex Partnership University Trust continues to demonstrate a high level of commitment to improving patient and carer experiences of the organisation. It is positive to note a number of reported mechanisms for receiving real time feedback that have been established.

CONCLUSION

The Commissioners are aware that Essex Partnership University Trust have developed their Quality Priorities for 2019/20 in response to the National quality goals, which are based on patient safety, service user and carer experience and clinical effectiveness and triangulated this with the organisational themes arising from Serious Incidents and Complaints and areas identified for improvement by the CQC and commissioners would endorse this approach and support the Trust's chosen quality priorities for 2019/20. If this approach is aligned with a strong focus on quality assurance and quality control it will provide the framework and foundations for the organisation to work towards achieving the organisational aspiration of an `Outstanding` CQC rating within the next five years.

Overall the report is reflective of the commissioner knowledge of the Trust quality activities and aspirations. The STP and the Trust are undertaking a significant transformational work programme over the next two years and we look forward to continuing our strong alliance to strengthen the quality of commissioned mental health services in 2019/20 and beyond.



Jane Foster-Taylor
Chief Nurse

Response to Essex Partnership University trust (EPUT) Account 2018-19 from Healthwatch Essex

Healthwatch Essex (HWE) is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by Essex Partnership University Trust. In this case, we have received quality of feedback about services provided by the hospice, and so offer only the following comments on the Essex Partnership University Trust Quality Account.

- HWE is assured by the EPUT approach to management, leadership and governance. HWE recognises the leadership development roles being undertaken and is keen to see the outcome of such an approach.
- HWE recognises the CQC rating as good overall and will continue to seek assurance around areas such as safe domain and quality of overall services.
- HWE commends the trust on its work around Suicide and unexpected deaths and the introduction of the tool kit, prevention , learning and family & Carer involvement. These measures will support the trust and its staff and ensure wider involvement in patient care and accountability.
- HWE recognises that recruitment of staff remains a target and there has been an improvement on recruitment for the trust. HWE would like to see these recruitment plans developed over the next 12 months. Staff shortages and quality of staff have been highlighted across the wider health & social care arena and HWE will support the trust where possible.
- HWE is supportive of the overall approach to Patient Experience for Patients, Staff, Carers and families. The continued development of 'your voice' meetings has shown wide interest from external partners and the public.
- HWE notes the solid ongoing patient experience work around stakeholder forums, SURG, coproduction, open impact meetings, buddy scheme and the outpatient survey. HWE would recommend that EPUT continue to develop new voices to be heard and engage in a more diverse collection of Lived Experience. HWE will support this.
- HWE recognises the great effort undertaken by the complaints and compliments team. HWE would still like to see continued reduction on complaints but are assured by the approach taken by staff and senior management to learning from the complaints.
- HWE is supportive of the trust in its role within the wider ICS programme and recognise that the trust will possibly see more change in the future. HWE are assured that senior management and board are capable of delivering this change.
- HWE recognises the learning from PLACE visits and the patient survey.
- HWE is assured by the EPUT and this quality account and is supportive of the trust in its work since the merger.

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

Dr David Sollis
Chief Executive Officer, Healthwatch Essex
NOTE: received via email 24 May 2019

Essex Partnership University NHS Trust
Head Office
The Lodge, Lodge Approach
Wickford
Essex
SS11 7XX

Essex County Council

BY EMAIL

6 June 2019

Dear Sir/Madam

Comments on Quality Accounts

Please find reproduced below our comments on your draft Quality Accounts:

The HOSC continues to push for higher prominence of mental health in STP plans and encourages the Trust to do all it can in this connection.

We welcome the opening up of Peter Bruff ward as an assessment ward which we believe will help reduce out-of-area placements. However, we believe that further focus is needed to improve responding to crisis and, in particular, the crisis line.

The HOSC is encouraged that, despite the challenges of the recent merger, regulatory ratings are improving. Whilst recognising there has been better engagement with stakeholders, the HOSC encourages continuing focus and effort to maintain these important relationships.

The HOSC looks forward to working with the Trust in the coming year.

Thank you for the opportunity to comment.

Councillor Jillian Reeves
Chairman of the Health Overview Policy and Scrutiny Committee

Councillor Jill Reeves
Member for Hadleigh

Members' Suite
PO Box 11, County Hall, Chelmsford CM1 1LX
Email: cllr.jillian.reeves@essex.gov.uk

NOTE: received via email 6 June 2019

ANNEXE 2 – Statement of Directors' Responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to May 2019;
  - papers relating to quality reported to the board over the period April 2018 to May 2019;
  - feedback from commissioners received May 2019;
  - feedback from governors received 23 May 2019;
  - feedback from Overview and Scrutiny Committees received May 2019;
  - the Trust's complaints report (appertaining to 2018/19) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2018 and presented to the Board of Directors in May 2019;
  - the 2018 national patient survey published in November 2018;
  - the 2018 national staff survey published in March 2019;
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019
  - CQC inspection reports dated 26 July 2018, 11 February 2019, 9 March 2019 and 13 March 2019;
- the Quality Account presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

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

By order of the board

Professor Sheila Salmon
Chair
Essex Partnership University NHS FT
23 May 2019

Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

ANNEXE 3 – Independent Auditor's Report to the Council of Governors on the Annual Quality Account

22 May 2019

Council of Governors
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex
SW11 7XX

Dear Governors.

External Assurance on the Trust's Quality Report

We are pleased to present our findings following our review of the Essex Partnership University NHS Foundation Trusts (the Trust's) Quality Report for the year ended 31 March 2019.

The purpose of this report to the Council of Governors is to set out the work that we have performed, our findings and conclusions and any recommendations for improvement concerning the content of the Trusts Quality Report and our testing on mandated and local indicators as required by NHS Improvement.

We would like to take this opportunity to thank the employees of the Trust for their assistance during the course of our work

Yours faithfully
Associate Partner For and on behalf of Emst & Young LLP Enc

Limited assurance report on the content of the Quality Reports and mandated performance indicators

Independent auditor's report to the Council of Governors of Essex Partnership University NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Essex Partnership University NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of Essex Partnership University NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report) and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 29 September 2017. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (page 70) Out of area placements (page 68)
- We refer to these national priority indicators collectively as the 'indicators'

Limited assurance report on the content of the Quality Reports and mandated performance indicator

Respective responsibilities of the directors and Emst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'Detailed requirements for quality report' issued by NHS improvement Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018), which is supported by NHS Improvement's Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement,
- the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the Detailed guidance for external assurance on quality reports 2018/19 and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports 2018/19

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance and consider the implications for our report if we become aware of any material omissions.

Limited assurance report on the content of the Quality Reports and mandated performance indicators

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - "Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ("ISAE 3000). Our limited assurance procedures included, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the "NHS Foundation Trust Annual Reporting Manual 2018/19 to the categories reported in the Quality Report.
- reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19 and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Essex Partnership University NHS Foundation Trust

Limited assurance report on the content of the Quality Reports and mandated performance indicators

We read the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the Detailed guidance for external assurance on quality reports 2018/19'. These are:

- Board minutes for the period April 2018 to May 2019
- Papers relating to quality reported to the Board over the period April 2018 to May 2019
- feedback from commissioners, dated May 2019
- feedback from Governors, dated May 2019
- feedback from Overview and Scrutiny Committee dated May 2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
- the latest national patient survey, published November 2018
- the latest national staff survey, published February 2019
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019, and
- Care Quality Commission inspection report, published July 2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the documents"). Our responsibilities do not extend to any other information

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Essex Partnership University NHS Foundation Trust as a body, to assist the Council of Governors in reporting Essex Partnership University NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Essex Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing,

Limited assurance report on the content of the Quality Reports and mandated performance indicators

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Essex Partnership University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement
- the Quality Report is not consistent in all material respects with the sources specified in EPUT Quality Report 2018/19, and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement

Enst & Young
Luton
28 May 2019

GLOSSARY

ADOS	Autism Diagnostic Observation Schedule
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAMHS	Child and Adolescent Mental Health Service
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CCQI	(Royal College of Psychiatry) College Centre for Quality Improvement
CHS	Community Health Services
CIPs	Cost Improvement and Income Generation Plan
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHT	Crisis Resolution Home Treatment
CRN NT	Clinical Research Network – North Thames
DAFNE	Dose Adjustment For Normal Eating
DHSC	Department of Health & Social Care
DTOC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EIS	Early Intervention Service
EPUT	Essex Partnership University NHS Foundation Trust
FEP	First Episode of Psychosis
FNP ADAPT	Family Nurse Partnership – Accelerated Design and Programme Testing
FRESH	Future, Recovery, Education, Skills, Hope (Recovery College)
FT	Foundation Trust
GP	General Practitioner
HEF	Home Enteric Feeding
HOSC	Health Overview and Scrutiny Committee
HRA	Health Research Authority
IAPT	Improved Access to Psychological Therapies
IOT	Intensive Outreach Team
IT	Information Technology
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicator
LD	Learning Disabilities
LTC	Long Term Condition
MANTRA	Maudsley Model of Anorexia Nervosa Treatment for Adults
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System

MHRA	Medicines and Healthcare Products Regulatory Agency
MHS	Mental Health Services
MHU	Mental Health Unit
MRSA	Methicillin Resistant Streptococcus Aureus – antibiotic resistant bacteria
MSK	Musculoskeletal
NCAPOP	National Clinical Audit Patient Outcome Programme
NCB	National NHS Commissioning Board
NELFT	North East London NHS Foundation Trust
NEP	North Essex Partnership University NHS Foundation Trust
NHS	National Health Service
NHSI	NHS Improvement (previously Monitor), the health sector regulator
NICE	National Institute for Health and Care Excellence.
NIHR	National Institute for Health Research
NIHR CRN	National Institute for Health Research Clinical Research Network
NPSA	National Patient Safety Agency
NRES	National Research Ethics Service
NRLS	National Reporting and Learning System
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PNIMH	Perinatal and Infant Mental Health champions
POMH UK	Prescribing Observatory for Mental Health UK
PRESCQIPP	Prescription Quality, Innovation, Productivity and Prevention
QIPP	Quality Innovation Productivity and Prevention
QNIC	Quality Network for Inpatient CAMHS
RAID	Rapid Assessment Interface and Discharge
RCA	Root Cause Analysis
REC	Research Ethics Committee
SEPT	South Essex Partnership University NHS Foundation Trust
SI	Serious Incident
SMI	Severe Mental Illness
SPoA	Single Point of Access
STaRS	Specialist Treatment and Recovery Service
STOMP	Stopping Over-Medication of People with a learning disability, autism, or both
STORM	Skills-based Training On Risk Management for suicide prevention
STP	Sustainability and Transformation Plan
SUHFT	Southend University Hospital NHS Foundation Trust
SUTS	Sign Up To Safety national campaign
TASI	Therapeutic and Safe Intervention
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
VLU	Venous Leg Ulcer
VTE	Venous Thromboembolism – blood clots

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