**APPENDIX C**

Local Services, Local Solutions

# SEPT QUALITY REPORT 2016/17 (DRAFT)

## EXECUTIVE SUMMARY

We recognise that for organisations like ours, providing a range of different services, in different geographic areas, this document can be somewhat complex. To help readers navigate our Quality Report, a summary of content and where you can find specific information that you may be looking for is provided below.

## PART 1: STATEMENT ON QUALITY FROM SALLY MORRIS, CHIEF EXECUTIVE OF SEPT 2016/17

I am delighted to present this Quality Report for 2016/17, which shows how South Essex Partnership University NHS Foundation Trust (SEPT) met its quality commitments for the past year and outlines the quality priorities in 2017/18 for our new, merged organisation – Essex Partnership University NHS Foundation Trust (EPUT).

This was an exciting year for SEPT as we prepared to merge with North Essex Partnership University NHS Foundation Trust (NEP) to form EPUT in April 2017. The merger is an excellent outcome for the people who rely on our services. We said from the start that we would be stronger together. Now we can harness the real enthusiasm we have to take the best from both organisations to deliver sustainable and transformative mental health, learning disabilities and community health services for the benefit of local people.

However, we didn't allow the proposed merger to distract SEPT's continued firm focus on the provision of high quality services. Much of the good practice outlined in this statement and throughout this report has been carried forward into the new organisation, taking us from strength to strength. The formation of EPUT enables us to continue to drive forward these quality improvements and more.

The preparation of this Quality Report has been particularly complex this year as we are required to look back on 2016/17 as SEPT and to look forward to 2017/18 as EPUT. 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 have any queries.

### Some of SEPT's quality highlights

Quality highlights from the past year include:

- Continuing high levels of achievement against the national safety thermometer, a national tool for measuring the achievement of harm free care.
- On-going reduction in the number of avoidable category 3 and 4 pressure ulcers acquired in our care, with two out of our three Community Health Services achieving no avoidable category 3 or 4 pressure ulcers across the entire year.
- Acceptance to be part of the NHS Improvement Falls Collaborative which is a 90 day programme, involving 21 volunteer Trusts, designed to improve the management of falls in an inpatient setting by ensuring that providers have the information, skills and tools to reduce injurious inpatient falls and improve reporting and care.
- On-going implementation of the Trust's Quality Academy with more than 65 quality champions being trained during the year and dates for training more quality champions scheduled.
- Development and implementation of a new "quality dashboard" for the Trust Board which provides the Board with an overview of key quality indicators, providing assurance and, where necessary, the opportunity for clarification and challenge.
- Implementation of a number of actions within the Sign up to Safety Initiative, with strong links to the national team supporting it.
- Awarded the Skills for Health Quality Mark Award for education and training.
- Family Food First – accreditation awarded for a number of local pre-school and nurseries in Bedfordshire.
- Installed a state-of-the-art X-ray machine at Saffron Walden Community Hospital.
- Launched the "Ask 3 Questions" programme in west Essex.
- Participated in the Essex-hosted Diabetes Games and Family Fun Day.
- Achieved excellent PLACE (clinical environment) results – above average in all categories.
- Received positive feedback following a visit from The Right Honourable the Lord Bradley to our Criminal Justice Liaison & Diversion Team.
- Achieved consistently excellent national Staff Survey results.
- Launched 2017's Buddy Scheme for training in mental health services.
- Dr. Ashish Patak, Consultant Psychiatrist, awarded Trainee Leader of the Year in the Health Education East Awards.
- Psychiatrists Dr David Ho, Dr Raman Deo and Dr Vivek Bisht, presented a symposium at the International Association of Forensic Mental Health Conference in New York (June 2016).

- Jacky Syme, practice development manager for 0-19 service in Bedfordshire, received the runner-up award for the Julie Crawford Award, given by the Baby Feeding Law Group (BFLG).
- Open Arts recognised again at the National Positive Practice in Mental Health Awards 2016.

You will find details of a number of these and many other achievements in this report.

**Systems for ensuring quality at the highest levels throughout 2016/17**

SEPT had a number of systems in place to ensure quality at the highest levels throughout the year. These systems have carried forward into EPUT and will continue to evolve as the new organisation develops.

As an NHS Foundation Trust, SEPT had a Council of Governors which included elected members of the public and staff, as well as a Board of Directors, both of which were led by the Chair of the Trust. Together they 'drove' the Trust, ensuring our staff were delivering services to the high standards to which we all aspire and they held me and my executive team to account for the day-to-day running of the Trust.

Our Board of Directors met in public and ensured proactively that we focused not only on national targets and financial balance, but also continued to place significant emphasis on the achievement of quality in our local services. Our performance was, therefore, monitored consistently and any potential areas for improvement addressed swiftly.

Robust quality governance systems were in place to safeguard patient safety and, ultimately, to provide assurance to the Board of Directors on the quality of SEPT services. These quality governance systems included production of comprehensive quality (including safety, experience and effectiveness) and performance dashboards on a monthly basis; undertaking compliance checks mirroring Care Quality Commission's (CQC) reviews and implementing any necessary remedial actions; an active national and local clinical audit programme; monitoring of patient experience and complaints and a robust risk management and escalation framework. Visits to services to assess quality and triangulate the information gained from these processes were made regularly by Non-Executive Directors, executive directors, Governors and commissioners.

I also place great importance on checking personally that things are as they should be in the Trust. I made unannounced visits to services at all times of the day and night throughout the year to observe the care provided and to hear directly from the people using the services at the time.

The quality governance system, actual quality performance and assurance on the arrangements in place were overseen by sub-committees of the Board of Directors and assurance provided to the Board of Directors.

**How others feel about our services**

SEPT placed great importance on listening to, involving and engaging with the people who come into contact with our services – patients / service users, carers and our staff and volunteers. This will also be a key priority for EPUT. During 2016/17, we continued to enhance our robust mechanisms for capturing feedback and also, and most importantly, acting on that feedback and using it to improve and shape services. We have included details of some of the activities undertaken, the feedback gained and changes made as a result in section 3.5 of this report.

Listening to our staff and their views on the quality of services was equally important to SEPT and will continue to be so in the new organisation. During 2016/17, we continued to ensure that our staff felt supported and encouraged to speak out about any issues, concerns or challenges. There were robust policies in place to enable staff to do this and a number of mechanisms by which they could raise any concerns. This included the "I'm worried about" intranet button for staff to raise issues anonymously directly with the senior leadership team, as well as the 'Freedom to Speak Up' initiative which gives staff the opportunity to speak to a 'Principal Guardian' about any concerns they might have.

**Meeting the requirements of our external regulators**

During 2015, we received an independent external assessment of the quality of our services under the CQC's comprehensive inspection national programme. SEPT's services were rated GOOD overall and GOOD for being effective, caring, responsive and well-led - a tremendous achievement. However, we were not complacent and the inspection reports indicated areas where we could improve further.

Since then, we have driven forward all the actions required to address the CQC's findings and undertook a detailed assessment of our progress in September 2016. As a result, the Board agreed that all actions with the exception of one had been implemented successfully. It was felt that whilst it was evident that action had been taken to improve access to psychology provision, further work was required. A thorough review of our service has been carried out and recommendations are being implemented. Further details are included in section 2.4.5 of this report. Our programme of internal inspections has continued to ensure that we have focused consistently and firmly on maintaining high standards in our services and making further improvements going forward.

Until the end of quarter 2 of 2016/17, we were fully compliant with the "Monitor" targets set by our external regulator. From 1 October 2016, NHS Improvement (which replaced Monitor as our external regulator from 1 April 2016) introduced new stretching targets for NHS organisations and the Trust has struggled to achieve some of these. Most are within our gift to achieve and I am determined that we will improve our position in 2017/18.

**Looking to the future**

There is always opportunity for improvement. This is an exciting time for the Trust with the launch of our new Essex Partnership University NHS Foundation Trust from 1 April 2017. A significant amount of work was undertaken with NEP throughout 2016/17 to prepare for this merger and to ensure that the quality of services is maintained and continues to go from strength to strength. Section 2.2 of this report sets out the quality priorities we have agreed for the new organisation, based on the specific priorities within each of the predecessor organisations.

This merger brings significant opportunities to design and deliver new models of service. There will be no immediate changes to services. It will be "business as usual" for service users and carers for the foreseeable future. Clinicians from both Trusts are working together with commissioners and people with lived experience to develop a proposed new clinical model for Essex-wide mental health services. Any changes to current services proposed by this model are likely to be subject to formal consultation.

Funding challenges may mean sometimes standards of service delivery have to be redefined to be affordable. Our continuous focus on the quality of service provision, regardless of the complexity of the external environment, means that we, our commissioners and regulators can be confident about the quality of our existing service provision.

To support our development work, the Quality Academy established in SEPT will continue to act as a catalyst to improve quality across the organisation. We will do this by providing an opportunity to capture and sustain the commitment and enthusiasm of staff, supporting them and enabling them to drive forward changes which make a difference to the care we provide.

**Our staff are our greatest asset**

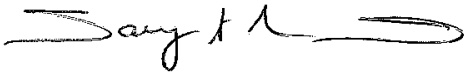
Our staff take pride in everything they do and provide consistently professional and high quality services. They work very hard to provide the highest quality care for our patients and I am immensely proud of them. Without each and every one of them, SEPT would not have been able to deliver the excellent services we and our patients expect.

We have a Staff Recognition Scheme and each month staff were nominated for In Tune Awards for their excellent customer service. On 1 February 2017 we held our annual SEPT Star Awards where more than 40 staff were recognised for their innovations and achievements with 26 proud winners taking home a trophy. Additionally, more than 400 staff were recognised for their excellent service throughout the year at our monthly Board Meetings.

After reading this Quality Report, I hope you will understand how seriously we all take quality and how hard we work to ensure that we continue to deliver services in a caring, dignified and respectful way. We believe that our patients, service users, carers, staff, volunteers and other stakeholders are the best people to tell us what constitutes the highest quality of service. We will continue to strive to meet their expectations and provide the highest standards of care by listening carefully to them and taking action promptly where necessary.

**Statement of Accuracy**

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



**Sally Morris**
**SEPT Chief Executive 2016/17**
**Chief Executive of the Interim Board of Directors, EPUT from 1 April 2017**

## PART 2
## OUR QUALITY PRIORITIES FOR IMPROVEMENT DURING 2017/18 AND STATEMENTS OF ASSURANCE FROM THE BOARD FOR 2016/17

***Progress against the quality priorities for improvement for 2016/17, as set out in SEPT's 2015/16 Quality Report, is set out in Part 3 of this document.***

**What services did SEPT provide in 2016/17?**

During 2016-2017, SEPT provided hospital and community-based mental health and learning disability services across South Essex as well as a small number of specialist mental health and learning disability secure services in Bedfordshire and Luton. SEPT also provided community health services in Bedfordshire, South East Essex and West Essex.

**How have we prepared this Quality Report?**

This Quality Report has been prepared in accordance with the national legislation / guidance relating to the preparation of Quality Reports and Quality Accounts in the NHS. From 1st April 2017, SEPT merged with North Essex Partnership University NHS Foundation Trust (NEP) to form Essex Partnership University NHS Foundation Trust (EPUT) and from this date responsibility for the finalisation of this Quality Report transferred to EPUT. The legislation / national guidance on Quality Reports and Accounts specifies mandatory information that must be reported within the Report 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 Report and independent assurance from an external auditor.

This Quality Report 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 has been set out in three sections in accordance with the national legislation / 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 in draft form and they were given 30 days in which to consider the draft and provide comment / a statement for publication in the final Quality Report. 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 Annex A of this Quality Report *{to be inserted in final version prior to publication}.* The draft report was also sent to Local Authority Health and Wellbeing Boards for consideration and comment should they wish. The Lead Governor for SEPT also provided a statement, on behalf of the SEPT Council of Governors, which is included in Annexe A.

The report was sent in draft form to the Trust's external auditors in April 2017, 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 C of this Quality Report. *{To be inserted in final version prior to publication}.*

The EPUT Board of Directors approved the final version of this Quality Report 2016/17 and their statement of responsibilities in this respect is included at Annexe B of this report. *{To be inserted in final version prior to publication}.*

### *2.1 Key actions to maintain and / or improve the quality of services delivered in 2017/18*

**How have we developed our priorities for the coming year?**

As part of the preparation for the merger, SEPT and NEP established a joint planning process that led to the development of aligned strategic priorities and action to be taken to achieve these. Two joint stakeholder planning events for EPUT were held in December 2016. Those in attendance included commissioners, representatives from statutory and voluntary partners, staff, governors and service users and carers.

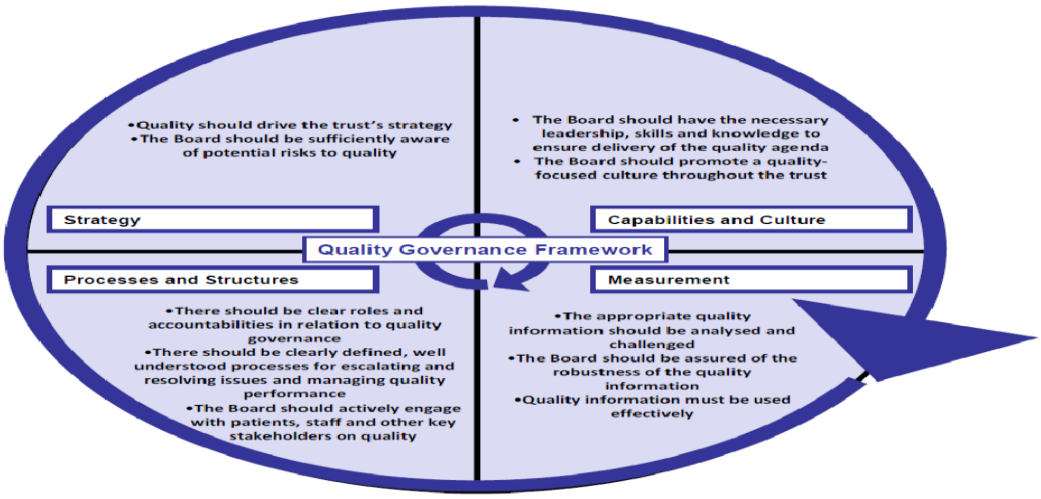
EPUT's vision commencing on 1st April 2017 is "working to improve lives". The priorities for quality for our new organisation have been produced with input from the Board, the Trust's Leadership Team, health economy partners and the Council of Governors. In addition, a number of economy wide discussions have been held with partners at Board and Executive level on the delivery of the Five Year Forward View and system wide Sustainability and Transformational Plans (STPs).

A safe transition from two organisations to one is clearly the key priority. A detailed "Post-Transaction Implementation Plan" (PTIP) was developed and scrutinised by NHS Improvement and by external auditors. A Quality Merger Workstream was put in place during 2016/17 and sub-workstreams established to oversee the review and harmonisation of systems, processes and policies associated with the management of quality in EPUT. Clear plans were put in place to establish harmonised processes required on day 1 of the new organisation (ie those most critical processes, for example adverse and serious incident reporting; complaints handling etc) and to understand those processes that could run in parallel until full harmonisation has taken place in a managed and safe way during the first 12 months post transaction.

In support of the above, harmonised written policies / procedures were developed for the critical processes for implementation on Day 1; and a prioritised plan is in place to harmonise remaining policies over the coming 12 month period.

EPUTs approach to quality will be firmly aligned to the quality governance framework principles.

Figure 1: The Quality Governance Framework




The Interim Board, put in place in November 2016 to prepare for the merger, identified that achieving the highest quality standards would be one of the key benefits of merger. EPUT's ambitions in respect of quality are to achieve a "good" CQC rating in the first comprehensive inspection post-merger; to achieve maximum autonomy in NHS Improvement segmentation ratings and to achieve top quartile ranking in the national transparency index.

Delivering quality services is one of the new Trust's four key strategic priorities, demonstrating that quality will drive the trust's strategy. The following overarching quality priorities have been identified as a result of the planning process put in place to develop the 2017/18 annual plans and articulate the key actions that will deliver EPUT's strategic vision for quality. These quality priorities have been identified as corporate objectives to ensure that they are integral to the delivery of the Trust's strategic and operational plans and are as follows:

*Implementation of a new mental health clinical model***:** the implementation of a new clinical model will be one of the key drivers and contributors to the strategic vision of the Trust in 2017/18. We aim to develop the proposed model and consult with stakeholders on it, with a view to implementation starting in 2018/19.

*Continued reduction in harm***:** both NEP and SEPT have taken action under the "Sign up to Safety" campaign to reduce harm. EPUT will align systems and processes and continue to reduce harm in the following areas**:**

- Pressure ulcers
- Avoidable falls
- Unexpected deaths
- Medication omission
- Physical health of mental health patients and early warning systems for deteriorating patients
- Restrictive practice

*Record Keeping and Care Planning:* both trusts experience on-going challenges associated with ensuring that high quality care records are maintained and that care plans are complete and personalised. Action will be taken to agree revised standards for record keeping and personalised care planning based on best practice and putting in place trust-wide training and practice development programmes to support excellence.

*Mortality Review Processes:* The CQC published the outcome of a comprehensive review of mortality review processes in December 2016. Both organisations have taken action in 2016 to establish local mortality review processes in response to the Southern Health report findings but these require review in light of CQC findings and recommendations (and the National Guidance on Learning from Deaths subsequently published by the National Quality Board in March 2017) and embedding in organisational systems and culture going forward.

*Using Technology***:** utilisation of new electronic systems and tools and maximising the use of those in place already will be required as part of changing culture and creating efficiencies required to deliver the agreed financial plan.

*Standardisation and reducing variation:* there are some excellent examples of leading practice and high quality services in both predecessor Trusts but neither could demonstrate consistently high standards across their entire portfolio. The new Trust will utilise the obvious internal opportunity to strengthen the use of benchmarking to identify clinical variation within mental health services provided in north and south Essex and action will be taken to agree a standardised approach to recording outcomes and the metrics in place to monitor them.

Creating a culture of quality improvement will be a high priority for EPUT. The Trust will develop and roll out a unique systematic approach to quality, building on the Quality Academy that was in place in SEPT and the Star Quality initiative in NEP. The EPUT approach to quality will support delivery of the agreed quality strategy; providing staff with the tools and training to support improvement activities and recognising and rewarding quality improvement as it takes place and makes a real difference to patient care.

The organisational development plan put in place to support merger identifies strong clinical leadership as integral to the trusts' aims. Within the workforce plan, a commitment has been made to develop a talent management programme to grow effective clinical leaders and managers within the organisation to support sustainable improvement.

## *2.2 Quality priorities for 2017/18*

In setting the specific Quality Report / Account priorities for 2017/18, the EPUT Interim Board of Directors considered the strategic context, their knowledge of the predecessor Trusts and feedback from staff and stakeholders during the planning cycle. The Interim Board of Directors believe that the quality priorities outlined below will continue to deliver the improvements most often identified by our stakeholders and will lead to improved health outcomes for our patients and service users.

It is EPUTs intention to be ambitious with quality improvement and to set stretching targets. However, as a new organisation, it is the intention to undertake benchmarking and assessment of current position across the entirety of the new organisation in quarter 1 before setting appropriately ambitious and measurable improvement targets to be achieved through the remainder of the year. The priorities outlined below are therefore articulated to reflect this approach.

**PRIORITY 1 - PATIENT SAFETY – Continued reduction in harm**

*NEP and SEPT have taken action under the "Sign up to Safety" campaign to reduce harm. EPUT will align systems and processes and continue to reduce harm.*

**Target: To continue to reduce harm across the organisation in the following key areas:**

- **Pressure ulcers**
- **Avoidable falls**
- **Unexpected deaths**
- **Medication omissions**
- **Physical health of mental health patients and early warning systems for deteriorating patients**
- **Restrictive practice**

To achieve this, the Trust will deliver the following actions during 2017/18:

**1) Pressure ulcers, avoidable falls, medication omissions and restrictive practice**

- During Q1, the Trust will establish a baseline for the new organisation for each of the above areas and standardise processes and reporting where differences exist.
- At the end of Q1 when the baseline across EPUT has been established, the Trust will establish appropriate reduction targets for the remainder of the year.
- The Trust will monitor performance in each of the above categories during Q2 – Q4 and will have achieved an appropriate reduction against the new organisational baseline established in Q1 for:
    - The number of avoidable grade 3 and 4 pressure ulcers acquired in our care
    - The number of avoidable falls that result in moderate or severe harm
    - The number of omitted doses within services
    - The number of prone restraints
- The Trust will achieve above 95% harm free care from the "Safety Thermometer" every month throughout the year.

**2) Unexpected deaths**

- During Q1 the Trust will review the different suicide prevention training packages in place across the Trust and establish the organisational baseline for staff having completed suicide prevention training.
- At the end of Q1, the Trust will agree the training approach going forward and appropriate trajectories for completion of agreed suicide prevention training across the Trust.
- The Trust will monitor training completion during Q2 – Q4 and will have achieved the agreed completion rate by the end of Q4.

**3) Physical health of mental health patients and early warning systems for deteriorating patients**

- During Q1 the Trust will review the physical health monitoring tools in place across the Trust, standardise and deliver training on the agreed tool.
- During Q2, the Trust will undertake an audit of physical health and early warning systems for deteriorating patients and agree appropriate outcome measures to achieve by the end of Q4.
- At the end of Q4, the Trust will review performance against the agreed outcome measures.
- The Trust will consistently achieve the following targets in terms of patients with psychosis receiving a cardio metabolic assessment from Q1:
    - Inpatients 90%
    - Early Intervention in Psychosis patients 90%
    - Community patients on CPA
- The Trust will consider how to implement a sustainable process which ensures that all patients with psychosis receive a cardio metabolic assessment and will set stretch targets for the remainder of the year at the end of Q1.

**PRIORITY 2 - CLINICAL EFFECTIVENESS – Record keeping and care planning**

*Both trusts experience on-going challenges associated with ensuring that high quality care records are maintained and that care plans are complete and personalised. Action will be taken to agree revised standards for record keeping and personalised care planning based on best practice and putting in place trust-wide training and practice development programmes to support excellence.*

**Target: To develop and implement revised standards for record keeping and achieve an improvement in the quality of record keeping between Q1 and Q4.**

To achieve this, the Trust will deliver the following actions during 2017/18:

- During Q1, the Trust will undertake a record keeping baseline audit and develop and launch revised standards for record keeping.
- At the end of Q1, the Trust will agree appropriate improvement targets to be achieved by Q4 against the established baseline.
- The Trust will undertake a further record keeping audit in Q4 and will have achieved a percentage improvement in the quality of record keeping.

**Target: To ensure that all patients identified as on an "end of life" care pathway have a personalised care plan in place.**

To achieve this, the Trust will deliver the following actions during 2017/18:

- During Q1, the Trust will undertake an audit of the number of patients identified as on an "end of life" pathway who have a personalised care plan in place.
- During Q4, the Trust will undertake another audit of the number of patients identified as on an "end of life" pathway who have a personalised care plan in place and will have achieved an increase in the number.

**PRIORITY 3 - CLINICAL EFFECTIVENESS – Mortality Review**

*The CQC published the outcome of a comprehensive review of mortality review processes in December 2016. Both organisations have taken action in 2016 to establish local mortality review processes in response to the Southern Health report findings but these require review in light of CQC findings and recommendations and newly issued National Quality Board's "Learning from Deaths" guidance (March 2017).*

**Target: To develop and implement organisational systems to deliver the National Quality Board's "Learning from Deaths" Guidance issued in March 2017.**

To achieve this, the Trust will deliver the following actions during 2017/18:

- By September 2017, the Trust will have developed and approved an updated Mortality Review Policy in line with the "Learning from Deaths" national guidance.
- From Q3 onwards, the Trust will report mortality information on a quarterly (and annual) basis in line with the requirements of the "Learning from Deaths" national guidance (data to be published will be from April 2017 onwards). This will include the total number of the Trust's in-patient deaths and those deaths that the Trust has subjected to case record review; of the deaths subjected to review, an estimate of how many deaths were judged more likely than not to have been due to problems in care; and learning points.
- At the end of Q4, the Trust will undertake an audit of implementation of the Policy to assess whether processes have been embedded and are operating effectively.

**PRIORITY 4 - PATIENT EXPERIENCE – Family and carer involvement in mortality review**

*The National Quality Board's "Learning from Deaths" Guidance (March 2017) highlights the importance of engaging meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death. As a starting point, the focus will be on all deaths which occur in in-patient services and those deaths occurring in a community setting which are classified as a "serious incident".*

**Target: To achieve high quality family and carer engagement and involvement after the death of an in-patient or the death of a patient in a community setting which is classified as a "serious incident" in line with the national guidance on learning from deaths.**

To achieve this, the Trust will deliver the following actions during 2017/18:

- By September 2017, the Trust will have developed a Family and Carer Engagement and Involvement Policy which will include how families and carers are involved after the death of a patient who died in in-patient services or the death of a patient in a community setting which is classified as a "serious incident".
- By September 2017, the Trust will design appropriate mechanisms of seeking feedback from families and carers in terms of their engagement and involvement following the death of a patient in in-patient services or the death of a patient in a community setting which is classified as a "serious incident".
- The Trust will implement these mechanisms and undertake an audit through Q3 – 4 to establish the position in terms of the effectiveness of engagement and involvement, aiming to achieve a target of 100% of families / carers of patients whose death was in in-patient services or classified as a serious incident indicating that they were satisfied with their engagement and involvement after the death.
- The outcomes of the Q3 - Q4 audit will be assessed and actions agreed that could be taken to achieve improvement for on-going monitoring.

All of the above quality priorities will be monitored on a monthly basis by the Executive Directors of the Trust as part of the routine quality and performance report and the Board of Directors will be informed of any slippage against agreed targets. EPUT will report on progress against these priorities in their Quality Account for 2017/18.

***2.3 Stretching goals for quality improvement – 2017/18 CQUIN Programme (C**ommissioning for **Qu**ality and **In**novation) **for EPUT***

Commissioners have incentivised Essex Partnership University NHS Foundation Trust (EPUT) to undertake 57 CQUIN projects in 2017/18 which aim to improve quality of care and encourage collaborative working.

The value of the 2017/18 CQUIN scheme for EPUT is £6,534,062 which equates to 2.5% of Actual Annual Contract Value, as defined in the 2017/18 NHS Standard Contract. In contrast to previous years, all are national CQUIN schemes with the single exception of one which is a local scheme negotiated in South East Essex community services to continue an existing 2016/17 area wide transformation scheme.

The CQUIN programme content is markedly different in 2017/18 in line with national NHS England guidance which explains *"The CQUIN scheme has shifted focus from local CQUIN indicators to prioritising system wide Sustainability and Transformational Plans (STP) engagement and delivery of financial balance across local health economies. It is anticipated that that this approach will free up commissioner and provider time and resource to focus on delivering critical priorities locally."*

Given the financial and capacity challenges facing the NHS and the need to transform area-wide care pathways involving many service providers to effectively deliver care, the 2017/18 CQUIN programme contains 7 CQUIN themes (total 14 projects) that incentivise providers to collaborate and deliver quality and efficiency through transformation.

There are five CQUIN themes (22 projects) that enable the embedding of existing project work from 2016/17:

- Staff Health & Well-being (Year 2) – a 3-part CQUIN applicable to community and mental health contracts that incentivises provision of a well-rounded programme of physical and mental health initiatives to support and promote staff wellness.

- Physical Health (Year 4) – a 2-part CQUIN applicable to mental health contracts only that encourages physical health monitoring for patients with schizophrenia through consistent assessment and documenting of physical health and better partnership working with GP's.
- Neighbourhood Workforce Development (Year 2) – rollout of the 2 pilot neighbourhoods to the remaining 6 areas will embed the integration and transformation work initiated during 2016/17.
- Reducing Restrictive Practice (Year 2) – exploration of staff and service user experience of restrictive practice is developing initiatives that support least restrictive practice.
- Recovery College (Year 2) – successfully launched FRESH, our new Recovery College and objectives for this year will embed this initiative.

The commitment to rollout of national CQUIN programmes for a minimum of 2 years and 5 years in the case of Physical Health for people with Severe Mental Illness is very positive in our view. This acknowledges the length of time for real change to occur especially regarding change in health behaviour and supports embedding of change in practice.

In conclusion, the Trust is dedicated to continually improving services 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. We are mindful of contextual events including transition within a newly merged organisation, and dependencies inherent in the progression of shared CQUIN schemes that may present risks but anticipate teams will ably meet the challenges for the coming year.

## 2.4 Statements of Assurance from the Board relating to SEPT 2016/17

### *2.4.1 Review of services*

***During 2016/17, SEPT provided and/or sub-contracted 156 relevant health services.***

***SEPT has reviewed all the data available to them on the quality of care in 156 of these relevant health services.***

***The income generated by the relevant health services reviewed in 2016/17 represents 96 per cent of the total income generated from the provision of relevant health services by SEPT for 2016/17.***

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2016/17 monthly data quality reports have been produced in a consistent format across all services. These reports monitor both timeliness of data entry and data completeness. The Trust has continued to make significant improvement in compliance throughout 2016/17. This has once again been achieved with the continuation of the reports introduced in 2014/15 and there has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information in terms of data is included in section 2.4.6 below.

### *2.4.2 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). Robust programmes of national and local clinical audit that result in clear actions being implemented to improve services is a key method of ensuring high quality. Clinical audit is a tool to assist in improving services. The Trust participates in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes and additional national and locally defined clinical audits identified as being important to clinical outcomes of our service users.

***During 2016/17 12 national clinical audits and 1 national confidential enquiry covered relevant health services that SEPT provides.***

***During that period SEPT 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 SEPT was eligible to participate in during 2016/17 are as follows:***

*National clinical audits:*

- *Sentinel Stroke National Audit Programme Round 4 (SNAP) 2016/17*
- *National Diabetes Foot Care Audit Round 2*
- *NHS National Benchmarking*
- *National Chronic Obstructive Pulmonary Disease (COPD) Audit* - Pulmonary Rehabilitation Workstream Round 2
- *National Audit Of Parkinsons Disease*
- *POMH uk Topic 15a Prescribing for Bipolar Disorder - (2015/16 project completed in 2016/17)*
- *POMH uk Topic 14b Prescribing for substance misuse and alcohol detoxification – (2015/16 project completed in 2016/17)*
- *POMH uk Topic 11c Prescribing antipsychotic medication for people with dementia*
- *POMH uk Topic 7e Monitoring of patients prescribed lithium*
- *POMH uk Topic 16a Rapid tranquilisation*
- *POMH uk Topic 1g &3d Prescribing high dose and combined antipsychotics on adult psychiatric wards –( data collection will complete in 2016/17)*
- *National Early Intervention in Psychosis services*

*National confidential enquiries:*

- *Suicide and homicide*

***The national clinical audits and national confidential enquiries that SEPT participated in during 2016/17 are as above.***

***The national clinical audits and national confidential enquiries that SEPT participated in, and for which data collection was completed during 2016/17, 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**<br>*(POMH = Prescribing Observatory for Mental Health)* | **Number of cases submitted as a percentage of the number of registered cases required by the terms of the audit / enquiry** |
|---|---|
| Sentinel Stroke National Audit Programme Round 4 (SSNAP) 2016/17 | Data collection is on-going and continuous. |
| National Diabetes Foot Care Audit Round 2 | Data collection is on-going and continuous. |
| National Audit Of Parkinson Disease | 100% of relevant cases had information provided to national organisers. |
| POMHuk Topic 11c Prescribing antipsychotic medication for people with dementia | 100% of required cases had information provided to national organisers. |
| National Early Intervention in Psychosis services | Organisational information provided to national organisers. |

| | |
|---|---|
| POMHuk Topic 7e- Monitoring of patients prescribed Lithium | 100% of required cases had information provided to national organisers. |
| NHS National Benchmarking for:<br><br>Community Services<br><br>Community Hospitals<br><br>Cardiac and respiratory Specialist Nursing | West Essex Community Services participation. All relevant cases included in the Benchmarking Process. |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit - Pulmonary Rehabillitation Workstream Round 2 | West Essex CHS 100% of relevant cases had information provided to national organisers. |
| POMHuk Topic 16a Rapid Tranquillisation | 100% of required cases had information provided to national organisers. |
| POMHuk Topic 1g & 3d Prescribing high dose and combined anti-psychotics on adult psychiatric wards | 100% of required cases had information provided to national organisers. |
| National Confidential Enquiry - Suicide and Homicide | 100% of relevant cases were submitted with information to national organisers. |

***The reports of 6 national clinical audits were reviewed by SEPT in 2016/17 and we intend to take the following actions to improve the quality of healthcare provided (examples only are listed):***

- A checklist (for prescriber and patient to sign off) regarding the risks posed during pregnancy using sodium valproate to be added to Section 3 Treatment of Bipolar Affective Disorder Mental Health Formulary and Prescribing Guidelines.
- Process put in place for patient leaflet (as identified in MHRA suite of resources from MHRA alert Jan 2015) to be issued to all relevant patients on sodium valproate.
- Letter template amended for GPs to be advised of risk factors for patient of child bearing age prescribed sodium valproate.
- Findings from national POMHuk Audits will be used by the Physical Health Implementation Group to identify key areas of concern for action planning and priorities.
- Following the audit into early intervention in psychosis the service is undergoing a review and resources are being negotiated to provide services as outlined in NICE QS80.
- Induction of Junior Doctors to include teaching on basic principles of taking a complete alcohol history when clerking patients.

***(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.)***

SEPT's priority clinical audit programme for 2016/17 was developed following consultation with senior mental health and community health service managers to focus on agendas required to provide assurance to the Trust and stakeholders that services being delivered are safe and of high quality. A centralised Clinical Audit Department oversee all priority clinical audits, 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.

***The reports of 36 local clinical audits were reviewed by SEPT in 2016/17 and we have or intend to take the following actions to improve the quality of healthcare provided (examples only are listed):***

- New suicide prevention awareness and response training commissioned which includes safety planning and risk management planning.
- Small group training on the handling of Controlled Drugs to be provided to all wards not achieving compliance with the standards.
- Changes made to Mobius Electronic Patient Record system to highlight if patient has a carer, therefore making it easier to include them in care decisions.
- Following the falls audit, posters and presentations have been implemented. Handouts included in doctors induction packs.
- Improving complaints processes to ensure they are also child friendly.
- Ensure new doctors are made aware of DVT risk assessment form (including need to prescribe anti-VTE stockings) at induction.
- Introduced Distress Thermometer (Holistic Assessment Tool) within Oncology and Palliative Care.
- Consideration to piloting the use of tablet computers in hospital teams.

### *2.4.3 Clinical Research*

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical Research' is defined as Health and social care research undertaken within the NHS and in NHS England this means research that has received Health Research Authority (HRA) approval. Information about clinical research involving patients is kept routinely as part of a patient's record.

For NHS research taking place in England there is a new process of approval via the HRA that brings together the assessment of governance and legal compliance, undertaken by dedicated HRA staff, with the independent Research Ethics Committee (REC) provided through the UK Health Departments' Research Ethics Service. HRA Approval replaces the need for local checks of legal compliance and related matters by each participating NHS organisation in England. This allows participating NHS organisations to focus their resources on assessing, arranging and confirming their capacity and capability to deliver a study.

As a demonstration of our commitment to research and development we continue to participate in studies funded by the National Institute for Health Research (NIHR) and this is very much our core research activity. We continue to work with our partner organisations to develop research and to support students undertaking research as part of further education courses.

***The number of patients receiving relevant health services provided or sub-contracted by SEPT in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 619.***

### *2.4.4 Goals agreed with commissioners for 2016/17*

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support the 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 SEPT's income (2.5% of contract value) in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between SEPT 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. Further details of the agreed goals for 2016/17 and the following 12 month period are available electronically at:*** *http://www.eput.nhs.uk*

The SEPT CQUIN programme for 2016/17 included 27 schemes negotiated with commissioners across the areas in which SEPT was commissioned to operate services. The CQUIN programme included a mix of local (1.5% of contract value) and national (1.00% of contract value) schemes and was valued at just under £4.4 million which represents 2.5% of contract value for the Trust. This compares to the 2015/16 CQUIN programme which again represented 2.5% of contract value equating to £4.87 million.

The current forecasted achievement is 96% (£4.2 million income), reflecting strong operational performance within each of the five services in achieving a complex programme and challenging expectations of Commissioners. Given the financial and operational challenges facing the NHS in 2016/17 overall we are pleased that collaboration to deliver shared CQUINs is helping to strengthen links with partners. There is clear evidence of improving quality for patients across the breadth of community, mental health and specially commissioned services run by SEPT over the last 12 months.

The Trust's CQUIN programme included the two national CQUINs applicable for Community Health Services and/or Mental Health Services. These are:

- Staff Health & Well-being – a new 3-part CQUIN applicable to South East Essex and West Essex community and South Essex mental health contracts.
- Physical Health (Year 3 Cardio-metabolic Assessment) - a 2-part CQUIN applicable to South Essex mental health contract only.

We implemented a total of 11 CQUIN schemes across the organisation under the above three national schemes. The remaining 16 out of the total of 27 CQUIN schemes were set locally in discussion with the Clinical Commissioning Groups based on local priorities.

Several locally negotiated CQUINs e.g. Workforce Development and Motivational Interviewing in West Essex and Care Packages and Pathways in South Essex were continued from 2015/16. Year 2 schemes ensured an opportunity to consolidate and embed earlier work.

Notable schemes in which Commissioners have given very positive feedback include:

- Payment by Results CQUIN – staff from SEPT including the CQUIN project lead, operational leads in Mental Health Services (MHS) and Performance worked closely with commissioners in South Essex developing a collaborative approach to review care pathways, cost care delivery and select appropriate outcome measures to evidence efficacy.
- Palliative Care Support (PCS) Register CQUIN – the PCS team and Modern matrons in South East Essex Community Health Services (CHS) trialled attending hospital based Multi-Disciplinary Team meetings aiming to identify patients and support hospital staff to be more confident in making referrals. They are now focussing on support for care home staff to increase referrals and support a greater number of patients to plan care at the end of their life and avoid unnecessary hospital admissions.
- The Care Home Multi-Disciplinary Team (MDT) CQUIN in West Essex Community Health Services (CHS) supported GP's to launch and embed new care home MDT's in order to encourage effective partnership working. The aim was to reduce the number of unplanned avoidable admissions from care homes into acute care in comparison to 2015/16 activity.
- The second year of the Workforce Development CQUIN in West Essex CHS successfully supported integrated working across West Essex through joint inductions, joint training and shadowing opportunities.
- The Nursing Home CQUIN in Bedfordshire Community Health Services provided an opportunity for the SEPT community health services to work collaboratively with nursing home staff aiming to improve skills and knowledge regarding the wound care formulary, SSKIN bundle for managing pressure ulcer risk and the diabetic foot attack pathway.

- There are 3 notable CQUINs in Specialist Services that launched during the year - a new carers evening for parents and carers in Child and Adolescent Mental Health Services (CAMHS); a Recovery College for adult inpatients in 3 locations within secure mental health services; and an initiative to understand and reduce restrictive practices through staff and service user involvement in secure mental health services.

In conclusion, the Trust has continued to be dedicated to continually improving services 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.

### *2.4.5 What others say about the provider?*

***SEPT is required to register with the Care Quality Commission and during 2016/17 its registration status was 'Registered Without Conditions'.*** *Please note that SEPT was de-registered with the Care Quality Commission on 31st March 2017 and the services were re-registered by EPUT on 1st April 2017.*

***The Care Quality Commission has not taken enforcement action against SEPT during 2016/17.***

***SEPT has participated in special reviews or investigations by the Care Quality Commission (CQC) relating to the following areas during 2016/17:***

**Safeguarding Children's Inspection for Southend (July 2016)**

***We intend to take the following action to address the conclusions or requirements reported by the CQC:***

- Develop a Think Family approach in Mental Health and Sexual Health Services.
- Standardise the utilisation of alerts on mental health electronic systems.
- Establish operational governance and quality assurance to support mental health staff delivering best safeguarding practice.
- Develop liaison and communication pathways between Mental Health and STaRs.
- Expedite transition to single electronic patient record system in sexual health services.
- Ensure training, supervision and record keeping in sexual health services reflects national guidance.
- Work with Commissioners to increase visibility of sexual health services into wider safeguarding networks.
- Strengthen liaison between health visiting, school nursing and midwifery.

***SEPT has made the following progress by 31st March 2017 in taking such action:***

- Action plan in place and progress reported to Clinical Commissioning Group quarterly. There are no concerns in terms of the ability to complete the actions in accordance with the plan.

***Please note, the Trust has completed all actions arising from the Inspections undertaken in 2015/16 reported in last year's Quality Report.***

The most recent Care Quality Commission (CQC) Inspection of SEPT was the Comprehensive Inspection of all Trust Services in June / July 2015 undertaken as part of its on-going comprehensive health inspection programme. This reviewed compliance against the Fundamental Standards and Key Lines of Enquiry (KLOE's). The feedback reports published by the CQC in November 2015 confirmed that the Trust had received an overall rating of "Good". The Trust received 16 reports which confirmed the overall rating for the Trust and a rating for each core service (as defined by the CQC) as at the point of Inspection in 2015 – these were as follows:


**Are services**

| | |
|---|---|
| Safe? | Requires improvement |
| Effective? | Good |
| Caring? | Good |
| Responsive? | Good |
| Well led? | Good |

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with learning disabilities or autism | Requires improvement | Good | Good | Good | Good | Good |
| Child and adolescent mental health wards | Requires improvement | Good | Good | Good | Good | Good |
| Forensic inpatient/secure wards | Requires improvement | Good | Good | Good | Good | Good |
| Acute wards for adults of working age and psychiatric intensive care units | Good | Good | Good | Good | Good | Good |
| Community-based mental health services for adults of working age | Good | Good | Good | Good | Good | Good |
| Specialist community mental health services for children and young people | Good | Good | Good | Good | Good | Good |
| Wards for older people with mental health problems | Good | Good | Good | Good | Good | Good |
| Mental health crisis services and health-based places of safety | Good | Good | Good | Good | Good | Good |
| Community mental health services for people with learning disabilities or autism | Good | Good | Good | Requires improvement | Good | Good |

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Community health services for adults | Good | Good | Good | Good | Good | Good |
| Community health inpatient services | Good | Good | Good | Good | Good | Good |
| Community dental services | Good | Good | Good | Good | Good | Good |
| Community health services for children, young people and families | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |

As a result of this Inspection, the CQC identified 4 “Must Do” and a number of “Should Do” recommendations. Following the receipt of the final feedback reports in November 2015, the Trust developed a detailed action plan aimed at addressing the recommendations made by the CQC and bringing about real improvement within Trust services. The action plan was taken forward by a series of Task and Finish Groups, overseen by an Executive Task and Finish Group.

The Trust recognised that simply reporting progress with the agreed actions may not have provided sufficient assurance that there had been learning from the inspection and that actions taken had actually engendered change / improvement. It was agreed therefore that a robust compliance process would be implemented in order to provide the Executive Team, Quality Committee and ultimately the Board of Directors with the necessary assurance in respect of the position reported in September 2016.

The Compliance process implemented consisted of two separate assurance "tests" carried out on each recommendation.

- **Test 1 Have the actions been completed as reported?** This was undertaken as a desktop audit to check the actions reported as being completed had in fact been completed. The audit involved checking every action identified and collating evidence of the action reported.
- **Test 2 Is there evidence that the action taken has engendered change / improvement?** A comprehensive programme of audit was undertaken by the Compliance Team to determine whether the recommendations made by the CQC had been addressed and if any improvement had been made as a result. The audits included data gathering, speaking with patients and staff, reviewing patient notes, undertaking observations and reviewing the environment.

The Trust Compliance Team collated and analysed the results of both tests and presented these to the Executive Task and Finish Group. Further discussions were held collectively and individually with Executive Directors in order to agree the final position to be reported to the CQC.

The Trust reflected on the outcome of both Test 1 and Test 2 in order to agree the recommendation position overall for each CQC recommendation as at September 2016. The Trust concluded that there was sufficient assurance available to recommend closure of all but ONE CQC recommendation taking into account the action taken and the assurance available on the difference it had made.

The recommendation that it was felt could not be closed as a result of this process required the Trust to "ensure that all relevant patients have easy access to psychological therapies". The Trust was satisfied that some action had been taken but was not satisfied that this had led to change or improvement. The Director of Mental Health was therefore requested to take this action forward to improve the current provision and in March 2017 the Quality Committee received assurance that good progress was being made to improve the service and this will continue in 2017/18.

In drawing its conclusions, the Trust was clear the action plan submission to the CQC was not the end of the follow-up and implementation of the CQC recommendations. Where there was not full assurance that action taken had resulted in change / improvement, on-going action and appropriate monitoring arrangements were established. Sustainability / monitoring arrangements for 2017/18 will also be implemented to minimise the risk of issues identified by the CQC in 2015 being identified in any future inspection.

### *2.4.6 Data Quality*

The ability of the Trust to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for the Trust 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 the Trust to undertake meaningful planning and enables services to be alerted of deviation from expected trends.

2016/17 has been a challenging year within the Trust with the implementation of a new information system for Mental Health services. The new system provides a unified patient summary database which houses all key inpatient and community Mental Health and Learning Disability information. This will ensure more robust information capture and reporting and provides facilities to respond to ever growing information requirements (both nationally and locally). The introduction of the new system has led to a change in a number of operational procedures for both inputting information and extracting information from the system. Due to the system change over, there were periods of time in 2016/17 where information was not available to support contractual and national reporting. Considerable work has been undertaken training staff and there has been ongoing data validation. An in-depth data quality audit was undertaken at the end of the financial year looking at data provided for 10 Key Performance Indicators, this involved the audit of over 750 records. Substantial Assurance was achieved.

In addition to the system change the following key developments have been made:

- Undertaking of an increased number of Data Quality Audits by internal audit to continue the focus on data quality in year.
- Presentation of a regular Data Quality Reports to the Information Governance Steering Sub Committee.
- Successful submission of the new Children and Younger Persons Dataset (CYDS) focusing on the high level of data quality and which showed the trust to be one of the highest for data quality.
- Continued production of Routine Data Quality Reports available via the Trust's Intranet - these reports highlight missing and out of date data fields.

***SEPT did not submit records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.*** *Note: This was due to significant system upgrade running over 2016/17 with submission due to re-commence with month 12 data which will be provided in April 2017.*

*The projected percentage of records in the published data:*

*1) which included the patient's valid NHS Number was:*

- *99.15% for admitted patient care;*
- *99.96% for outpatient care; and*
- *Accident and emergency care – Not applicable*

*2) which included the patient's valid General Medical Practice Code was:*

- *98.96% for admitted patient care;*
- *99.89% for outpatient care; and*
- *Accident and emergency care – Not applicable*

***SEPT's Information Governance Assessment Report overall score for 2016/17 was 74% and was graded Green (Level 2 or above (Satisfactory)).***

***SEPT was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.***

***We will be taking the following actions to improve data quality:***

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

## 2.5 National Mandated Indicators of Quality

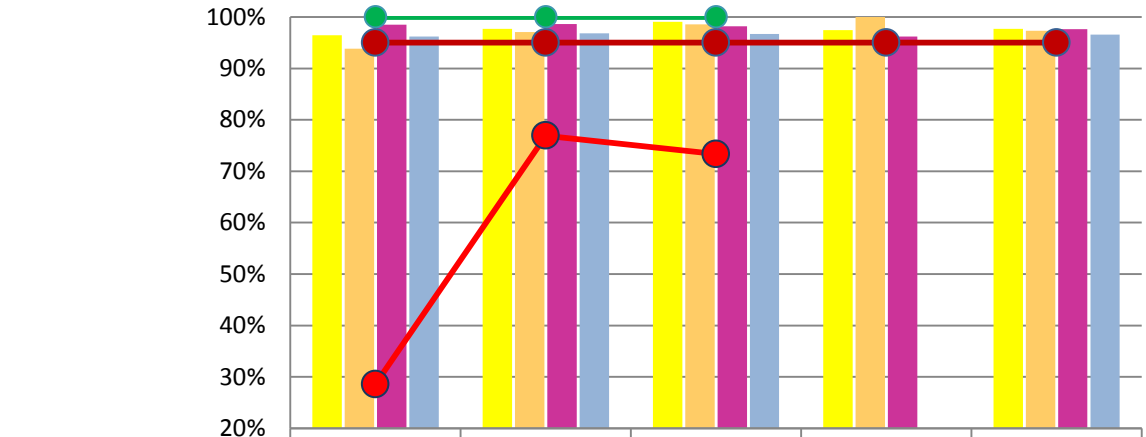
A letter from NHS England dated 6th January 2017 and guidance from NHS Improvement (previously Monitor) published in February 2017 outlined the reporting and recommended audit arrangements for Quality Accounts / Reports for 2016/17. The National Health Service (Quality Accounts) Regulations 2010 had been previously amended to include changes of the mandatory reporting of a core set of quality indicators. Those indicators relevant to the services SEPT provided during 2016/17 are detailed below, including a comparison of SEPT's performance with the national average and also the lowest and highest performers. The information presented for the mandated indicators has been extracted from nationally specified datasets, and as a result, is only available at a Trust-wide level.

The provision of mental health services in Bedfordshire and Luton transferred to a new provider from 1st April 2015. Historical data (ie up to 31st March 2015) for this service has only been retained in this section where it has not proved possible to disaggregate the SEPT figures and such indicators are marked clearly.

Please note, we have reported the latest actual position on the graphs in the section below and have included details of the figure reported at quarter end to NHS Improvement (formerly Monitor) via the Health and Social Care Information Centre (and to the Board of Directors) where this is different in the associating narrative. Such differences in the quarterly figures will occur in some instances due to information / data being received after the national submission / report to the Board of Directors.

The letter from NHS England dated 6th January 2017 asked NHS Trusts to consider including in Quality Reports/Accounts again this year the results from the NHS Staff Survey indicators relating to the "percentage of staff experiencing harassment, bullying or abuse from staff" and the "percentage of staff believing their Trust provides equal opportunities for career progression and promotion". The results of these indicators are therefore included at the end of this section.

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




| | Q1 | Q2 | Q3 | Q4 | Outturn |
|---|---|---|---|---|---|
| SEPT 2014-15 | 96.5% | 97.7% | 99.0% | 97.5% | 97.7% |
| SEPT 2015-16 | 93.8% | 97.1% | 98.6% | 100.0% | 97.30% |
| SEPT 2016-17 | 98.5% | 98.6% | 98.2% | 96.2% | 97.65% |
| All Trusts 2016-17 | 96.2% | 96.8% | 96.7% | | 96.6% |
| Highest Performer | 100.0% | 100.0% | 100.0% | | |
| Lowest Performer | 28.6% | 76.9% | 73.3% | | |
| Target | 95.0% | 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.

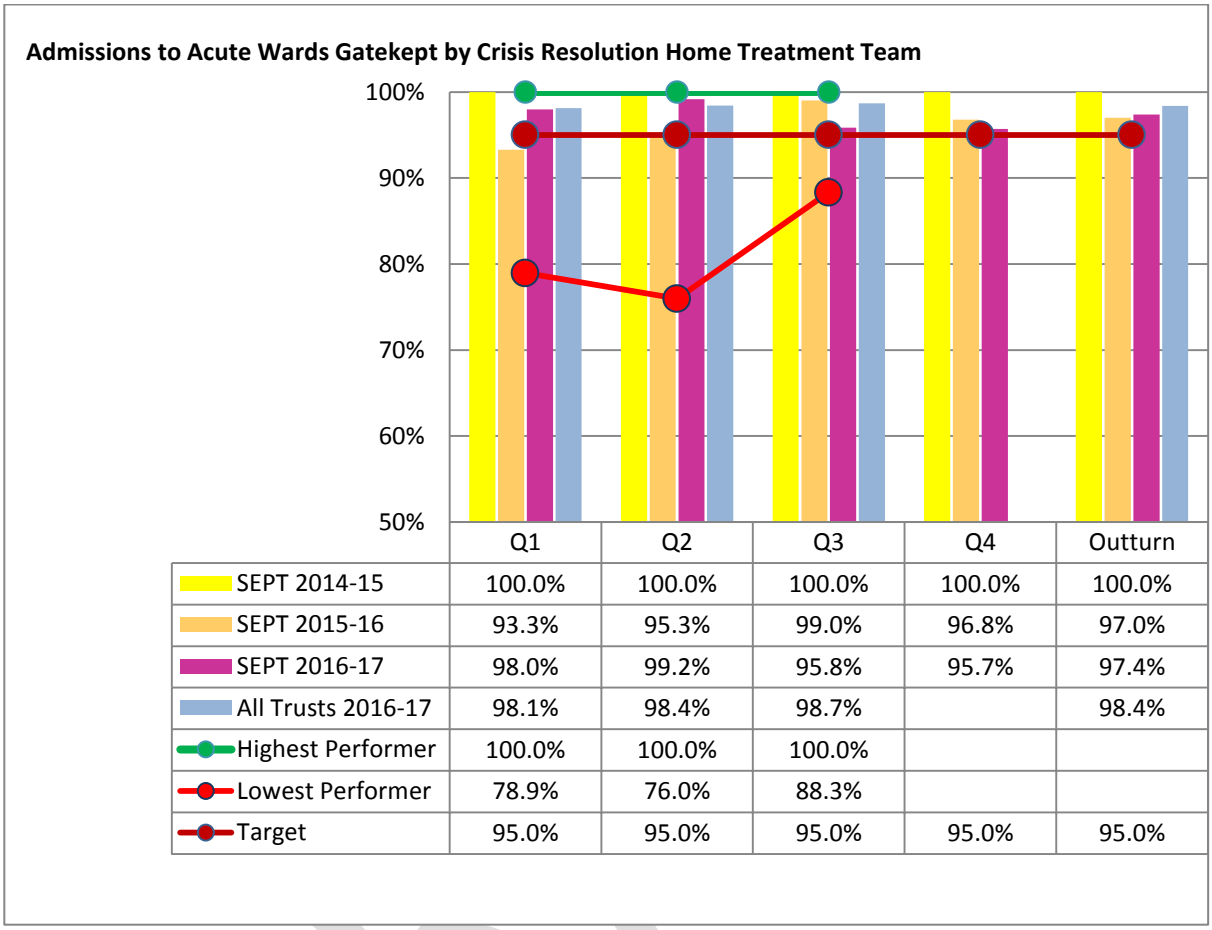
This target has been met consistently each quarter during 2016/17 and for the year as a whole.

In order to improve this percentage and thus the quality of its services, SEPT has been routinely monitoring compliance with this indicator on a monthly basis and identifying the reasons for any patients not being followed up within seven days of their discharge. Any identified learning is then disseminated across relevant services.

*Please note, at the time of preparing this draft, Q4 figures (and refreshed Q1 – 3 figures) are still to be published nationally and figures may subsequently change in the final published Quality Report.*

**Data Source :** DoH Unify2 Data Collection – MHPrvCom
**National Definition** applied: Yes

Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team




| | Q1 | Q2 | Q3 | Q4 | Outturn |
|---|---|---|---|---|---|
| SEPT 2014-15 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| SEPT 2015-16 | 93.3% | 95.3% | 99.0% | 96.8% | 97.0% |
| SEPT 2016-17 | 98.0% | 99.2% | 95.8% | 95.7% | 97.4% |
| All Trusts 2016-17 | 98.1% | 98.4% | 98.7% | | 98.4% |
| Highest Performer | 100.0% | 100.0% | 100.0% | | |
| Lowest Performer | 78.9% | 76.0% | 88.3% | | |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |

This indicator measures the percentage of adult admissions which are gatekept by a crisis resolution / home treatment team.

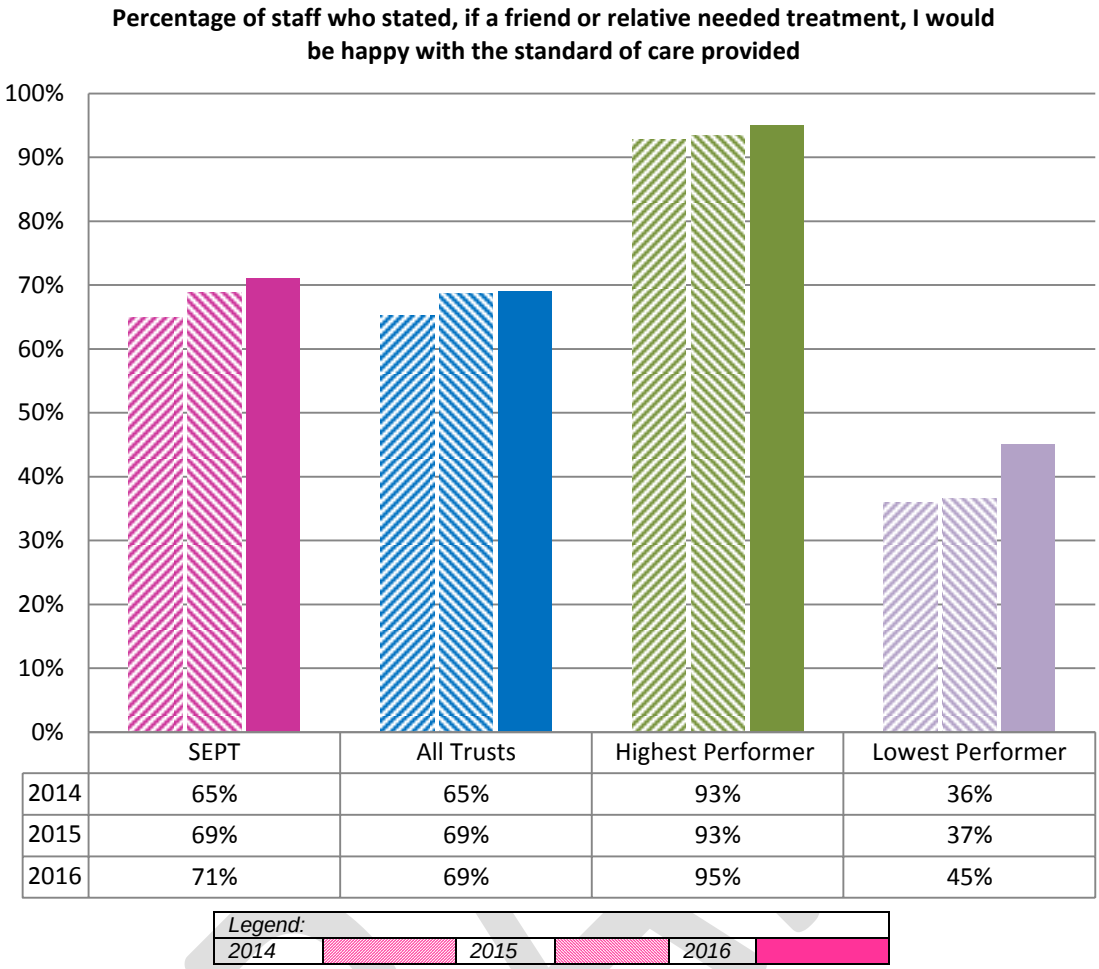
This target has been met consistently each quarter during 2016/17 and for the year as a whole.

In order to improve this percentage and thus the quality of services delivered, the senior operational staff in each locality responsible for the delivery of mental health services review the causes of any breaches each month to ensure that no common themes or trends are developing.

*Please note, at the time of preparing this draft, Q4 figures (and refreshed Q1 – 3 figures) are still to be published nationally and figures may subsequently change in the final published Quality Report.*

**Data Source :** DoH Unify2 Data Collection – MHPrvCom
**National Definition** applied: Yes

Staff who would recommend the Trust to their family or friends




| | SEPT | All Trusts | Highest Performer | Lowest Performer |
|---|---|---|---|---|
| 2014 | 65% | 65% | 93% | 36% |
| 2015 | 69% | 69% | 93% | 37% |
| 2016 | 71% | 69% | 95% | 45% |

SEPT participates on an annual basis in the national staff survey for NHS organisations. Within the survey staff are asked to answer the question "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation".

This year ALL staff received a survey – instead of just a sample size as per previous years. 1800 surveys were returned giving a response rate of 43%. This is an excellent response rate and carrying out a full census survey means we are able to get a truer picture of the levels of engagement within the organisation.

Our response rate remains in line with other combined mental health / learning disability and community trusts in England.

It is pleasing to note that the percentage of staff who stated that they would be happy with the standard of care provided if a friend or relative needed treatment continues to increase. Our level of satisfaction on this question is now above average nationally.

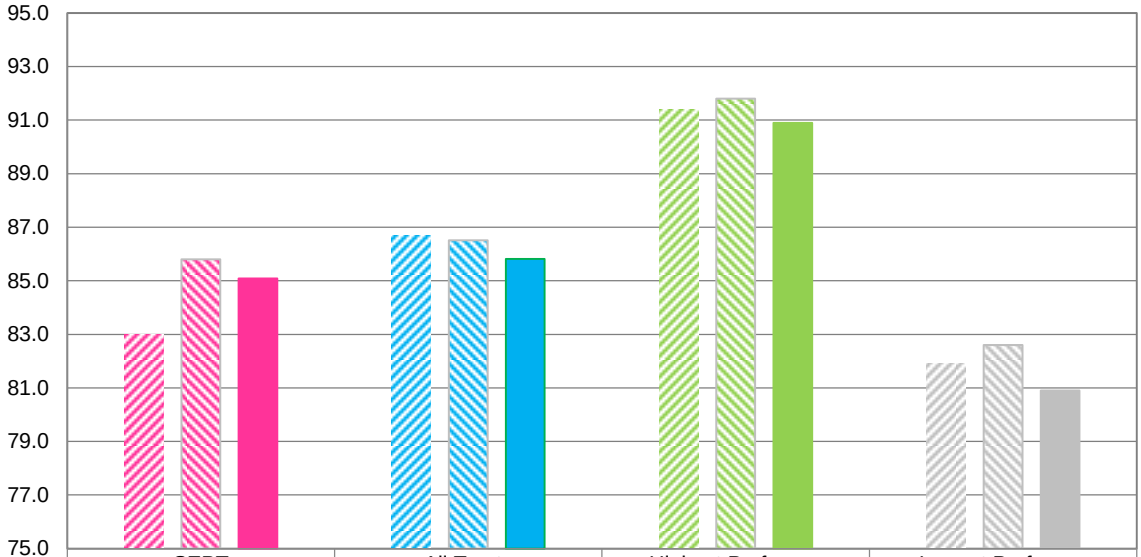
A full action plan to address the results of the staff survey is being implemented in order to ensure that the Trust continues to achieve positive results in this area. This will focus on our lowest performing areas of the survey and those questions where we were below the national average (only five out of a total of 32 questions).

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

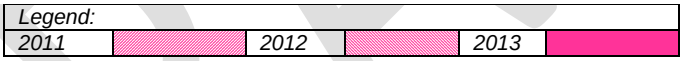
**Data Source:** National NHS Staff Survey Co-ordination Centre/ NHS Staff Surveys 2014, 2015, & 2016
**National Definition applied:** Yes

## Patient experience of community mental health services

The Trust's 'Patient experience of community mental health services' indicator score reflects patients' experience of contact with a health or social care worker. The score was calculated as a weighted average of the responses to four distinct questions.

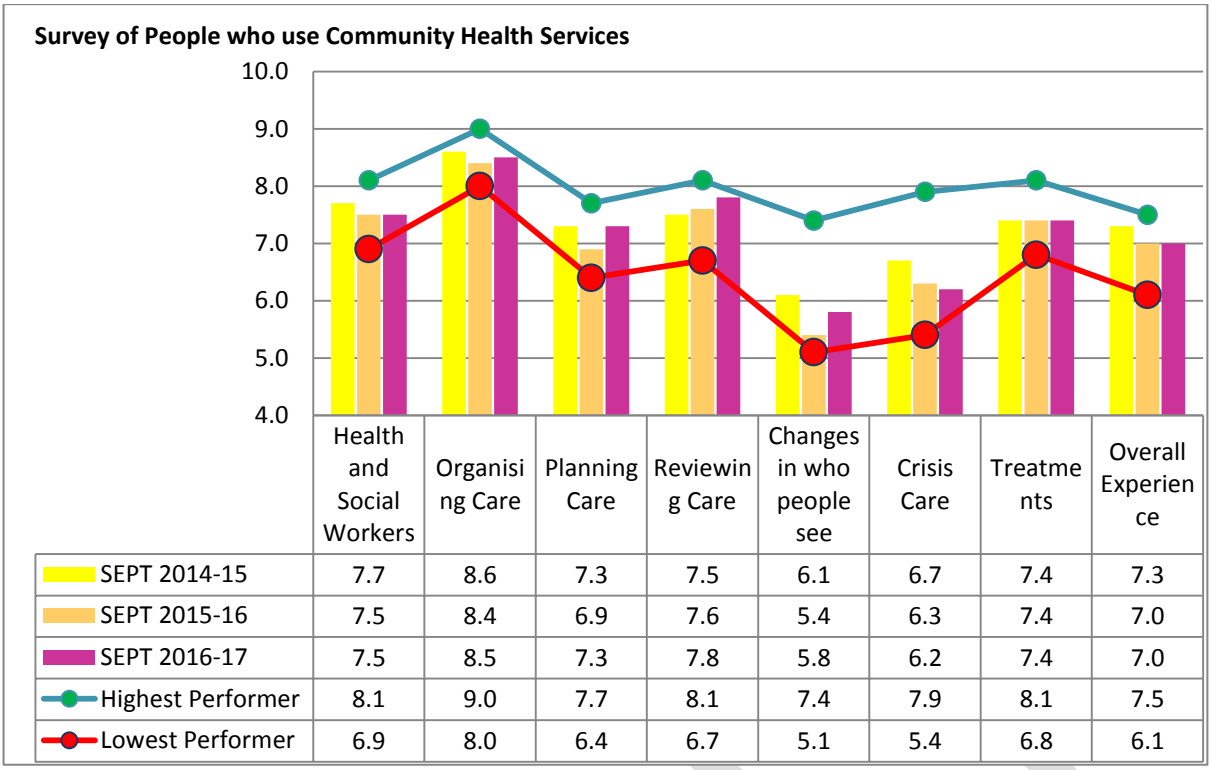



| | SEPT | All Trusts | Highest Performer | Lowest Performer |
|---|---|---|---|---|
| 2011 | 83.0 | 86.7 | 91.4 | 81.9 |
| 2012 | 85.8 | 86.5 | 91.8 | 82.6 |
| 2013 | 85.1 | 85.8 | 90.9 | 80.9 |




*Please Note: Although the Trust has been mandated to provide this indicator in its Quality Account, due to a change in the national patient survey questions in 2014, the Health and Social Care Information Centre are no longer able to use the same questions to calculate an overall measure of patient experience for Trusts as they had done in previous years (and as reported above). Therefore, please find following a summary of the key section results of the Survey for 2014, 2015 and 2016 for information. The outcomes of all the community mental health surveys nationally can be found at http://www.cqc.org.uk/content/community-mental-health-survey .*

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.




| | Health and Social Workers | Organising Care | Planning Care | Reviewing Care | Changes in who people see | Crisis Care | Treatments | Overall Experience |
|---|---|---|---|---|---|---|---|---|
| SEPT 2014-15 | 7.7 | 8.6 | 7.3 | 7.5 | 6.1 | 6.7 | 7.4 | 7.3 |
| SEPT 2015-16 | 7.5 | 8.4 | 6.9 | 7.6 | 5.4 | 6.3 | 7.4 | 7.0 |
| SEPT 2016-17 | 7.5 | 8.5 | 7.3 | 7.8 | 5.8 | 6.2 | 7.4 | 7.0 |
| Highest Performer | 8.1 | 9.0 | 7.7 | 8.1 | 7.4 | 7.9 | 8.1 | 7.5 |
| Lowest Performer | 6.9 | 8.0 | 6.4 | 6.7 | 5.1 | 5.4 | 6.8 | 6.1 |

The results of the 2016/17 community mental health patient survey show that SEPT has scored “About the Same” as the England average and our score is within the expected range of results.

The results of the 2016/17 are compared in the graph above to the two previous years by section score. Across the eight section scores, SEPT is showing improvement in four sections, remaining the same as last year in three sections. However patient experience of crisis care has deteriorated slightly from 6.3/10 in 2015-16 to 6.2/10 in 2016-17

The Trust has developed an action plan to address the outcomes of the National Survey, ensuring that targeted action is taken to improve the quality of services. Its implementation is being overseen by the Senior Management Team, led by the Executive Director responsible for Mental Health Services.

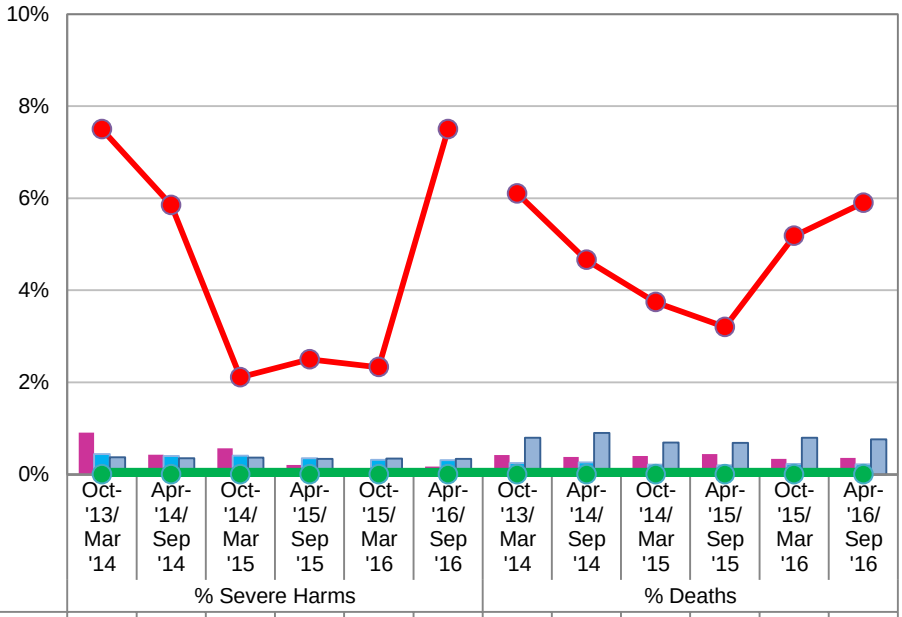
Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

**Data Source:** HSCIC/Community Mental Health Services Surveys
**National Definition applied:** Yes

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

| Reported Dates | 1st October 2015 – 31st March 2016 | | | 1st April 2016 - 30th September 2016 | | |
|---|---|---|---|---|---|---|
| Organisation | All incidents | Severe harm | Deaths | All incidents | Severe harm | Deaths |
| All UK & Wales | 906202 | 2875 | 2121 | 938314 | 2893 | 2032 |
| SEPT | 3807 | 2 | 13 | 3581 | 6 | 13 |

The graphs below shows the percentage of all incidents reported by SEPT to the NRLS that resulted in severe harm and those which resulted in death, compared to the rates of all UK & Wales NHS trusts, all Mental Health Trusts, and also includes the highest and lowest reported rates of all UK & Wales NHS trusts.




| | % Severe Harms | | | | | | % Deaths | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Oct-'13/ Mar '14 | Apr-'14/ Sep '14 | Oct-'14/ Mar '15 | Apr-'15/ Sep '15 | Oct-'15/ Mar '16 | Apr-'16/ Sep '16 | Oct-'13/ Mar '14 | Apr-'14/ Sep '14 | Oct-'14/ Mar '15 | Apr-'15/ Sep '15 | Oct-'15/ Mar '16 | Apr-'16/ Sep '16 |
| SEPT | 0.91% | 0.43% | 0.57% | 0.21% | 0.05% | 0.17% | 0.42% | 0.38% | 0.40% | 0.44% | 0.34% | 0.36% |
| All Trusts | 0.44% | 0.40% | 0.41% | 0.35% | 0.32% | 0.31% | 0.25% | 0.26% | 0.21% | 0.20% | 0.23% | 0.22% |
| All Mental Health Trusts | 0.37% | 0.35% | 0.37% | 0.34% | 0.34% | 0.34% | 0.80% | 0.90% | 0.69% | 0.68% | 0.80% | 0.76% |
| Highest Reported | 7.50% | 5.85% | 2.11% | 2.50% | 2.33% | 7.50% | 6.10% | 4.66% | 3.74% | 3.20% | 5.18% | 5.90% |
| Lowest Reported | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |

Patient safety data for period 1st October 2015 to 31st March 2016 was published in September 2016. The report for the next 6 month period, ending 30th September was published in March 2017. The national collection of patient safety incident data for period 1st October 2016 to 31st March 2017 is due to be completed by the end of May 2017 and publication of reports is anticipated to be around September 2017.

The rate of incidents resulting in severe harm (detailed on the left-hand side of the above table/graph) which had previously shown a downward trend has increased in the final 6 months reported. These figures for the most recent period where national data is available show SEPT's % of severe harm (0.17%) remains below the national average for All Trusts (0.31%) and for All Mental Health Trusts (0.34%). The rate of incidents reported as resulting in death (detailed on the right-hand side of the above table/graph) is 0.36% for SEPT for the latest reported period. Whilst higher than the national average for All Trusts (0.22%), this compares favourably with the national average of All Mental Health Trusts (0.76%) and the highest reported rates of death (5.90%).

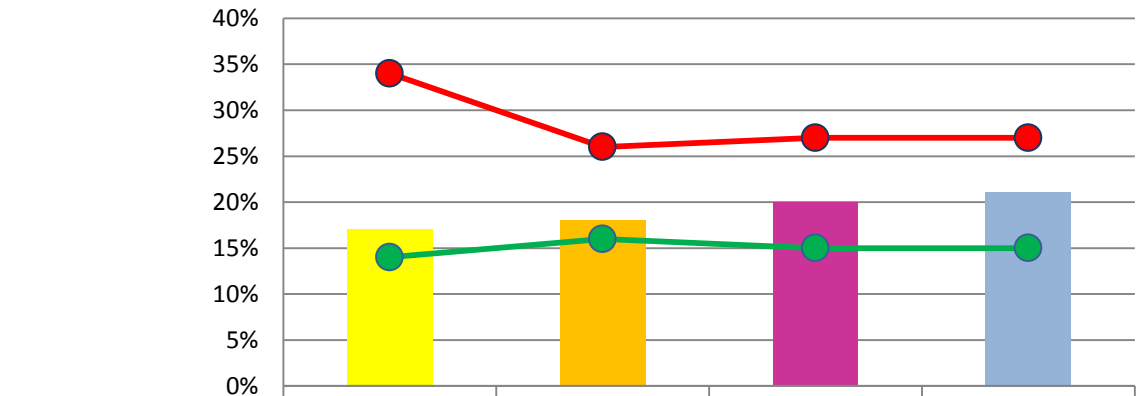
Significant work has been and continues to be taken forward across the Trust to reduce harm and details of some of this work are included throughout this report. A number of the quality priorities for the coming year outlined in section 2.2 are specifically intended to reduce incidents resulting in harm; and work in this area will continue to be monitored closely by the Trust.

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

**Data source**: NRLS NPSA Submissions
**National Definition applied**: Yes

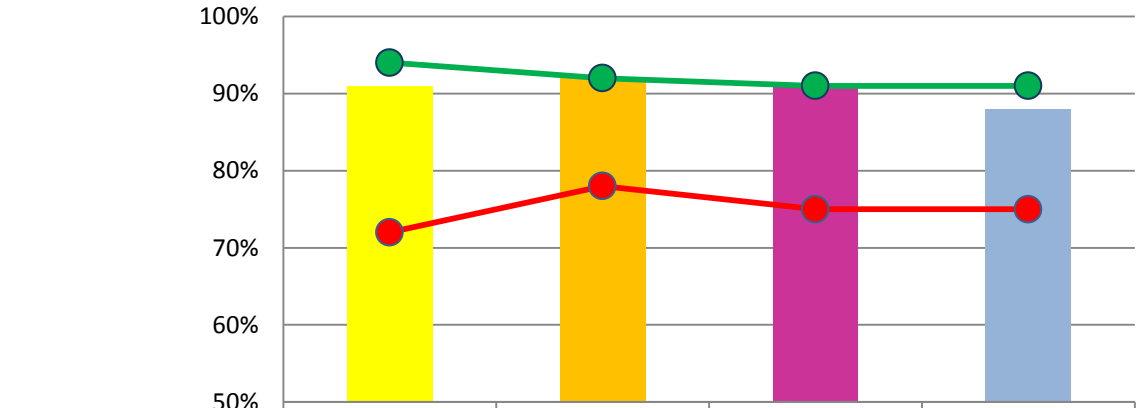
Workforce Race Equality Standard

**KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months**




| | 2014 SEPT | 2015 SEPT | 2016 SEPT | All Trusts 2016 |
|---|---|---|---|---|
| % SEPT Score | 17% | 18% | 20% | 21% |
| Highest Performer | 34% | 26% | 27% | 27% |
| Lowest Performer | 14% | 16% | 15% | 15% |

**KF21 Percentage of staff believing that trust provides equal opportunities for career progression or promotion**




| | 2014 SEPT | 2015 SEPT | 2016 SEPT | All Trusts 2016 |
|---|---|---|---|---|
| % SEPT Score | 91% | 92% | 91% | 88% |
| Highest Performer | 94% | 92% | 91% | 91% |
| Lowest Performer | 72% | 78% | 75% | 75% |

Even though we remain under the highest levels nationally, this year shows a steady increase in the proportion of respondents that have experienced some form of harassment or bullying at work. A specific bullying and harassment action plan has therefore been developed to address this over the financial year 2017/18 and progress in implementation will be monitored.

We are very pleased at the level of perception that there are career opportunities and our scores in this area are within the top scoring bracket for trusts of our type.

The work to improve the experience of our black, asian and minority ethnic workforce will be contained within its own Workforce Race Equality Standard (WRES) action plan which will be published with our full staff survey results in July 2017.

Please note that historical figures include Bedfordshire and Luton Mental Health Services which transferred out of SEPT in April 2015 as it is not possible to extract these from the data published nationally.

**Data Source:** National NHS Staff Survey Co-ordination Centre/ NHS Staff Surveys 2014, 2015, & 2016

**National Definition applied:** Yes

## 2.6 Implementing the Duty of Candour and "Sign up to Safety"

This year, NHS England have again asked Trusts to consider including information in their Quality Reports relating to the implementation of the Duty of Candour and of the national Sign Up To Safety (SUTS) campaign. The following sections therefore outline the progress made by SEPT in 2016/17.

### *Implementing the Duty of Candour*

The *Duty of Candour* is the requirement for all clinicians, managers and healthcare staff to inform patients/relatives of any actions which have resulted in harm. It actively encourages transparency and openness and the Trust has a legal and contractual obligation to ensure compliance with the standard. SEPT has considered such openness and transparency to be vital in ensuring the safety and quality of services; and has continued to drive forward work in this area.

Work undertaken in 2016/17 has included:

- Mandatory online training courses for staff as follows:
  - Short overview course for all clinical staff
  - Detailed course for managers/team leads and senior staff.
- Duty of Candor and Being Open session included within Trust induction.
- The identification of a Family Liaison Officer / Duty of Candour lead for all serious incidents and weekly reporting to the Executive Team.
- Information and evidence in terms of meeting Duty of Candour requirements collated within Datix system.
- Weekly review of all moderate incidents to assess if the Duty of Candour is applicable and ensuring that necessary actions are taken.
- The addition of Duty of Candour sections to root cause analyses reports and the Decision Monitoring Tool for Serious Incidents to ensure it is addressed for all incidents.
- The introduction of monthly reporting in the Trust's Performance Report of relevant incidents, with weekly progress chaser / situation reports sent to Directors and senior managers.

The Trust is confident that the ongoing work being taken is contributing to the on-going development of a culture which is open and transparent.

### *Implementing "Sign up to Safety" (SUTS)*

The Trust has been committed to "Sign Up To Safety" (SUTS), a national safety campaign, since its launch in June 2014. The mission of the national campaign is to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. A Safety Improvement Plan was developed by the Trust and submitted to NHS England. The Plan covers six priorities aligned with the Quality Strategy as follows:

- Early detection of deteriorating patient
- Avoidable pressure ulcers
- Avoidable falls
- Avoidable unexpected deaths
- Reduction in use of restraint
- Reduction in omitted doses of medication

These align with the six Quality Priorities SEPT set for 2016/17 (progress reported in section 3.1 of this report) and with Quality Priority 1 set for the new merged Trust (EPUT) for 2017/18 detailed in section 2.2.

Leads have been assigned to each of the "Sign up to Safety" workstreams to ensure the Safety Improvement Plan actions are taken forward and monthly meetings have been held with these workstream leads

throughout the year to review progress. A regular update on each workstream is presented to the Quality Committee. Key actions delivered this year include:

- Recruitment to Practice Educator posts with a focus on supporting staff with physical health skills.
- Review of the early warning scoring system chart (MEWS) and incorporation of a hydration status and Glasgow Coma Scoring chart to encourage an integrated approach when monitoring vital signs.
- Review of mandatory falls prevention training and implementation of a training package based on the national “Fallsafe” project.
- Development and recruitment to a new post of Falls Co-ordinator with responsibility for the provision of support to nursing, therapy and medical staff to provide a systematic approach to falls prevention and management.
- Investment in a wide range of falls prevention assistive technology and a digital reminiscence therapy system for older people’s wards that helps clinical staff in the delivery of better care by tailoring meaningful activities for their patients.

The leads have continued to work with the national team to ensure best practice is implemented in the Trust and have also made links with a number of other organisations involved in the initiative with the aim of sharing best practice and learning. Work has taken place to align NEP and SEPT SUTS workstreams and actions; and a new SUTS action plan is to be developed for EPUT in 2017/18.

## PART 3:
## REVIEW OF SEPT QUALITY PERFORMANCE DURING 2016/17

This section of the Quality Report outlines the Trusts performance over the past year in terms of delivering on the quality priorities set out in the SEPT Quality Report 2015/16. It also details performance against some key indicators of quality service which have been reported on in previous years. The tables include previous year's results too as this gives an indication of whether the Trust is getting better at quality or if there are areas where action needs to be taken to improve. Where this is the case, we have detailed the actions we intend to take.

This part of the Quality Report is divided into five sections, as follows:

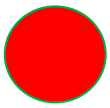


To enable readers to get an understanding of the Trust's performance in local areas, performance against indicators is detailed by locality area where it is possible to do so.

## *Section 3.1: Progress against the quality priorities we set for 2016/17*

The SEPT 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 six Quality Priorities for 2016/17. These built on our quality priorities for 2015/16 and are linked with the national 'Sign up to Safety' Campaign.

RAG (**R**ed **A**mber **G**reen) 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.



**R**AG rated **RED** to indicate that performance has not met the target by more than 10%
(Avoidable Falls employs a 20% threshold due to small numbers)

R**A**G rated **AMBER** to indicate that performance has met the target by +/- 10%.
(Avoidable Falls employs a 20% threshold due to small numbers)

RA**G** rated **GREEN** to indicate that performance has exceeded the target by more than 10%.
(Avoidable Falls employs a 20% threshold due to small numbers)

The provision of mental health services in Bedfordshire and Luton was transferred to a new provider from 1st April 2015. Data for these services has therefore been extracted for the purposes of the historical data presented in this section so that it is possible to make meaningful year-on-year comparisons of the data presented.

**Quality priority**: To reduce the number of restrictive practices undertaken across the Trust

**TARGET:** *We said we would have less prone restraints in 2016/17 compared to 2015/16 (266 prone restraints)*

**Data source**: Datix
**National Definition applied**: Yes

**Why did we set this priority?**

Across health and social care services, people who present with behaviour that challenges are at higher risk of being subjected to restrictive interventions. These can include physical restraint, seclusion and segregation. Many restrictive interventions place people who use services, and to a lesser degree staff and those who provide support, at risk of physical and/or emotional harm. Increasing concerns about the inappropriate use of restrictive interventions across health and care settings led to guidance being developed.

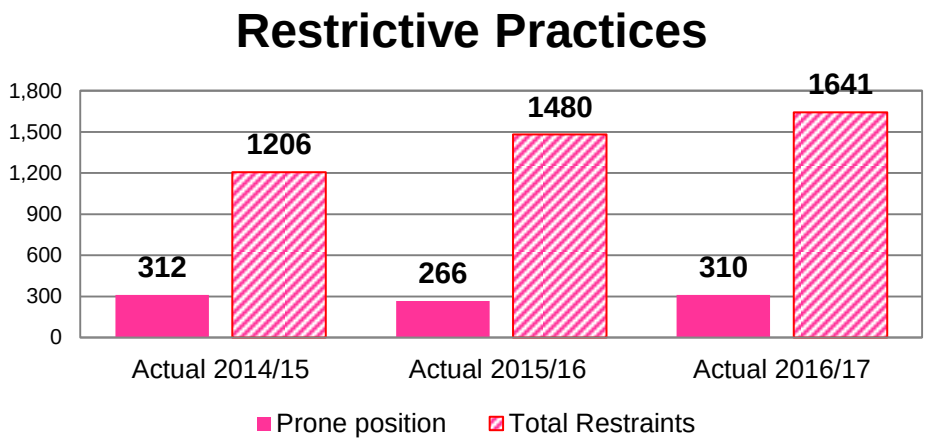
**During 2016/17 we have taken the following actions:**

- Worked to NICE guidance of Management of Violence and Aggression.
- Reviewed and updated training programmes.
- Built on existing networks across health to support best practice and learned from other trusts.

**Has the target been achieved?**

The Trust has not achieved this target. During 2016/17 the number of prone restraints was 310, which is an increase on the 266 reported in 2015/16. The table below also illustrates an increase in total reported restraints (from 1480 to 1641). These increases are considered likely to be the result of increased awareness and reporting of restrictive practices due to the focused work in this area and also a rise in the number of patients who presented particularly challenging behaviours. Following the publication of the DOH benchmarking report on the use of restraints, further analysis of the use of restraints has been undertaken. The figures show that using the DOH benchmark of restraints per 10 beds, SEPT has a monthly average of 2.85 uses of restraint per 10 beds over the year to date. This is higher than the national average of 2.80.

Reduction in the number of restraints in in-patient areas has again been set as a quality priority for 2017/18 and monitoring processes are in place. A programme of work is in place with the aim of achieving a reduction; implementation progress and numbers of restrictive practices will be closely monitored through 2017/18. The Restrictive Practice Steering Group has also set a target for zero avoidable restraint which will be monitored.

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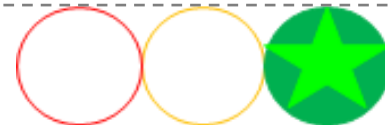
## 3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

**Quality priority**: To further reduce the number of avoidable grade 3 and 4 Pressure Ulcers acquired in our care.

**TARGET:** *We said we would have less avoidable grade 3 and 4 pressure ulcers acquired in our care in 2016/17 compared to 2015/16.*

*A total of 17 avoidable pressure ulcers were identified following RCAs for 2015/16.*

**Data source**: Datix
**National Definition applied**: Yes



**Why did we set this priority?**
Avoidable pressure ulcers are seen as a key indicator of the quality of nursing care and preventing them happening will improve all care for vulnerable patients. Within SEPT over the past 3 years, we have had an ambition for 'no avoidable pressure ulcers' and a number of areas of work had been taken forward with significant progress, but this work needed to be sustained to meet our ambition.

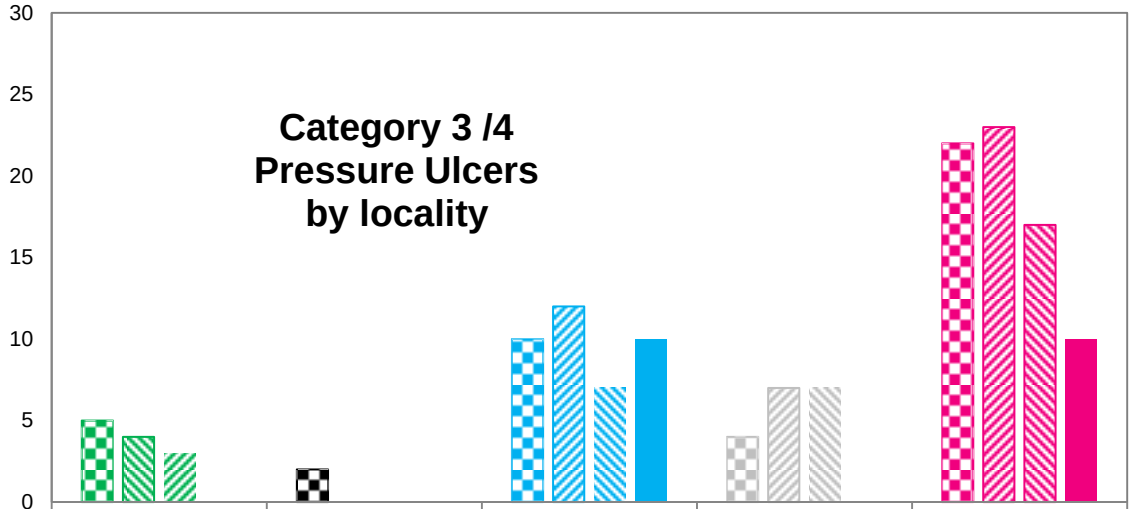
**During 2016/17 we have taken the following actions:**

- Continuation of Skin Matters groups within each community service.
- Facilitated an independent review of Skin Matters panels to ensure robust procedures/scrutiny continue, and that learning identified during the review process is taken forward.
- Learning from RCAs undertaken for category 3 and 4 pressure ulcers shared with teams.
- Review of policy and procedures to ensure compliance with NICE Guidance and European Pressure Ulcer Advisory Panel (EPUAP) guidance.
- Developed and embedded a process for reporting and managing Suspected Deep Tissue Injuries (SDTIs).
- Celebrating World Stop the Pressure Day with events held to engage with the public over supporting themselves and relatives to understand the risks and how to avoid pressure ulcer development.
- Tissue Viability Nurse attendance at regional networking meetings, national and international conferences to ensure awareness of best practice developments and innovations are considered and implemented where appropriate.
- Review of National Sign Up To Safety work streams regarding pressure ulcers.
- Formulary reviews with pharmacy and wound management colleagues to ensure prescribing guidelines and product availability are in line with best practice.
- Initiated a review of diabetic foot ulcer prevalence in South East Essex to consider the next steps in taking forward a work stream relating to this issue.
- Confirmed our commitment to the NHSI relaunch of the ambition to reduce/eliminate avoidable pressure ulcers.
- Formalised a reporting process for poor discharges for patients from acute trusts (in the context that pressure ulcer management has featured in a percentage of poor discharges).

**Has the target been achieved?**

The Trust has achieved this target. During 2016/17 the Trust has identified 10 avoidable grade 3 / 4 pressure ulcers, which is seven fewer than in 2015/16. In addition, it is very positive to note that two out of the three community health services have achieved zero avoidable pressure ulcers.

The variation in the number of pressure ulcers in South East Essex compared to other localities is attributed to different SEPT services being commissioned in each area, together with different operating practices within these services. The Trust has commissioned an analysis of the reporting of avoidable grade 3 /4 pressure ulcers across localities to determine the root cause of the variation. In addition, the Skin Matters process has identified areas of learning required within the community teams and these are being addressed through formal and informal education sessions, enhanced supervision for staff (including reflective practice) and review of pathways for equipment provision to ensure they are clear and comprehensive.




| | Bedfordshire CHS | South Essex MH | South East Essex CHS | West Essex CHS | SEPT |
|---|---|---|---|---|---|
| 2013/14 | 5 | 2 | 10 | 4 | 22 |
| 2014/15 | 4 | 0 | 12 | 7 | 23 |
| 2015/16 | 3 | 0 | 7 | 7 | 17 |
| 2016/17 | 0 | 0 | 10 | 0 | 10 |

*Please note, one additional avoidable pressure ulcer identified in SEECHS in 2015/16 after publication of the Quality Report 2015/16 as a result of RCAs completed after preparation of the document.*

The Trust also has 45 Root Cause Analyses underway at the end of 2016/17 and there is the potential for some of these to be classified as avoidable grade 3 / 4 pressure ulcers when the investigations are complete. As a comparator, last year the Trust had 115 Root Cause Analyses underway at the end of 2015/16 and only one additional avoidable grade 3 / 4 pressure ulcer was identified when the investigations were complete.

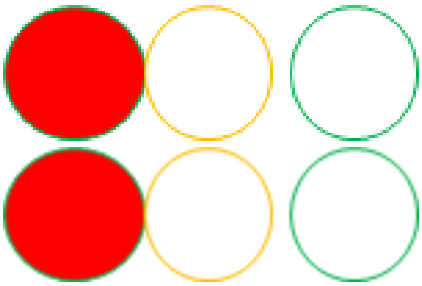
## 3.1.1 Safety 3.1.2 Experience 3.1.3 Effectiveness

**Quality priority**: Reduction in avoidable falls that result in moderate or severe harm within inpatient areas

**TARGETS:**

*1. We said we would have less avoidable falls that result in moderate or severe harm in 2016/17 compared to 2015/16.*

*2.We said we would have a reduction in the number of patients who experience more than one fall in 2016/17 compared to 2015/16 ( 203 ).*



**Data source**: DATIX
**National Definition applied**: Yes

**Why did we set this priority?**

Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community 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, resulting in an annual cost to the NHS of around £1.7 billion for England. Of this, 45% of the cost is for acute care, 50% for social care and long term hospitalisation, and 5% for drugs and follow up.

The causes of falls are multifaceted. People aged 65 years and older have the highest risk of falling, with 30% of the population over 65 years and 50% of those older than 80 years falling at least once a year. People admitted to hospital are extremely vulnerable as a result of their medical condition, as are those with dementia. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in those over the age of 75 years. Prevention of falls is a vitally important patient safety challenge as the human cost includes distress, pain, injury, loss of confidence and independence and, in some cases, death. Since 2013/14, the trust has had a priority to reduce the level of avoidable falls, and again a number of areas of work had been taken forward with significant progress, but this work needed to be sustained to meet our ambition.

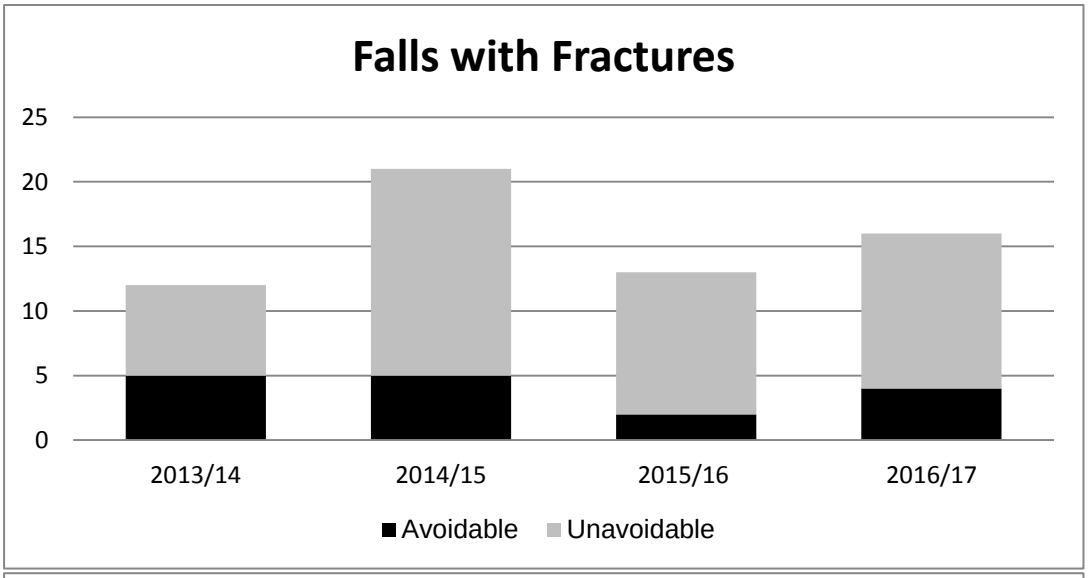
**During 2016/17 we have taken the following actions:**

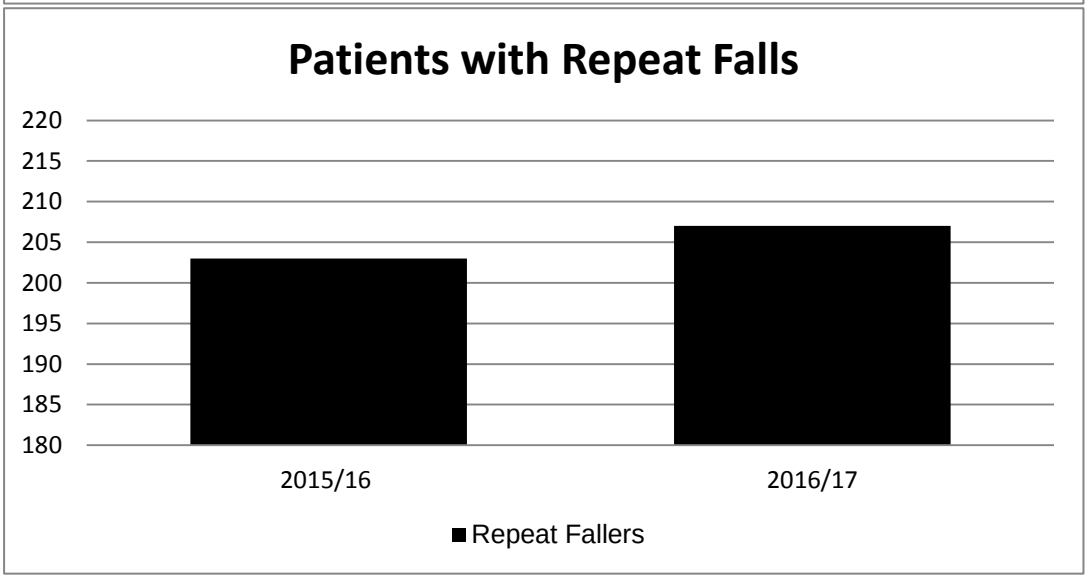
- Continuation of the Trust wide Falls Group with strengthened multi-disciplinary membership.
- Introduced a training package for registered staff on older people's wards based on the national Fallsafe Project. This includes patient risk factors, environmental risk factors, the use of specialist equipment and actions to be taken following a fall.
- Face to face training has also been delivered on olders people's inpatient units.
- Further reviewed the Trust wide Risk Assessment tool to ensure that the complex nature and causes of falls were captured and to support clinical decision making in the prevention and management of falls.
- Refinement of the Root Cause Analysis tool.
- Recruitment to a new post of Falls Co-ordinator – a physiotherapist with responsibility for taking a primary role in providing support to staff around falls prevention and management.
- Purchase of a digital reminiscence therapy system for older people's wards.

**Have the targets been achieved?**

The target to have fewer avoidable falls has not been met. During 2016/17 there was a total of 4 avoidable falls (out of a total of 16 falls classified as serious incidents). This is an increase of 2 against the total of 2 avoidable falls in 2015/16. However, this figure still represents a significant decrease from the baseline of 14 avoidable falls when falls work started in 2013/14 and the number of falls classified as serious incidents has decreased from 21 in 2014/15 to 16 in 2016/17.

The target to reduce the number of patients who experience more than one fall has not been met. During 2016/17 there was a total of 207 patients who experienced more than one fall compared to 203 for 2015/16. This represents an increase of 2%. It is possible that increased awareness of repeat fallers and a concurrent improvement in reporting rates have contributed to the increase in the number of repeat fallers identified.




We continue with our commitment to provide a safe and therapeutic environment for all patients in our care. The trust is one of nineteen in the country to be part of the NHSI Falls Collaborative, of which only three are mental health/integrated mental health and community health trusts. Participation in this important initiative will provide staff with vital quality improvement skills and create a system devoted to continuous learning and improvement.

We will continue work in this area through our Sign Up To Safety workstream. Further work will include targeted support to those areas where patients experience the greatest number of falls. This will include the introduction of Falls Care Bundles which are a set of interventions that, when used together, significantly improve patient outcomes.

## 3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

**Quality priority**: To embed system of early detection of deteriorating patient and preventative actions

**TARGET 1:** *We said we would increase the % of Modified Early Warning System (MEWS) scores recorded during 2016/17 from the baseline established in 2015/16 (70%).*

**TARGET 2:** *We said we would increase the % of MEWS scores greater than 4 (or a single score of 3) that are escalated appropriately (57%).*

**Data source**: Audit
**National Definition applied**: Yes

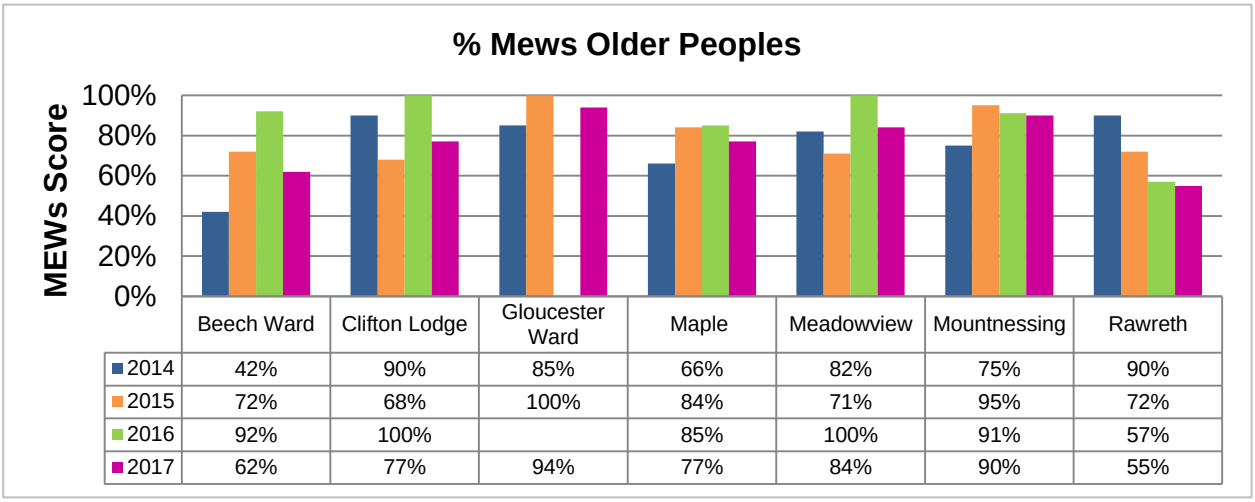
**Why did we set this priority?**
People with mental illness today have life expectancies as low as that of the general population of the UK in the 1950s and they account for more than a third of the 100,000 annual avoidable deaths from physical illnesses in the UK each year. They have three times the risk than the general UK population of dying from preventable coronary artery disease and are more likely than the general UK population to develop preventable and treatable long term physical health conditions (such as type 2 diabetes and hypertension) which, if unmanaged, are key causes of early preventable death. Physical healthcare assessment is a vital part of the holistic assessment and supports early detection of deteriorating patients. Current evidence suggests that early detection, timeliness of response and competency of the staff involved are vital to defining positive clinical outcomes.

**During 2016/17 we have taken the following actions:**

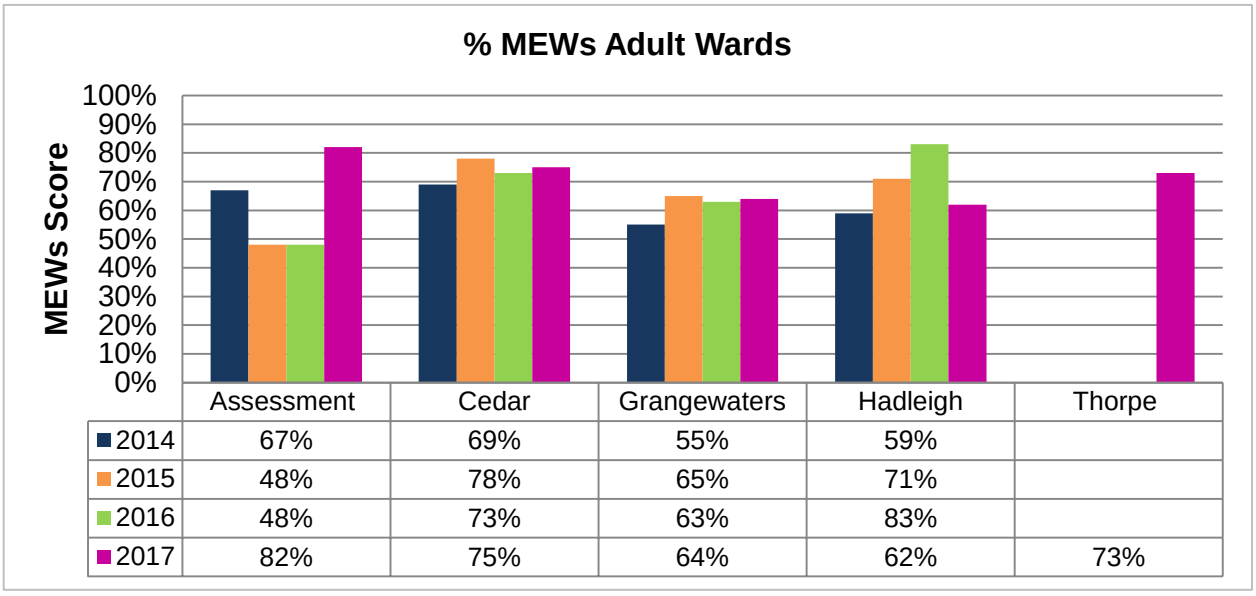
- The observation chart used to monitor patients' physical vital signs and act as an early warning system (MEWS) has been reviewed and revised to support more effective reporting. The aim of the scoring system is to standardise assessment of the severity of acute physical illness so that patients who are deteriorating physically or at risk of deteriorating are identified and managed consistently.
- The trust recruited to two fixed term Practice Educator posts with a focus on supporting staff with physical health skills and in particular how to identify patients who are or may becoming acutely physically unwell.
- Training in vital signs monitoring, interpretation and escalation of concerns continued and in order to maximise uptake, was delivered through a number of routes including being added to existing mandatory training. Additionally staff were supported with training in the clinical environment using scenario based situations on detecting patients who were becoming acutely physically unwell.
- The audit on use of MEWS has been expanded to include a review of patients with a raised MEWS score who are escalated appropriately.

**Has the target been achieved?**

The target to increase the % of MEWS scores recorded has not been achieved. Audits have been undertaken during 2016/17 which have resulted in an overall figure of 70% of MEWS scores being recorded. This is the same as the baseline figure of 70% for 2015/16. Two audits are undertaken per year and it is disappointing to note that the improved results of the first audit in 2016/17 were not maintained throughout the financial year and evidenced in the final audit result of 70%. The graphs below demonstrate baseline findings and use of MEWS from the recent audit on both older peoples and adult wards.




| | Beech Ward | Clifton Lodge | Gloucester Ward | Maple | Meadowview | Mountnessing | Rawreth |
|---|---|---|---|---|---|---|---|
| 2014 | 42% | 90% | 85% | 66% | 82% | 75% | 90% |
| 2015 | 72% | 68% | 100% | 84% | 71% | 95% | 72% |
| 2016 | 92% | 100% | | 85% | 100% | 91% | 57% |
| 2017 | 62% | 77% | 94% | 77% | 84% | 90% | 55% |




| | Assessment | Cedar | Grangewaters | Hadleigh | Thorpe |
|---|---|---|---|---|---|
| 2014 | 67% | 69% | 55% | 59% | |
| 2015 | 48% | 78% | 65% | 71% | |
| 2016 | 48% | 73% | 63% | 83% | |
| 2017 | 82% | 75% | 64% | 62% | 73% |

The target to increase the % of patients with a MEWS score greater than 4 (or a single score of 3) that are escalated appropriately has not been met. In 2016/17 the Trust escalated 22%, compared to the 2015/16 baseline of 57%. Inpatient staff have confirmed that they escalate following indications of deterioration and action is taken and discussions take place during handover. We will continue to ensure that our patients receive the safest and most effective care. This will be achieved through supporting staff working in mental health in the development of quality improvement skills and the knowledge and understanding required to recognise and respond to physical health deterioration. An action plan is being developed to address the decrease in escalation. Further work is underway to introduce the principles of the deteriorating patient to the annual mandatory Enhanced Emergency Skills training to increase coverage of training. In addition, on-site training has been delivered to the wards.

## 3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

**Quality priority**: Reduction in unexpected deaths (suicides)

**TARGET**: *We said we would implement a bespoke training package for suicide intervention and train 50% of relevant mental health front line staff during 2016/17.*

**Why did we set this priority?**

Around 4,400 people end their own lives in England each year, that is one death every two hours and at least 10 times that number attempt suicide. People with a diagnosed mental health condition are at particular risk and around 90% of suicide victims diagnosed with a mental illness suffer from a psychiatric disorder at the time of their death, although three-quarters of all people who end their own lives are not in contact with mental health services. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

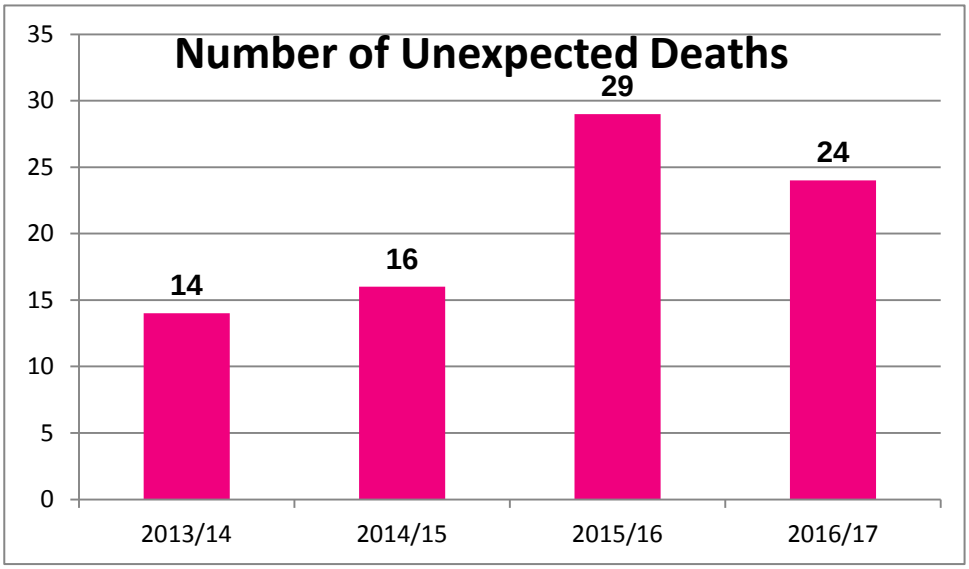
**During 2016/17 we have taken the following actions:**

- Reviewed the training programme and implemented a bespoke training programme targeted at equipping staff with the knowledge and skills to deliver appropriate interventions with the aim of preventing suicide.
- Purchased the "Connecting with People" suicide prevention training package consisting of three distinct modules. Seven clinicians have been trained to deliver the modules.
- In January 2017 it was recognised that more trainers were required to roll out the training and the Trust has therefore commissioned further "train the trainer" training for 8 more clinicians.
- Training was initially targeted at CRHT, First Response and the Mental Health Assessment Unit staff, but any available places have been utilised for other clinical staff.
- Engaged further with all members of the multi-disciplinary team to deliver suicide prevention culture across the Trust.
- Undertaken baseline audits of current practice in the detection and prevention of suicide, identify actions to be taken forward and repeat audits at agreed timeframes to monitor improvements.
- Raised public awareness.
- Purchased a range of self-help leaflets which complement the training and allow clinicians to make emergency safety plans with people in distress.

**Has the target been achieved?**

Training commenced at the end of quarter three and, as at the end of quarter four, 58 staff had been trained. This is below the target of 50% of frontline staff set. However, the requirement for additional trainer capacity to achieve the required roll out was identified in January 2017 and an additional 8 trainers are to be trained which will improve the capacity to roll out training to front line staff. The training will be reviewed with colleagues from North Essex who have also been providing training as part of the NEP Sign up to Safety Suicide Prevention work-stream, with a view to agreeing the training approach to be adopted by EPUT into the future.

Although the training target has not been achieved, the graph below indicates that an overall reduction in the number of unexpected deaths from 29 in 2015/16 to 24 in 2016/17 has been achieved.



## 3.1.1 Safety | 3.1.2 Experience | 3.1.3 Effectiveness

**Quality priority**: To reduce the number of medication omissions across the Trust and to reduce the number of medication omissions where no reason code is annotated.

**TARGET:** *We said we would reduce the number of omitted doses within services in 2016/17, compared to 2015/16.*

**Data source**: Audit
**National Definition applied**: Yes

**Why did we set this priority?**
Care Quality Commission standards require that people who use services will have their medicines at the time they need them and in a safe way. Between 2005 and 2010 more than 82,000 incidents involving omitted and delayed medicines were reported nationally to the National Reporting and Learning System (NRLS). 'Omitted and delayed medicines' was the most commonly reported category, accounting for nearly 16% of all medication incidents.

For some medicines such as antibiotics, anticoagulants and insulin, a missed dose can have serious or even fatal consequences. In some conditions it may lead to slower recovery or loss of function.

Doses of medicines may be omitted for a variety of reasons. Causes include:
- a valid clinical reason for not giving the medicine;
- the intention to prescribe a new or regular medicine is not carried through;
- the medicine is not available on the ward / in the patient's home;
- the route of administration is not available (i.e. nil by mouth, IV line tissued);
- 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.

**During 2016/17 we have taken the following actions:**
- Continued with Medicines Task and Finish Group as part of the Sign up to Safety campaign;
- Improved the reporting of omitted doses of medicines which occur within Community Health Services, especially community-based services; and
- Reviewed omitted medicines incidents as part of quarterly review of medication-related incidents at both Medicines Management Groups.

**Has the target been achieved?**
The Trust has not achieved the target to reduce the incidence of omitted doses.

| | **Total doses to be administered during period** | **Total doses omitted** | **% Omitted Doses** | **% Omitted Doses** adjusted for clinical omissions ( inc patient refusal ) |
|---|---|---|---|---|
| MH & LD | 29,665 | 1,215 | 4.1% | 0.8% |
| CHS | 7,515 | 324 | 4.3% | 1.3% |
| **Total** | **37,177** | **1,539** | **4.1%** | **0.9%** |

The 2017 audit demonstrated a slight deterioration over the 2016 results (0.9% compared with 0.8% in 2016), but overall this regular audit demonstrates an improving trend over the previous six years (2016 0.8%, 2014 1.3%; 2013 1.5%; 2011 1.9%).

In *Mental Health Services,* 29,665 doses of medication were due to be administered during the audit period. 0.8% of doses were omitted without a valid clinical reason (including patient refusal) against 1.2% in the audit undertaken in 2015/16.

In *Community Health Services*, 7.512 doses of medication were due to be administered during the audit period. 1.3% of doses were omitted without a valid clinical reason (including patient refusal) against 0.4% in the audit undertaken in 2016.

The Trust has developed a Safety Improvement Plan to support its commitment to the national Sign up to Safety campaign. The Sign up to Safety launch was used as an opportunity for front-line staff to volunteer or be nominated to participate in the future work of this workstream. Further actions identified at present include:

- Establishing the primary and secondary drivers for reducing the number of omitted doses which there is no clinically valid reason.
- Continue DATIX reporting and identify any areas to link with further improvements.
- Improving reporting of omitted doses of medicines which occur within Community Health Services, especially community-based services.
- Develop a mechanism for providing feedback to teams & services on reported incidents.
- Explore the use of a regular reporting tool, such as the NHS Medication Safety Thermometer to promote ownership at ward/team level.
- Explore potential training and resources within mental health and learning disabilities services to improve understanding of the risks associated with omitted doses of medication for physical health conditions.
- Explore whether advice is needed on how to approach patients who refuse medication.

## *Section 3.2:* Examples of local service quality improvements and Trust Workforce Developments during 2016/17

Outlined below are some examples of quality improvements that have been achieved by SEPT services during 2016/17 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 volume 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.

### Bedfordshire Community Health Services (Adults)

- Adult services are working with Local Authority colleagues to discuss the **development of improved integrated discharge planning** and develop more robust communication and monitoring systems.
- **Health Care Assistants** working with Community Nursing teams are now **delivering Low Molecular Heparin injections** to increase registered nursing time available for other responsibilities.
- Palliative Care nurses have introduced **Advanced Care Planning** and are implementing an **Outcome Assessment Complexity and Collaboration (OACC) pilot**. Discharge planning support packs have been distributed to 5 local acute trust providers to improve discharge planning processes and to aim to reduce unsafe discharges.
- All specialist nursing services are now using **Peer Review processes to review patient documentation** in order to improve record keeping and care planning standards.
- **Community Matron caseload is now shared with both acute trusts weekly** to improve communication routes and provide the opportunity for patients to be turned around in emergency departments back into community services if appropriate.

### Bedfordshire Community Health Services (Childrens)

- Collaboration to implement the **Asthma Friendly Schools** programme: all early years settings and schools staff have received training to manage emergency action on Asthma. School nurses are supporting the co-ordination of asthma champions in every school in Bedfordshire.
- **Future in Mind Schools project** is now in place where School Nurses offer emotional wellbeing support to young people and collaborate with Child and Adolescent Mental Health Service workers based in upper schools across Bedfordshire.
- Development of 11 **Perinatal and Infant mental health champions** across the 0-19 service who will train all partner agencies in detection and support of mothers with postnatal depression.
- Collaboration with ELFT to deliver the **Mums Matter's programme** for parents with perinatal mental health needs.
- Successful delivery of **25,263 vaccines** to school age children across Bedfordshire.
- Redesign of the **websites for both Health Visiting and School Nursing** to improve accessibility and information provision for families with children 0-19 years.
- Development and cascade of **Working Agreements** between Health Visiting and GP's and School Nurses and schools to enhance communication, relationships and working together.
- Development of the **Nurse Led Continence Pathway** including workshops for parents with children with complex needs.
- Roll out of **Health Passports** to improve communication between partners who work with children with complex needs.
- Development of an **Integrated Autism Pathway** including Nurse led clinics for post diagnosis follow up.

### Bedfordshire Community Health Services (Specialist)

- The Nutrition and Dietetic Service undertook an **audit of obesity referrals** in to the service for Luton which they have presented to Luton Borough Council as part of obesity pathway redesign to influence future commissioning and service design for childhood obesity.

- The Nutrition and Dietetic adult services completed a service review following which **internal processes have been redesigned to create capacity and increase flexibility** within the service to meet unpredictable and fluctuating demands.
- Introduction of an **eligibility assessment telephone appointment** before booking a dietitian home visit (for both home visit referrals and home-enterally fed patients) in order to eliminate unnecessary home visits, therefore creating capacity to help cope with rising demands and complexity of referrals.
- **Redesign of nutrition and dietetic clinics** by amending sessions, timings of appointment slots, method of booking appointments and creation of letter writing guidelines within the department. This has led to a decrease in admin time for dietitians and administrative staff, decreased DNA rates and decreased waiting times from 12-14 weeks to 8-9 weeks for adults. In addition, paediatrics have reduced 18 week breaches by 80% despite a rising number of referrals.
- **Streamlining of triaging/coding of referral processes** including creation of standard letters within the nutrition and dietetic department. This has resulted in reduced dietitian administrative time as referrals can be processed more quickly therefore patients are waiting less time to receive referral acknowledgment.
- The Food First team have developed **referral criteria and a new referral form for older people care homes** to use. In addition, referrals which are declined are evaluated to ensure appropriateness and safety of the criteria.
- The Food First team have updated their **care home audit standards** to ensure a more objective and consistent approach when awarding a Food First Care Home Certificate.
- The Food First team have employed a **Data Analyst** to free up dietetic time for other responsibilities and have employed a **Specialist Paediatric Dietitian** to support appropriate prescribing of infant formulas at primary care level.
- The Food First team have **designed and updated the Luton oral nutritional supplement prescribing guidelines.**
- The Food First team **presented at national events** - Food Matters Live and British Dietetic Association's BDA Vision.
- Paediatric Occupational Therapy has delivered **parent, carer and professionals workshops** for understanding sensory issues in children and young people.
- Development of a pilot project for the **prevention of foot ulcer in diabetic patients.** The project is designed to determine the efficacy of insoles, in deflecting the pressures from the vulnerable areas in diabetic feet and preventing plantar ulcers occurrences or relapse. This is an ongoing project and the records will be finalised by the end of November 2017.

**Children's Services – South East and West Essex**

- **FNP Adapt -** As part of the Southend 'A Better Start' programme we have been working with the Family Nurse Partnership (FNP) National Unit on FNP Adapt, which involves testing personalisation of the FNP programme. As part of this work we are extending the criteria for entry to the programme to ensure all the most vulnerable clients can access the service whilst enabling us to flex programme delivery to clients in order for us to meet their individual needs.
- **Partnership working with the Third Sector in Sexual Health Services -** We are working in partnership with Brook, a Third organisation, who specialise in the delivery of sexual health services for young people with very positive outcomes. Brook have been delivering the My Life, My Way programme to young people in Southend. This is a programme that was co-produced with young people which enables individuals and groups of young people to 'take charge' in order to improve their own health and well-being by exploring skills, goal setting and becoming more emotionally resilient.
- **Launch of the Children, Young People & Families Strategy (2016-19) -** The Trust wide Children, Young People & Families strategy was launched June 2016. This has been well received as it sets out a clear direction amongst the highly complex and changing environment of services for children, young people and families.
- **Development of Quality Champions and increasing the use of technology -** Given the client group it was felt that the use of technology was potentially a missed opportunity to engage with our target client groups using ways that are popular, easily accessible and most likely to be preferred by children and young people. We have had two Quality Champions (one from Health Visiting and one from Paediatric Speech & Language Therapy) who have been working on a project in relation to the use of communication technology within children's services. A West Essex Community Health Visiting Face book site is now active with followers beginning to sign up. The site contains information in relation to

the local Health visiting service including well child clinic provision, group & health promotion activities and contact details for local teams. We also hope to post health promotion messages linking into national campaigns. Followers can post a message for routine enquiries and will receive a response from one of the dedicated team within 3 working days. For any urgent enquires they are signposted to their GP or other local services. The local children centres are promoting the site within their settings to increase awareness which is positive. A dedicated team of staff in each locality lead by one of the clinical leads is monitoring activity on the site and moving forward will ensure its content is kept current and relevant for our service users within West Essex.

- **Parent Talk Essex project -** Over the last two years Health Visitors in West Essex have continued to work with Essex County Council, FutureGov researchers and clients to develop an interactive app which can enable antenatal and new parents to engage with each other and services in a unique and supportive way. This project has now advanced to the level of piloting the app with a group of antenatal women in the West Essex area. The app is named "Everymum"-meet other local mums to be. The development of this tool has been a true joint venture with clinicians, researchers, local authority and most importantly the women who will be using it and is based on what they valued in the current services and what would make services better for them.
- **Relationship Matters project -** Children's Services in West Essex have been supporting the relationship matters project being sponsored by Essex County Council focussed on the Waltham Abbey locality. One Plus One worked with frontline practitioners from Children's Centres, Health Visiting, Midwifery, Speech and Language Therapy and Family Solutions to test a professional development offer aimed at enhancing 'relational capability' through a mixture of activities and learning styles which included practitioner observations, specialist coaching, group learning and reflection. Alongside this they carried out research with families and professionals in Essex to gain a better understanding of why and how relationships matter, and what can hinder the development of trusting relationships. The results of this work have confirmed much of the hypothesis and Identified 10 key steps to improve and develop relational working.

## South East Essex Adult and Older People's Community Health Services

- The **Care Co-ordination Service for Castle Point & Rochford** was initially set up as a 12 month pilot in 2016/17 and will now be commissioned as a core service in 2017/18 and onwards. An independent assessment of the team's work carried out by CP&R CCG demonstrated a positive impact on acute activity reduction, a positive experience for patients and their carers, a saving on the prescribing spend and that more people had been supported to remain independent in their own homes. The core aim of the service is to identify frail patients at risk of decline and intervene at an early stage to assess patients, plan their care and provide support to ensure that they can remain healthy, independent and out of hospital for as long as possible.
- The **Complex Care Coordination service for Southend** was launched as an 18 month pilot in January 2017 and is a proactive service improvement aimed at enhancing the user's quality of care and health and social wellbeing outcomes. The service focusses on appropriate case management with an emphasis on pre-empting the escalation of the user's health and social care needs to prevent or delay deterioration. The service has been commissioned by NHS Southend Clinical Commissioning Group (CCG) and will see health and social care staff from a number of agencies working side-by-side including local GP practices, social care and housing, community physical and mental health and substance misuse.
- South East Essex Diabetes Specialist Nurses and Podiatrists became part of the **Integrated Diabetes Service**, led by Southend University Hospital NHS Foundation Trust in September 2017, working alongside acute physicians and nurses and increasing the team to include Dietitians and Psychologists. The new Service is designed to deliver a streamlined, cohesive and patient focused pathway that enables rapid access, when appropriate, to a comprehensive diabetes skilled team. A key component of the new service is strong multi-disciplinary working with weekly outpatients for patients in a community setting. The Integrated Diabetes Service covers both Southend and Castle Point CCG areas and will triage all referrals, determining appropriate clinical pathways, and provide specialist advice where requested or noted as clinically appropriate within 72 hours. The implementation of a pump service in the area will allow eventual repatriation of patients who are currently treated out of area.
- The **Community TB (Tuberculosis) Service** expanded in 2016/17 in respect of a further contract with Mid Essex providing risk assessments, TB screening, contact tracing and management along with patient education. This is for a resident population of 383,600 (covering Chelmsford, Braintree,

Halstead and Maldon). The team already provide similar services to West Essex and South East Essex residents.

- From January 2017, a new proactive care model for **Neighbourhoods/Localities** went live on Canvey Island. Weekly proactive care MDTs take place, identifying and care co-ordinating people with moderate needs to prevent or delay a crisis or the need for more intensive health and social care services. This model of care is already demonstrating improvement in efficiency (e.g. quicker direct referrals) and improved individual outcomes (e.g. increased independence). We are also scoping co-location of health, social and third sector staff within the neighbourhood to further develop integrated working and maximise benefits. Our neighbourhood model is a blueprint which can be adapted to every area with local demographic tweaks. For example we have seen wholesale acceptance of this model in Southend. This will form the basis of future integrated models of care to be utilised within south east Essex, and aligns to the principles being applied as part of the Mid and South Essex Success Regime of building resilient Out of Hospital models of care.
- The **Adult Speech and Language Therapy Service** developed an integrated process across Southend and Castle Point & Rochford for the management of assistive technology devices communication aids. This included improved access to devices and streamlined processes for the management of stock, including recycling. The proposal for improving the process gained agreement and additional funding from commissioning colleagues, and this will mean much extended use of devices such as I pads, I pods and light writers for people with communication difficulties.
- The **Tissue Viability Service** marked the international 'Stop The Pressure' awareness day on 17th November 2016 through a number of initiatives. This included training in pressure ulcer management and prevention for carers, raising public awareness in local shopping centres and drop-in clinics at health centres in the area. The service has worked closely with colleagues in Podiatry to develop a new wound formulary which will assist all clinicians involved in wound care in the community.

## South Essex Learning Disability Services

- The **Occupational Therapy Posture Service** is a collaborative project between Occupational Therapy, Speech and Language Therapy and Physiotherapy. Clinics are held with follow-up appointments, with the aim of improving the functional ability of those with complex postural needs; prevention/slowing down if further postural issues; improved collaboration between services in the management of an individual's posture; increased awareness of families and carers of the impact of postural issues.
- The LD Psychology Service has been working for a number of years to increase accessibility for people with LD who may require a dementia assessment. In 2016, the remit was extended to consider the **support offered by the LD Service to those with a diagnosis of dementia**. A multi-disciplinary group have produced a checklist that can be used as a guide for assessment, hence ensuring that a holistic approach is adopted and all possible interventions and forms of support are considered.
- The LD Psychiatrists have increased their role in **offering home visits** for those people with an LD who present with acute deterioration in mental health and/or challenging behaviour outside of planned clinics.
- The LD Health Facilitation Service has been **praised for the support given to those people with LD and their relatives/carers who were at the end of life care pathway and died due to physical health problems.** This praise was given to them following an independent review into the death of people with LD known to SEPT following a national report into the mortality of people with LD, specifically premature deaths.
- The LD community nursing service (Health Facilitation Service and Intensive Support Team) now offer a **daily duty system**. A Duty Person is allocated each day to ensure that all new referrals are screened in a timely manner and that assessments for new referrals are planned and undertaken. They also respond to crisis calls and ensure that, where indicated, an urgent home visit is made or regular telephone contact is maintained. If, following the call to duty, it is felt that the individual requires more intensive and consistent support then they are allocated to a member of the Intensive Support Team.

## South Essex Mental Health Services

- **REACH (Recovery, Empowerment, Achievement, Community and Hope), the South East Essex Recovery College**, was launched in January 2017. The previous work done by SEPT mental health services to pilot a Recovery College set the foundation to develop South Essex Recovery Colleges and SEPT mental health have continued to be a key driving force in the development of REACH and

continue to be an active consortium partner in REACH. REACH is an environment where people with lived experience support one another to a better way of life, creating opportunities to learn in a safe and supportive environment and to apply learning in daily life.

- South East Essex Community Perinatal Mental Health Services were successful in clinically leading a joint bid with North Essex Partnership Trust colleagues and Mental Health Commissioners for additional funding from 2016/17 to 2018/19 to **develop an Essex wide Specialist Community Mental Health Perinatal Service**. Significant progress has already been made to recruit the additional perinatal mental health staff required, draft out a service specification, begin to consult on a service model involving women with lived experience in all levels of the mobilisation plan, service design etc.. and ensure that effective links with all perinatal pathway partners are developed.
- Building on service user and focus group feedback, the **Therapy For You service has developed its on-line programme further**. This is now being re-filmed into shorter sections to meet the needs of the typical digital user of today to improve engagement. A social media campaign has been organised to operate alongside the new on-line programmes to also improve access to psychological therapies.
- The Trust has successfully run its first **cross specialties group with people from COPD, Cardiac and Stroke Services with support from IAPT.** The group was successful and the outcomes were positive both quantitatively and qualitatively. This **trans-diagnostic group** is run over five sessions and focusses on mood management, acceptance and change.
- Physiotherapists who are all trained as Postural Stability Instructors as an add-on skill and knowledge for **Falls Prevention and Management** have initiated balance and strength exercise programmes on wards at Rochford, Basildon MHU, Mountnessing Court and Meadowview. This has enabled the provision of strength and balance exercises classes for Older Adults in South Essex area as part of a multifactorial intervention programme as recommended by NICE Clinical Guidelines The Physiotherapy department is currently developing a similar 12 week balance and strength exercise programme for older adults in the community who would have otherwise been admitted for falls and fractures that may impact negatively on their functional abilities and mental health.
- **Mindfulness Based Interventions (MBIs)** have a strong evidence base across a number of mental health diagnoses. A multi-disciplinary steering group produced a Mindfulness Strategy and, in order to ensure an appropriately trained workforce is available to deliver effective MBIs, twelve multi-disciplinary staff completed a nationally recognised teacher training course in Mindfulness Based Cognitive Therapy (MBCT). MBIs are now being delivered across IAPT, Recovery and Well-being, First Response and In-patient Teams.
- An **Intermediate Care Transformation Joint Partnership between SEPT and North East London NHS Foundation Trust** is being progressed to create a community based solution that is able to flex capacity to manage patients in their own home environment, supporting patient to achieve optimal independence and reduce dependence on health and care packages for as long as possible. The success of the new model will be in part driven by a consistent and efficient referral pathway into the intermediate beds regardless of provider to ensure there are no avoidable delays in the discharge pathway. This will be achieved through a single referral pathway process for all intermediate care beds (both SEPT and NELFT) overseen through a bed screener.
- SEPT has been cited in the national Centre for Mental Health report on "Carers Support – Mental Health Carers Assessments in Policy and Practice" published in January 2017 as **'a carer-focussed organisation'**. The report includes examples of good practice in SEPT including the local authority funded carer link workers integrated into community mental health teams across Southend, Essex and Thurrock who have been integral to providing holistic and recovery focussed care for people with mental health needs and their carers.

## Specialist Mental Health Services

***Secure services in Essex, Beds and Luton:***

- Brockfield House has actively **increased patient participation in recruitment and local induction** for secure services. Patients now assess participants in pre-interview workshops, sit on the interview panel, and deliver components of the local induction programme. The feedback from both patients and staff has been very positive.
- A **peripatetic team of support workers** has been introduced at Brockfield House. The purpose of the team is to have fully inducted and trained members of staff who can be used flexibly within the service. The team reduce the use of bank and agency staff by flexibly filling gaps in the ward rota's due to annual leave, sickness, requirements for patient escorts or increased levels of observations.

- The SEPT **Criminal Justice Liaison and Diversion service**, which commenced as part of the wave 1 national pilot was **extended** in October 2016 to provide a whole Essex service. This has been achieved by working with NEP to ensure that Liaison and Diversion services deliver the national specification. Lord Bradley visited the pan–Essex liaison and diversion service in January 2017.
- Robin Pinto Unit in Luton introduced a **multi-disciplinary team (MDT) handover**. The handover gives the opportunity for all the MDT to be appraised about each patient at the start of the working day, allowing for a dynamic assessment of risk. The project received a STARS award for improving patient safety.

***Child and Adolescent Mental Health Services (Tier 4 in-patients – Poplar Ward):***

- The service has made significant headway in **reducing restrictive practice** on the unit. Just a few examples include, reviewing access to bedrooms, the introduction of mobile phone handsets and reduction in the number of restraints.
- Clinical leads on the unit have worked closely with counterparts in NEP CAMHS PICU to ensure there are **clear pathways in place** to assist with the smooth transition of young people from Poplar to PICU, and back out again, where a clinical need arises.
- The education unit for the service has achieved a **Good rating from OFSTED** at its recent inspection.

**West Essex Adult and Older People's Community Health Services**

- As part of the development of **community respiratory services**, the clinical liaison staff at the Single Point of Access have been trained to deliver a guidance pathway for patients known to the Community Respiratory Specialist Team so they can access agreed advice / pathways until 21.00 seven days per week. This enables patients to access the right support and advice to be able to self-manage during periods of exacerbation. This supports the delivery of out of hospital care and it is envisaged that this initiative will contribute to the system target for the reduction in non-elective attendances and admissions to hospital.
- As part of winter resilience initiatives, we identified that there was a need to improve the timeliness of streaming and treatment available to children at the front door of the **Urgent Care Centre, Whipps Cross**. Following discussion with the Clinical Commissioning Group and a successful funding bid, we piloted a GP with Special Interest (GPwSI) scheme, working across the urgent care centre and the emergency department. This has resulted in 680 children being seen in the service, with only 43 children being referred onto the paediatric emergency department, demonstrating the value of early and robust paediatric streaming and timely treatment.
- The **Care Home Multi-Disciplinary Team (MDT) CQUIN** has focused on the development of multi-disciplinary teams in care homes and SEPT has been a significant driver in both developing and delivering the model. This has resulted in better partnership working between care home staff, community matrons, District nurses and the MDT co-ordinator. Working together with the MDT coordinator and other partnership organisations ensures any barriers/actions identified at MDT meetings can be managed in a multidisciplinary forum which enables staff to work together in supporting the care homes to make change happen. Effective use of available capacity has also been demonstrated as the MDT co-ordinator can discuss the outcome of the MDT in relation to particular care home with relevant staff thereby reducing unnecessary overlapping activity between professionals. Community matrons are now calling the MDT co-ordinator proactively to ask advice regarding issues within the care homes.
- From 1st January 2017 the **Musculoskeletal (MSK) Physiotherapy Service** began to roll out a 'self-referral' service for patients. This commenced in the Harlow locality on 1st January, Uttlesford on 1st February and completed with roll out in Epping in March 2017. Patients aged 18 and over can self-refer to the service either by completing a questionnaire on the SEPT website or by telephone. This service has been commissioned by the West Essex Clinical Commissioning Group and is aimed at enabling patients to access the service in a timely and convenient manner without having to see their GP. It will also reduce demand on primary care, ensuring the best use of healthcare resources across the system. The MSK team continue to work closely with the Clinical Commissioning Group in adapting and continuing to improve access to this service.
- SEPT has taken an active leadership role in the development and delivery of the **Neighbourhood Model of Care** across West Essex over the last year. The development of the neighbourhood model of care has provided the opportunity to work with colleagues across the health, social care and voluntary sector to be patient-centered, act as equals and empower staff on the front line to develop new ways of working and ensure ownership of out of hospital care targets. We have contributed to specific projects

in all 5 West Essex neighbourhoods which aim to improve care closer to home for patients. These have included care home and domiciliary provider support, risk stratification and contributing to newly set up Frailty Clinics, care homes, care providers and risk stratification with which SEPT are fully involved, supporting the system targets around out of hospital care and avoiding unnecessary emergency admissions. We have recently aligned our Clinical Team leadership with that of social care and primary care to ensure robust governance and local neighbourhood leadership.

## Workforce Development

Having the right people, with the right skills, in the right roles at the right time is absolutely critical to the delivery of our quality aims and priorities. This section therefore details some examples of workforce initiatives that the Trust has undertaken over the past year - these initiatives have been designed to help to build the workforce of the future and upskill current staff, ensuring that the workforce is trained to the highest standards so that they can provide the safest and best possible care for patients and users now and into the future.

### Progression Pathways and Apprenticeship

There have been some alterations to the progression paths that are offered in the Trust as the universities and Trust prepare for the implementation of the apprenticeship levy and the removal of grants for nurse training.

As Anglia Ruskin University (ARU) are no longer offering the Foundation Degree which has been used by the Trust for some years, a partnership arrangement has been formed with Essex University for the delivery of the Higher Apprentice in Health and Social Care. This is a Level 5 qualification and delivers a similar skill set to the previous training. Progression from the Higher Apprenticeship Associate Practitioner qualification (Level 5) on to qualified nurse status will continue to be offered via a 'top up' route but this will also have an apprenticeship standard attached to it so that it will be possible to pay for this from the apprenticeship levy from 2018. Currently, the Trust has 5 Mental Health Work based learning students who are nearing the end of their course and 2 Adult nursing students who will complete later in 2017.

These programmes, combined with the Level 2 and Level 3 Heath Care Support Worker apprenticeships enable the Trust to offer clinical progression routes for staff. The Trust has a large non-clinical workforce as well and is committed to ensuring that there are development pathways for these staff. Apprenticeships are currently being offered in Business Administration (and there are staff in the Trust on all levels up to Level 4/5), Customer Service and Education and Training. Further apprenticeship routes will be considered as the standards are developed.

### Trailblazer Work

The changes to funding from Health Education England regarding nurse training, and the Government focus on apprenticeships, has meant that the Trust has started to prepare for apprenticeship nurses. SEPT has been involved in the development of the nursing standards and hopes to be one of the early implementers. The new standards will be ready for implementation from 2017 and the Trust will be working to find partner education providers.

The Trust is also the lead provider for development of the Psychological Well-being Practitioner apprenticeship standard. This has been an area of workforce that the Trust wanted to develop and it is felt that the apprenticeship route will promote recruitment from the local community which should aid retention. It is anticipated that this standard will be ready in early 2018.

### Student Education Facilitators (SEF) and Assessors

The SEFs are continuing to develop their roles and support students across the Trust. They are developing a number of short teaching sessions on areas of particular interest to students in the Trust and they lead on the delivery of the Associate Practitioner course. They have promoted the monthly student forums which are now held in Rochford as this has easy access by train.

Two dedicated assessors have been recruited to support the apprenticeship programmes delivery across the Trust. They will be running the 'off-work' learning sessions and working with the learners in their work-base to assess their progress.

**Leadership Development**

The Trust has invested in leadership development to support the in-house programmes and extend the access to NHS Leadership Academy courses. Additional optional modules have been added to the in-house management/leadership development programme with workshops on developing resilience and confidence building.

In addition, Health Education England has franchised delivery of the NHS Leadership Academy's "Mary Seacole" Programme through local trusts and this is being offered to staff at Band 7. This is a six month leadership development programme designed by the NHS Leadership Academy in partnership with global experts, the Hay Group, to develop knowledge and skills in leadership and management.

Further progression is then offered via the Anglia Ruskin Health Partnership Integrated Leadership Programme. This programme focusses on developing strategic thinking and offers learners the opportunity to take up short placements in other organisations within the local health and social care economy.

**Resources**

The Trust has continued to upgrade training facilities and equipment. Further work will be undertaken on the training venues at Epping and Rochford to ensure maximum use is made of the rooms.

E-portfolio systems are now being investigated which will enable the Trust to eliminate the need for paper files of learners' work and will enable the assessors to access work without needing to meet directly with the students.

**Student Placements**

The Trust has introduced the new nursing curricula. This means that practice staff are working with students on different curricula but with the support of the student facilitators - this transition has gone very smoothly. Running two curricula does mean that there can be difficulties with allocation of placements as the placement timetables are not co-ordinated. However, the placement teams in the Trust and the universities have worked hard to ensure that all students have had a rewarding placement experience and the student feedback has been very positive.

**Service User Co-Production – The Buddy Scheme and Course Evaluation**

The Mental Health Buddy scheme, whereby all second year Mental Health students at Anglia Ruskin University have been partnered with a service user and given the opportunity to undertake structured discussions with them on aspects of care has continued to be very well-received and was commended by the Multi-professional Deanery. Part of the Deanery Action Plan asked the Trust to consider extending the scheme to other professions. This is not quite as straightforward as other student groups tend to be smaller and tend to be on placement at diferent times. However, the workforce development team are working with the Occupational Therapy leads and plan to introduce this over the next year as a pilot.

The Trust has a very dedicated group of service users who assist with the Buddy Scheme and other projects within Workforce Development. In particular over the past year they have been involved in evaluating many of the Trust's mandatory training courses and all revised courses will be signed off by the serivce user group before delivery.

## *Section 3.3: Overview of the quality of care offered in 2016/17 against selected local indicators*

As well as progress with implementing the quality priorities identified in our Quality Report/Account last year, the Trust is required to provide an overview of the quality of care provided during 2016/17 based on performance against selected local 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.

Data for the services which transferred out of SEPT (Bedfordshire and Luton Mental Health on 1st April 2015, Suffolk Community Health Services from 1st October 2015 and Child and Adolescent Mental Health Services (CAMHS) from 1st November 2015) have been removed from this section to allow a representative comparison of 2016/17 performance with previous years.

### Trust wide indicators

The Key Performance Indicator (KPI) targets were established with the Commissioners: for C. Difficile and MRSA bacteraemia cases they must be solely attributable to the Trust and avoidable after investigation via root cause analysis (RCA).

## PATIENT SAFETY

### Hospital Acquired Infections

**Data source**: Infection Control Dept
**National Definition applied**: Yes

| Infection Control Measure | | 2014/15 Outturn | 2015/16 Outturn | 2016/17 Target | 2016/17 Outturn |
|---|---|---|---|---|---|
| Mental Health Services | Cases of avoidable C.Difficile | 0 | 0 | 0 | 0 |
| | Cases of avoidable MRSA Bacteraemia | 0 | 0 | 0 | 0 |
| Community Health Services | Cases of avoidable C.Difficile | 0 | 0 | 0 | 0 |
| | Cases of avoidable MRSA Bacteraemia | 0 | 0 | 0 | 1 |

There was one case of MRSA Bacteraemia reported in West Essex. This was reported as a Serious Incident and areas of learning for both Plane ward staff and the District Nursing team were identified.

# PATIENT SAFETY

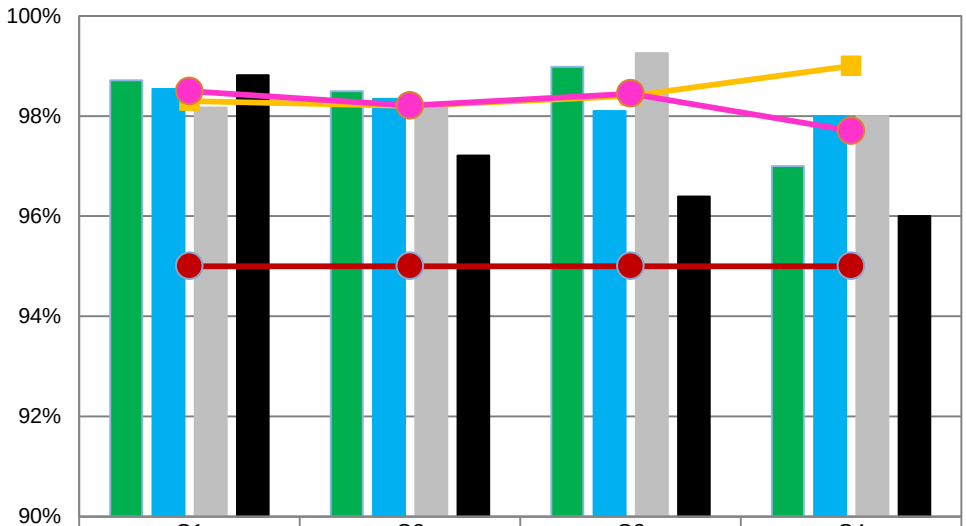
**Data source**: Safety Thermometer
**National Definition applied**: Yes

**Safety Thermometer (Harm Free Care)**

A monthly census is taken of patients in our care which meet the national criteria for Safety Thermometer to measure four areas of harm. Censuses are taken in over 100 teams covering adult and older people wards and community teams, but excluding specialist services, on a monthly basis.

The areas of harm are:- Category 2 / 3 / 4 Pressure Ulcers (acquired in care or outside our care), Falls within 72 hours, Catheter Urinary Tract Infection (UTI) or Venous Thrombo-Embolism (VTE).

The graph below show the percentage of patients that were visited or were an inpatient on the census date, who had not acquired any of the four harms whilst in SEPTs care. During 2016/17, SEPT successfully achieved above the 95% target. This information is reported to the Trust Board monthly as part of the Board of Directors Scorecards.




| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Bedfordshire CHS | 99% | 98% | 99% | 97% |
| South East Essex CHS | 99% | 98% | 98% | 98% |
| West Essex CHS | 98% | 98% | 99% | 98% |
| South Essex MH | 99% | 97% | 96% | 96% |
| SEPT 2015-16 | 98% | 98% | 98% | 99% |
| SEPT 2016-17 | 98% | 98% | 98% | 98% |
| Target | 95% | 95% | 95% | 95% |

# PATIENT EXPERIENCE

## 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 2016/17 a total of 5 complaints (2.4%) were referred to the Parliamentary & Health Service Ombudsman. This is six less than the 11 (5%) referred in the previous year.

One was partially upheld and the Trust was asked to acknowledge failings and apologise for the impact this had on the patient. The Trust was also asked to produce an action plan to describe the lessons learned and what the Trust will do to avoid a recurrence in the future.

The PHSO investigation has been discontinued for one referral and investigations are ongoing for the other three complaints.

### Complaints closed within timescales

The "% 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 99% for complaints closed within agreed timescale. This is an improvement on the 98% achieved in the previous financial year

### 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.

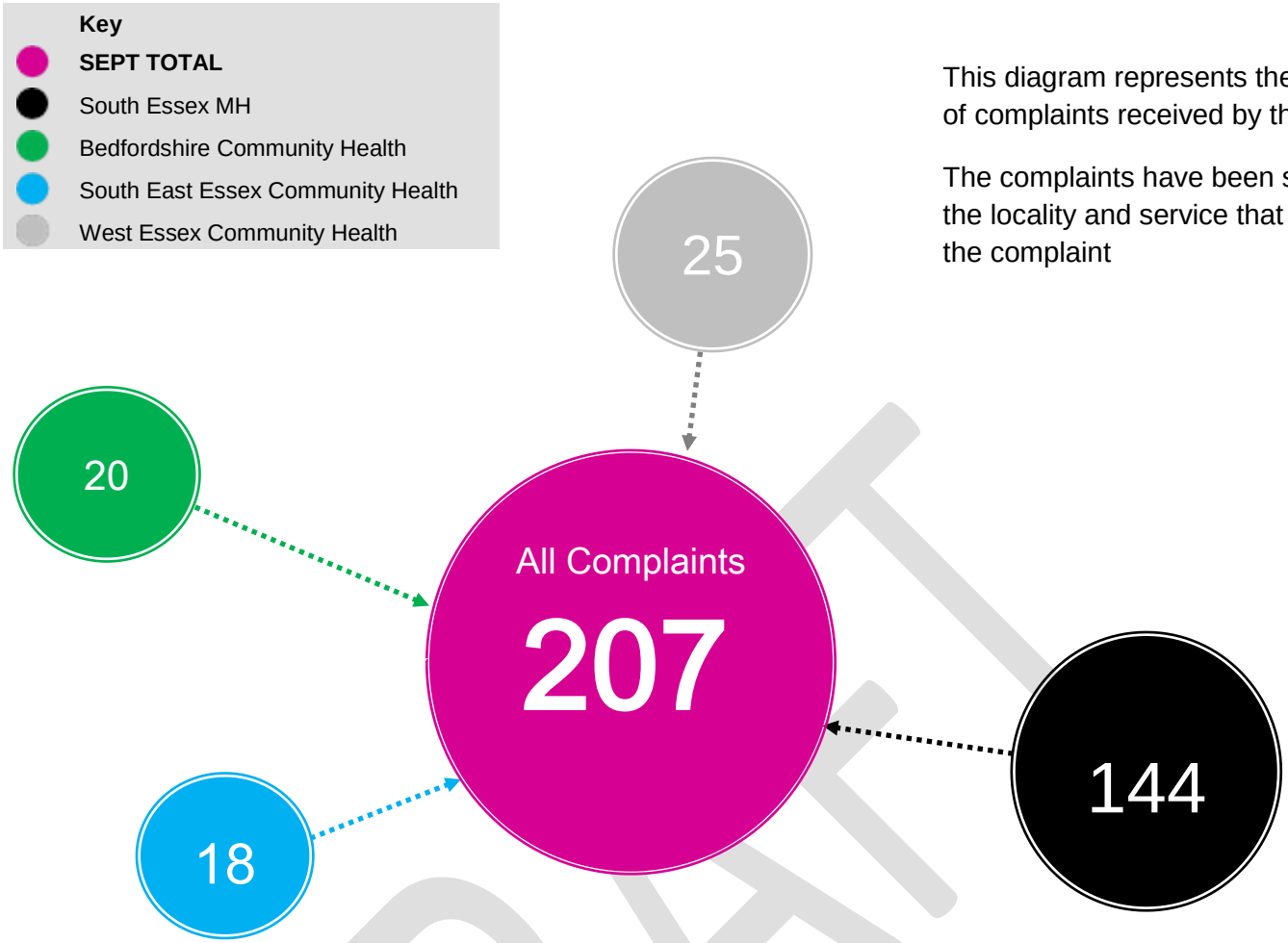
During 2016/17, the NEDs reviewed 56 complaint responses. The majority received a good or very good rating for how the investigation was handled and the quality of the response.

***Number of formal complaints received:***

| Performance Indicator | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|
| **Number of formal complaints received** | **377** | **237** | **207** |
| *Comprising:* | | | |
| *Total received Mental Health Services* | *277* | *153* | *144* |
| *Total received Community Health Services* | *100* | *84* | *63* |
| **Number of complaints withdrawn** | **12** | **5** | **3** |

*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 Report / 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.*

## Complaints Received by Locality and Service




This diagram represents the number of complaints received by the Trust.

The complaints have been split by the locality and service that received the complaint

***Number of active complaints at year-end:*** At year end, the number of active complaints was 22 which is a decrease from the position as at the end of March 2016 which was 23. All active complaints are on target to be responded to within their agreed timescale, by the end of May 2017.

***Number of complaints upheld / partially upheld:*** A total of 208 complaints were closed during the year of which 3 were withdrawn.

| Performance Indicator | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|
| Number of complaints upheld | 34 | 18 | 29 |
| Number of complaints partially upheld | 133 | 137 | 121 |
| Number of complaints not upheld | 69 | 74 | 47 |
| **Totals** | **236** | **229** | **197** |

The remaining 11 complaints closed in 2016/17 comprise: 5 not investigated (consent not given), 3 withdrawn, 2 conduct and capability and 1 locally resolved.

***Patient Advice and Liaison Service queries and locally resolved concerns:***

In addition, the Trust received a total of 1154 Patient Advice and Liaison Service queries and 175 locally resolved concerns in 2016/17.

***Nature of complaints received:***

The top three themes for complaints for both mental health and community during 2016/2017 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 - 2015/16 figures are included for comparison.

| Top Three Complaint Themes | Total Number of Complaints Received | | Upheld | | Partially Upheld | | Total Upheld or Partially Upheld | |
|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2015/16 | 2016/17 | 2015/16 | 2016/17 | 2015/16 | 2016/17 |
| Unhappy with treatment | 47 | 23 | 3 | 1 | 31 | 15 | 34 | 16 |
| Staff Attitude | 41 | 42 | 3 | 3 | 19 | 25 | 22 | 28 |
| Communication | 29 | 26 | 1 | 6 | 27 | 15 | 28 | 21 |

The remaining number were either not upheld, not investigated (no consent) or withdrawn.

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 EXPERIENCE

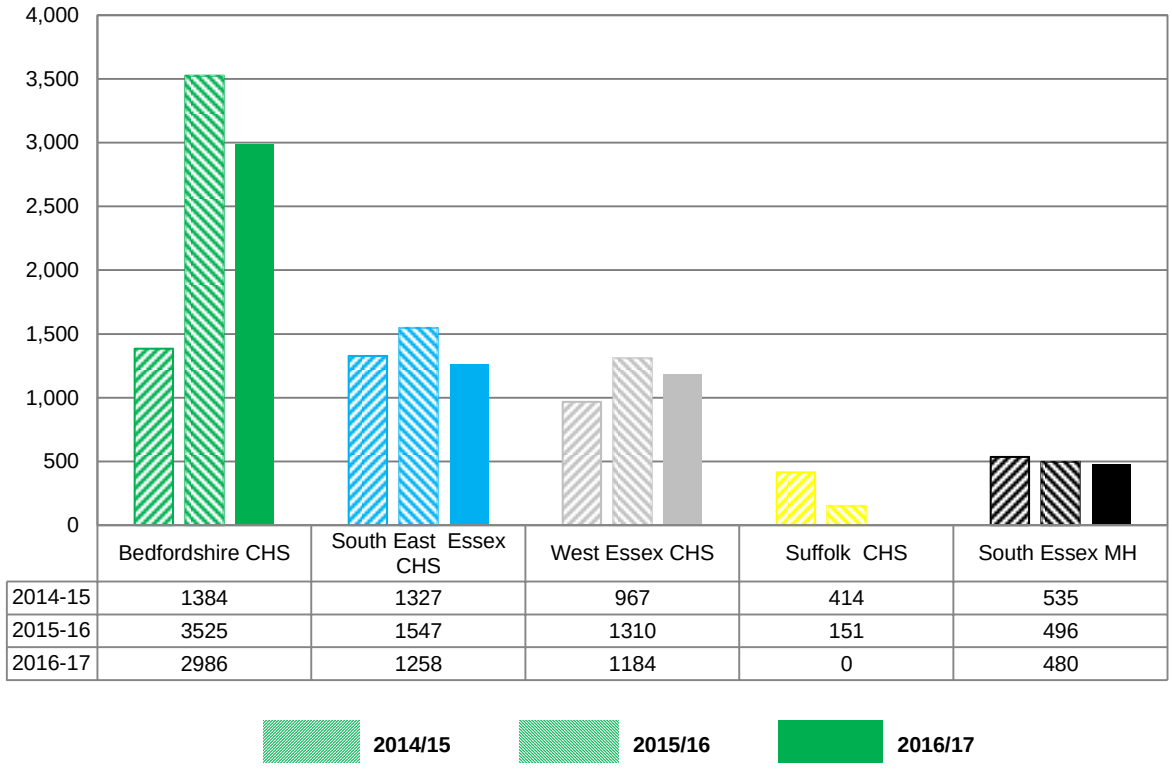
## Compliments

**Data source**: Datix
**National Definition applied**: N/A

Positive feedback is important to the Trust and is shared with staff and services across the Trust. All staff are encouraged to send the compliments they or their service receive to be logged and reported on. Compliments are published in the Trust publications and reported to the relevant Clinical Commissioning Groups. This year the Trust has received 5908 compliments, which represents a decrease of 1121 for the same services in 2015/16. The Community Health Services have experienced the biggest decrease, however, it should be noted that many of their compliments are taken from the Friends and Family Tests and various audits and they can therefore fluctuate accordingly over the year.

> "I just wanted to say a very big thank you to all the staff on Poplar Ward for all your work and efforts. You have given me my little girl back and I am so grateful."

| Compliments Received | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|
| Bedfordshire CHS | 1384 | 3525 | 2896 |
| South Essex MH | 535 | 496 | 480 |
| South East Essex CHS | 1327 | 1547 | 1258 |
| West Essex CHS | 967 | 1310 | 1184 |
| Suffolk CHS | 414 | 151 | N/A |
| **SEPT** | **4627** | **7029** | **5908** |
| **SEPT Ex Suffolk** | **4213** | **6878** | **5908** |

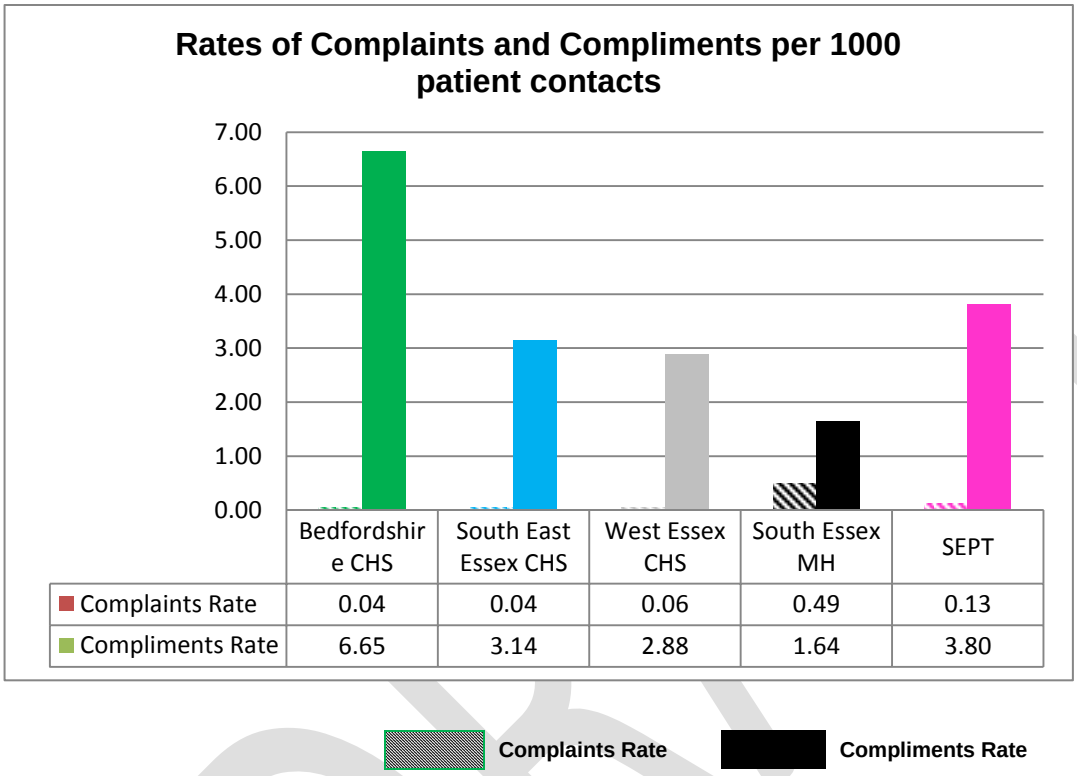



| | Bedfordshire CHS | South East Essex CHS | West Essex CHS | Suffolk CHS | South Essex MH |
|---|---|---|---|---|---|
| 2014-15 | 1384 | 1327 | 967 | 414 | 535 |
| 2015-16 | 3525 | 1547 | 1310 | 151 | 496 |
| 2016-17 | 2986 | 1258 | 1184 | 0 | 480 |

## Rate of Complaints and Compliments

**Data source**: SEPT systems (Datix and FFT)
**National Definition applied**: N/A

A comparison of complaints and compliments as a rate per 1,000 patient contacts demonstrates that the rate of compliments in each locality was significantly greater than the rate of complaints received during 2016/17.




| | Bedfordshire CHS | South East Essex CHS | West Essex CHS | South Essex MH | SEPT |
|---|---|---|---|---|---|
| Complaints Rate | 0.04 | 0.04 | 0.06 | 0.49 | 0.13 |
| Compliments Rate | 6.65 | 3.14 | 2.88 | 1.64 | 3.80 |

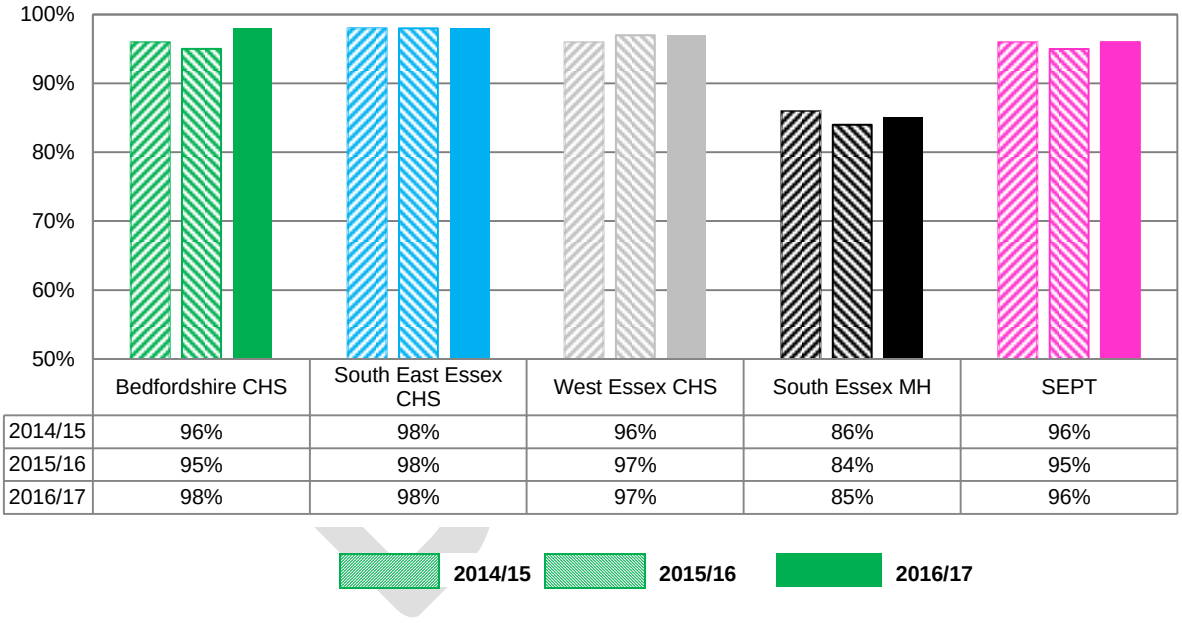
## Unified Friends and Family Test

**Data source**: Unified Patient Survey
**National Definition applied**: N/A

This survey draws together the NHS Friends and Family Test and a further series of questions around key areas we identified together with people who use our services.

In 2013/14, the Trust implemented a new unified patient survey. This draws together the national NHS Friends and Family Test (FFT) – detailed below - and a further series of local questions around key areas we identified together with people who use our services (detailed in Section 3.5). The 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 and guardians are also asked to complete the survey for those unable to fill it in themselves. Surveys are coded so that feedback can be provided at team-level; managers and teams receive scores and comments from the Friends and Family Test as well as from the locally agreed questions on areas that matter to our patients.

**"How likely is it that you would recommend the service you provide to a friend or family member who needed similar care or treatment"**




| | Bedfordshire CHS | South East Essex CHS | West Essex CHS | South Essex MH | SEPT |
|---|---|---|---|---|---|
| 2014/15 | 96% | 98% | 96% | 86% | 96% |
| 2015/16 | 95% | 98% | 97% | 84% | 95% |
| 2016/17 | 98% | 98% | 97% | 85% | 96% |

96% of the 10,081 responses to the FFT received from service users in 2016/17 indicated that they would be either "likely" or "very likely" to recommend the Trusts' services. The Trust continues to maintain a high recommendation percentage while seeking to increase the actual number of responses received and taking action on the feedback received.

Further details in terms of seeking and acting on service user feedback are included in Section 3.5 of this Quality Account.

In this section of the report a selection of Key Quality Indicators are presented to show performance for the community health services of Bedfordshire, South East Essex and West Essex over the past 12 months and where possible up to the past 36 months.

## Breastfeeding

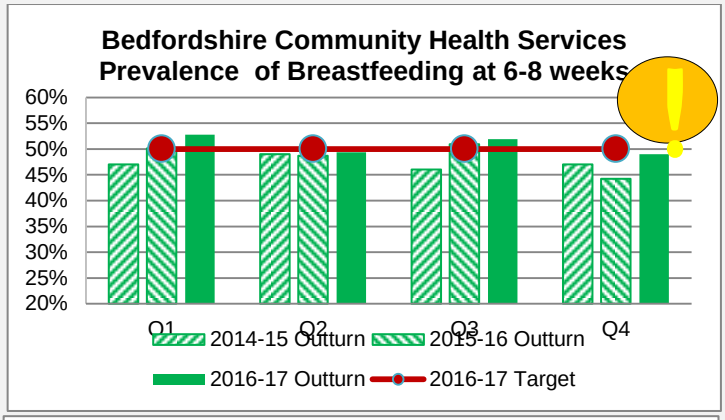
### CLINICAL EFFECTIVENESS

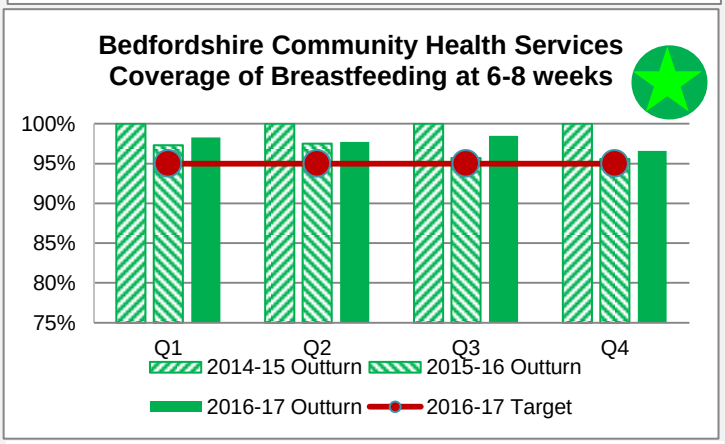
There are two types of breastfeeding measure used within community services. The first is breastfeeding coverage, which is the number of babies aged 6-8 weeks with breastfeeding status recorded. The second is breastfeeding prevalence, which is the number of babies being breastfed at the 6-8 week check.

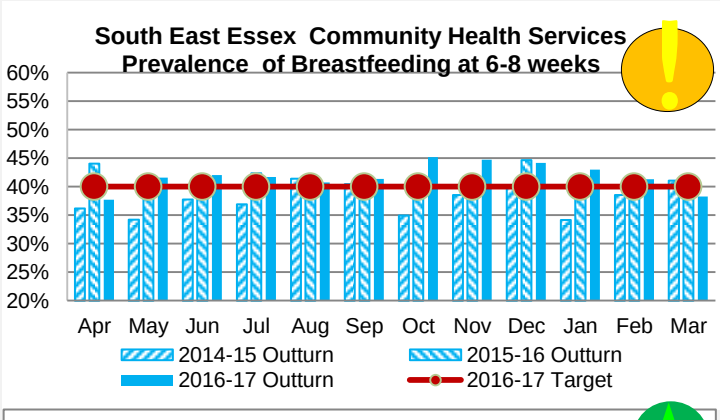
In Bedfordshire Community Health Services (BCHS) during 2016/17 the coverage of breastfeeding has exceeded 95% in every quarter and therefore provided good data quality. As in other previous years breastfeeding prevalence continues to increase in both Bedford Borough and Central Bedfordshire and this year reached its highest overall rate of 50%. The service is working on maintaining that high rate through a number of evidence based methods known to support mothers and babies. BCHS was re-accredited as UNICEF Baby Friendly in 2015 and is now working towards the Baby Friendly Gold Award. BCHS has been identified as a centre of excellence in the delivery of Antenatal information about breastfeeding. The Baby Friendly team has developed a specialist service supporting mothers and babies and received 100% positive feedback following analysis of patient experience submitted by families. Breastfeeding Buddies who volunteer to support across Bedfordshire have grown in number and provide a unique mother to mother support for breastfeeding mothers.

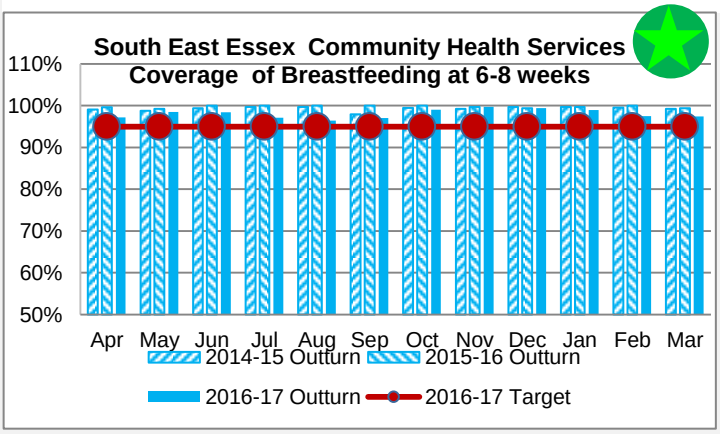
In South East Essex Community Health Services there has been a significant improvement in the 6-8 week breastfeeding rate in the second half of the year. The target of 40% prevalence was achieved for 10 months over the past year with 2 months just missing the target by less than 3%. There is a demographic difference between the two Local Authorities with the breastfeeding rate in Southend at 44.5% for the whole of 2016/17. To support and improve breast feeding rates we have invested in the Unicef Baby Friendly accreditation. In South east Essex we have achieved Level 3 the highest level of achievement. Breast feeding targets are not solely the responsibility of the health visiting service but shared with other providers such as maternity services and children's centres. In Southend we are working with children's centres to offer appropriate support and training for parents and we have worked with the local maternity services to support them with their Unicef Baby Friendly Accreditation.

**Data source:** SystmOne
**National definition applied:** Yes



# 18 Week Referral to Treatment

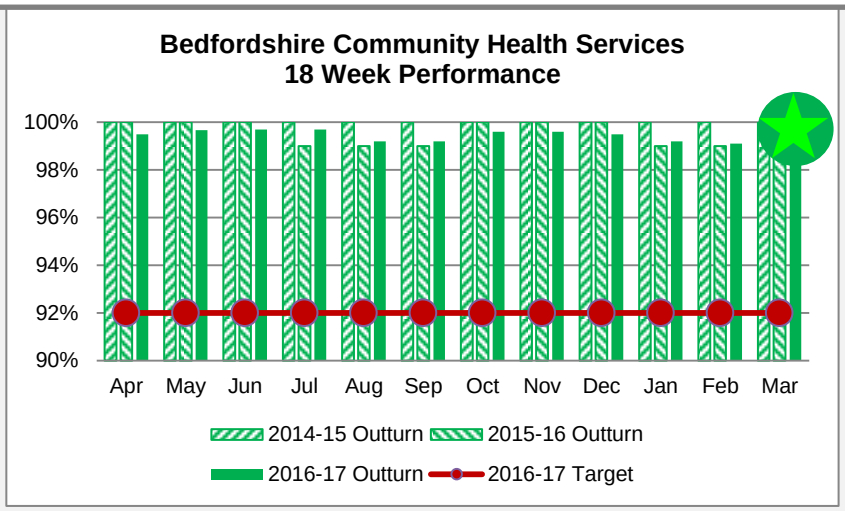
## PATIENT EXPERIENCE

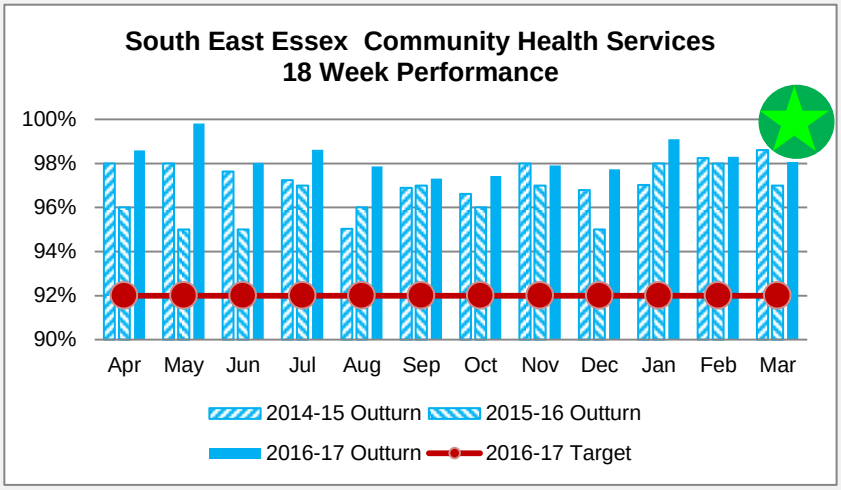
18 week referral to treatment performance measures the length of time in weeks between referral into the service and the end of each month. This is an important measure as it describes the length of time patients are waiting for treatment.

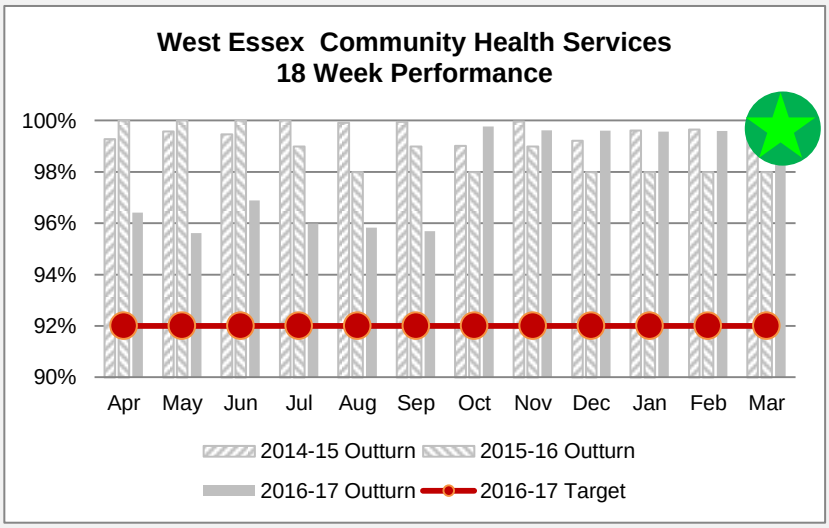
Community Health Services in all three localities consistently achieved the target of 92% every month in 2016/17.

**Data source**: SystmOne

**National definition applied:** Yes



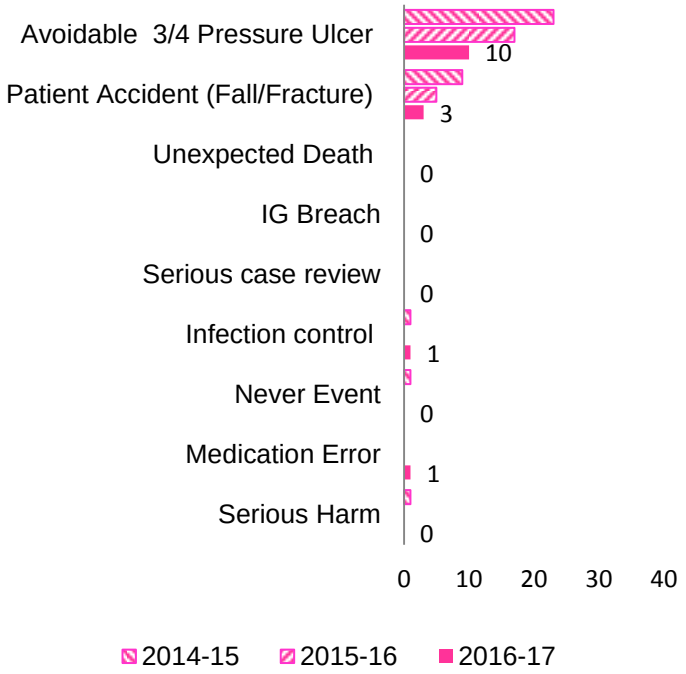
# Serious Incidents
## PATIENT SAFETY

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.

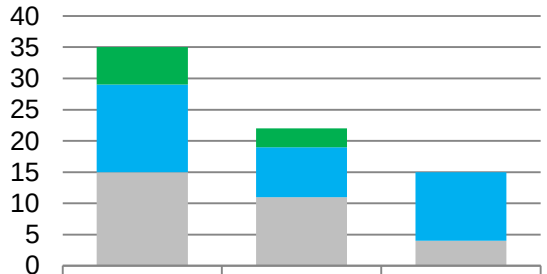
The Trust reported 15 serious incidents in Community Health Services in 2016/17 compared to 22 during 2015/16. Three of these incidents were falls leading to fractures, a decrease (improvement) of 2 on last year. The continued decrease in the number of Serious Incidents in the community is a major achievement for the Trust which has been made possible by the widespread implementation and adoption of the principles of our "Sign Up to Safety" campaign.

*Please Note : One additional SI reported for SEECHS in 2015-16 following identification of an avoidable grade 3/ 4 pressure ulcer following RCA after preparation of last year's Quality Report / Account.*

### Serious Incidents Occurring in Community Health Services




### Serious Incidents by Locality




| | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| Bedfordshire CHS | 6 | 3 | 0 |
| South East Essex CHS | 14 | 8 | 11 |
| West Essex CHS | 15 | 11 | 4 |

# Serious Incidents

## PATIENT SAFETY

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.

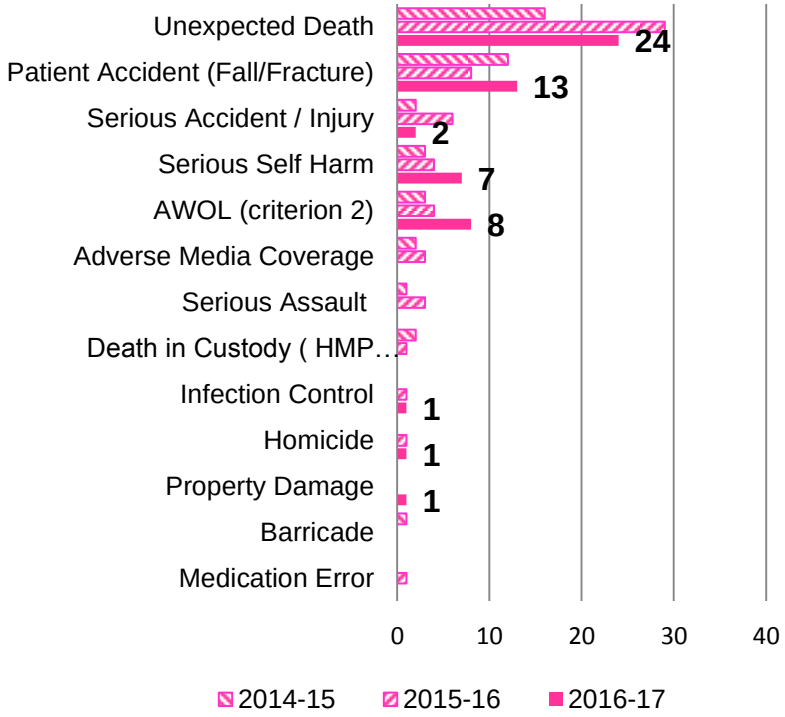
The Trust reported 57 serious incidents (SIs) in Mental Health Services in 2016/17 compared to 61 during the previous year.

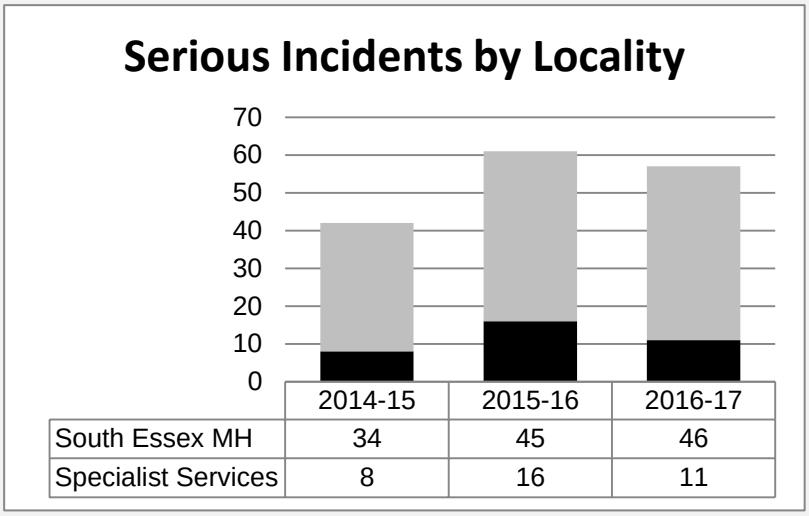
It is pleasing to note that the number of unexpected deaths has decreased from 29 last year to 23 in Mental Health Services and 1 in Specialist Mental Health Services in 2016/17.

The number of Serious Incidents in Specialist Services has decreased from 16 last year to 11 in 2016/17. In Specialist Services, although the number of AWOLS has increased from 4 to 8, there has been a decrease in the number of Serious Accidents from 6 last year to 2 in 2016/17 and reductions in other categories of serious incidents.

The Trust is committed to achieving an ambition of zero avoidable suicides by 2017 and has prioritised suicide reduction through its sign up to safety campaign. A comprehensive forward looking action plan has been developed to deliver transformational change to how staff assess and plan for safety within services, supported by the plan to commission specific suicide prevention training for all staff, underpinned by a cultural review of the organisations' understanding and attitudes towards suicide prevention.

**Data source**: Serious Incident Database
**National definition applied:** EoE and Midlands definition applied




| | 2014-15 | 2015-16 | 2016-17 |
|---|---|---|---|
| South Essex MH | 34 | 45 | 46 |
| Specialist Services | 8 | 16 | 11 |

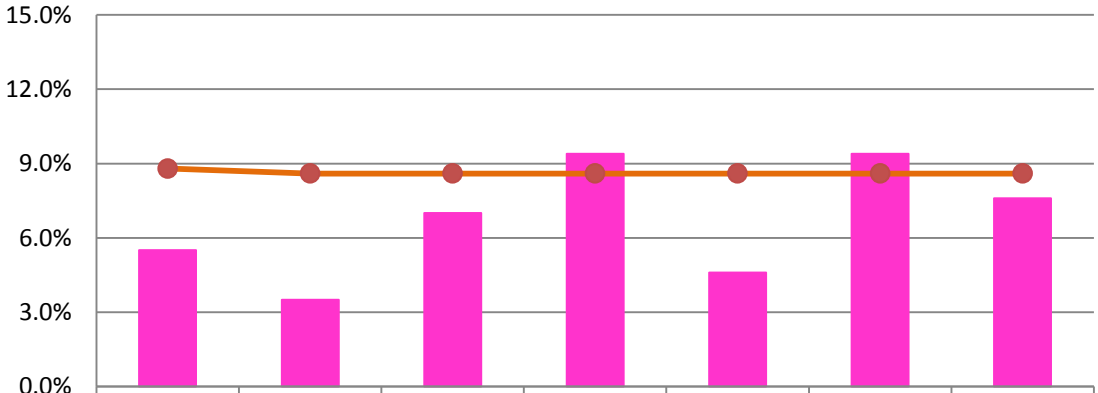
# Readmissions
## CLINICAL EFFECTIVENESS

Readmission rates have been used extensively to conduct national reviews into the effective delivery of health services as well as CQC cross-checking arrangements. The number of re-admissions, as well as the % re-admission rate are monitored regularly throughout the organisation. Performance is monitored at ward, speciality and locality level to ensure that any deviation from expected numbers can be quickly located and investigated. The targets for adult and older people re-admission rates are derived from the 2015/16 NHS Benchmarking Club (further information can be found at www.nhsbenchmarking.nhs.uk). In the graphs below, good performance is illustrated by levels of activity below the target line.

**Data source:** SEPT System (IPM) **National definition applied:** Yes

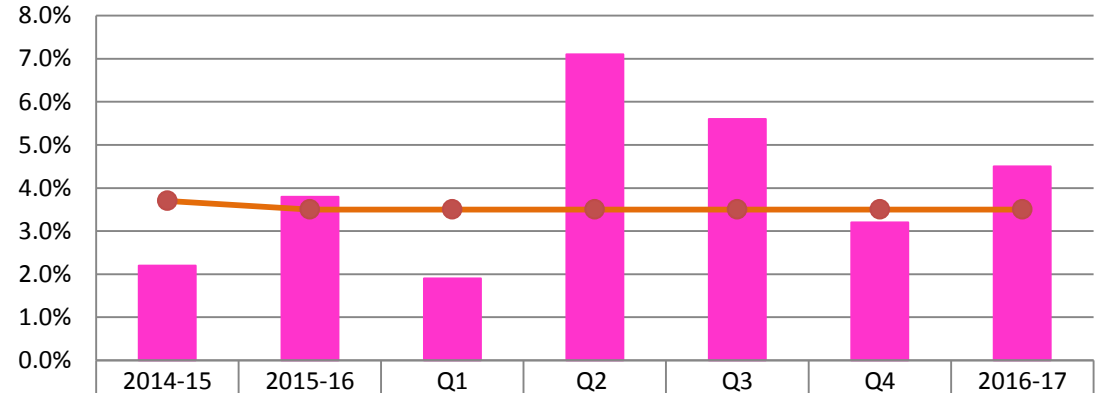
The target % for Adults Re-Admitted within 30 days has been achieved in the first and third quarters and for the year as a whole. However the target has been breached in the second and fourth quarter. Elderly Re-admissions achieved the target in the first and fourth quarters, but have breached the target in the second and third quarters and for 2016/17 as a whole. This % for Elderly readmissions represents 11 readmissions out of a total of 244 discharges. Due to reporting challenges associated with the implementation of a new information system for Mental Health services in 2016/17 (outlined in section 2.4.6), this data has only recently been available to the Trust and action is now being taken to follow up the reported performance.

**Adult Patients Re-Admitted Within 30 Days (Mental Health)**




| | 2014-15 | 2015-16 | Q1 | Q2 | Q3 | Q4 | 2016-17 |
|---|---|---|---|---|---|---|---|
| SEPT | 5.5% | 3.5% | 7.0% | 9.4% | 4.6% | 9.4% | 7.6% |
| Target | 8.8% | 8.6% | 8.6% | 8.6% | 8.6% | 8.6% | 8.6% |

**Elderly Patients Re-Admitted Within 30 Days (Mental Health)**



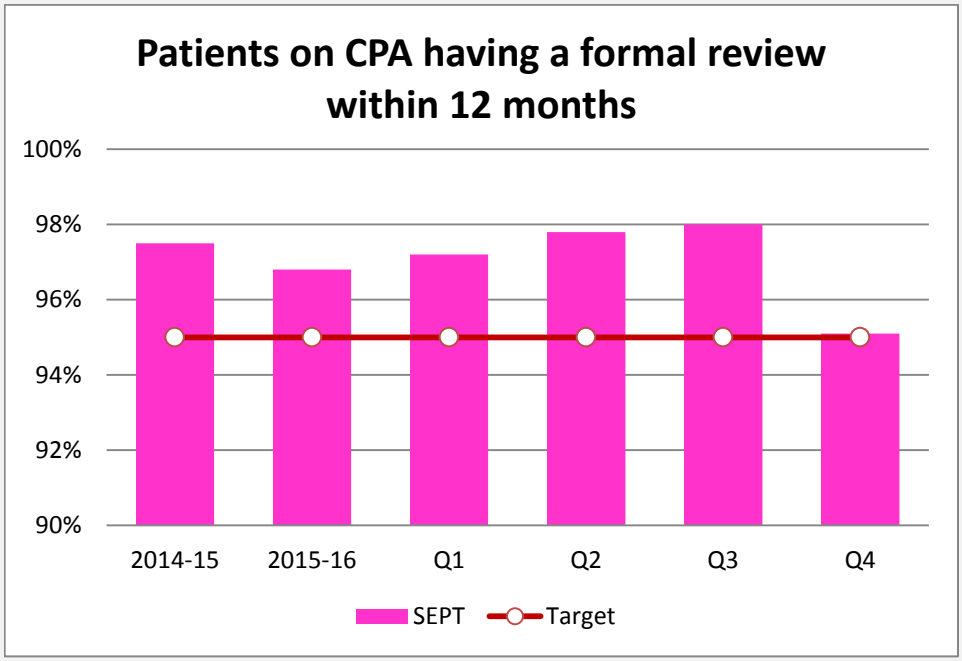

| | 2014-15 | 2015-16 | Q1 | Q2 | Q3 | Q4 | 2016-17 |
|---|---|---|---|---|---|---|---|
| SEPT | 2.2% | 3.8% | 1.9% | 7.1% | 5.6% | 3.2% | 4.5% |
| Target | 3.7% | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% |

## *Section 3.4: Performance against key national priorities*

In this section we provide an overview of performance in 2016/17 against specified key national targets relevant to SEPT's services contained in NHS Improvement's (NHSI) Single Oversight Framework. The Single Oversight Framework was introduced on 1 October 2016 to replace the Monitor 'Risk Assessment Framework' and the NHS Trust Development Authority 'Accountability Framework'. It is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. NHS Improvement specified in their national guidance for Quality Reports 2016/17 which of these indicators should be reported within Quality Reports for 2016/17. Data for two targets from the Single Oversight Framework required to be included in Quality Reports (ie "Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay" and "Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team") has been reported in the national mandated indicators section of this report (section 2.5). SEPT is pleased to report that, with the exception of one indicator ("Early Intervention in Psychosis referrals treated within 2 weeks of referral with NICE compliant care packages"), compliance has been achieved across all indicators reported below throughout 2016/17.

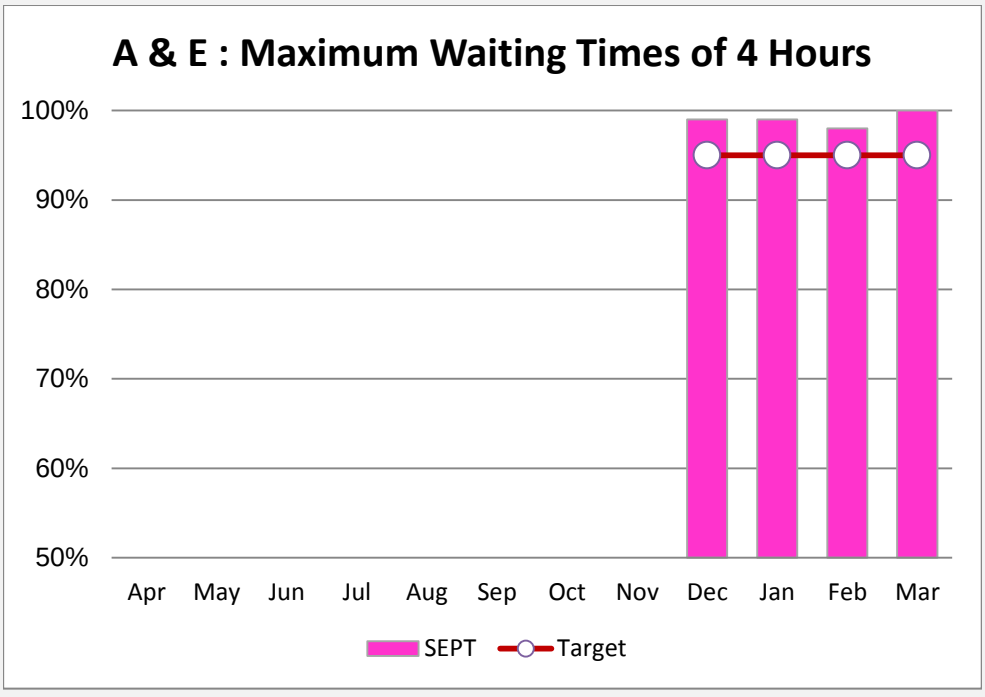
### People having a formal review within 12 months

This indicator applies to adults who have been on the Care Programme Approach for at least 12 months. The target set by NHS Improvement (formerly MONITOR) of 95% provides tolerance for factors outside the control of the Trust which may prevent a review being completed for all patients every 12 months. Compliance has continually been achieved throughout 2016/17.




### A & E: Maximum waiting times of 4 hours

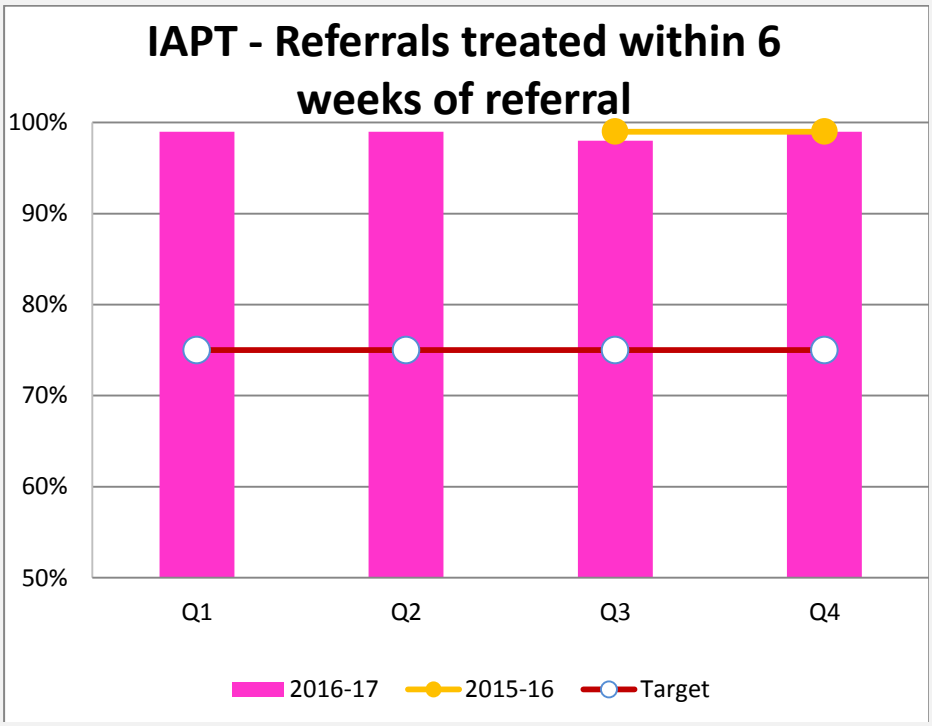
The NHSI compliance threshold is for 95% of patients to be admitted/ transferred or discharged from A & E within 4 hours of arrival. In November 2016 SEPT commenced management of the Urgent Care Centre in West Essex and has achieved this target during the remainder of 2016/17.

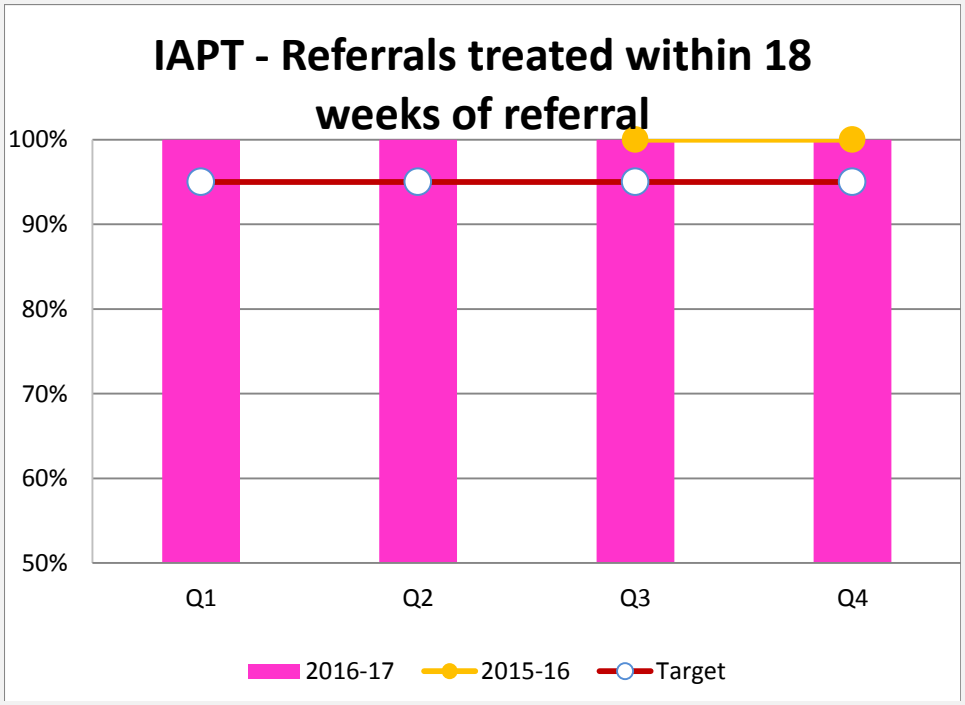


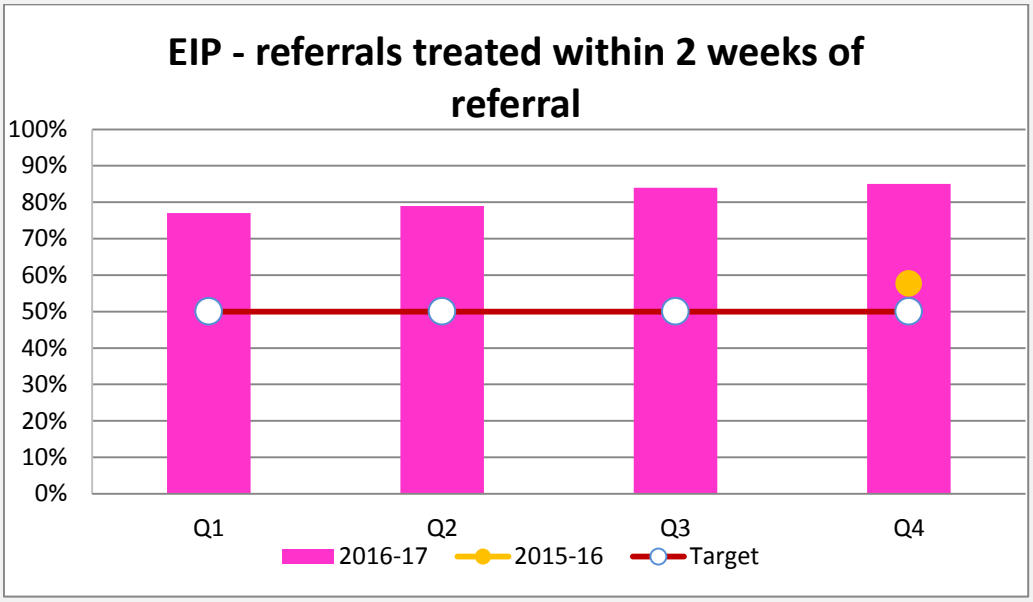
## Improving Access to Psychological Services: Referrals treated within 6 weeks and 18 weeks of referral

These indicators were introduced from Q3 2015/16 to measure the time between referral and treatment by IAPT services.

Compliance with both of these targets has been achieved consistently throughout 2016/17





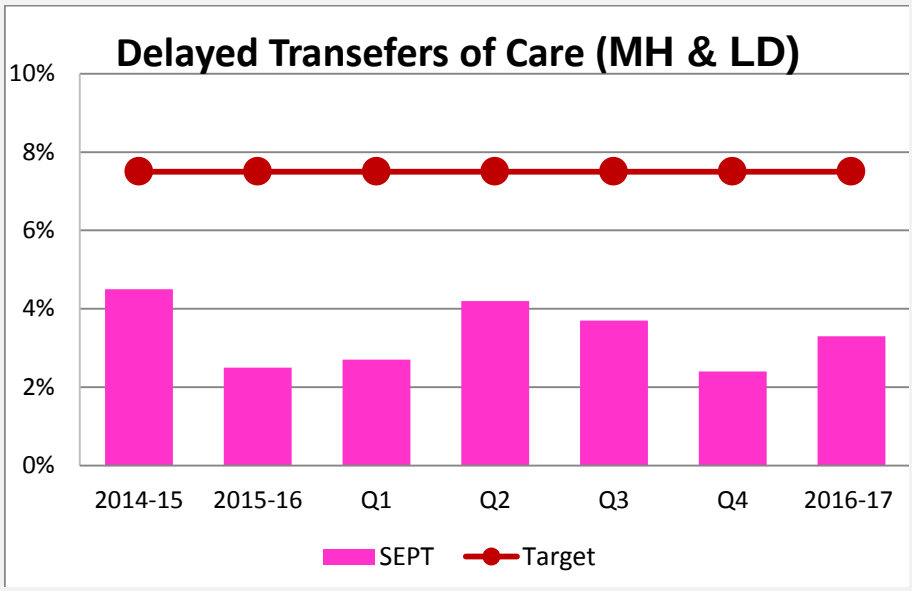

## Early Intervention in Psychosis: Referrals treated within 2 weeks

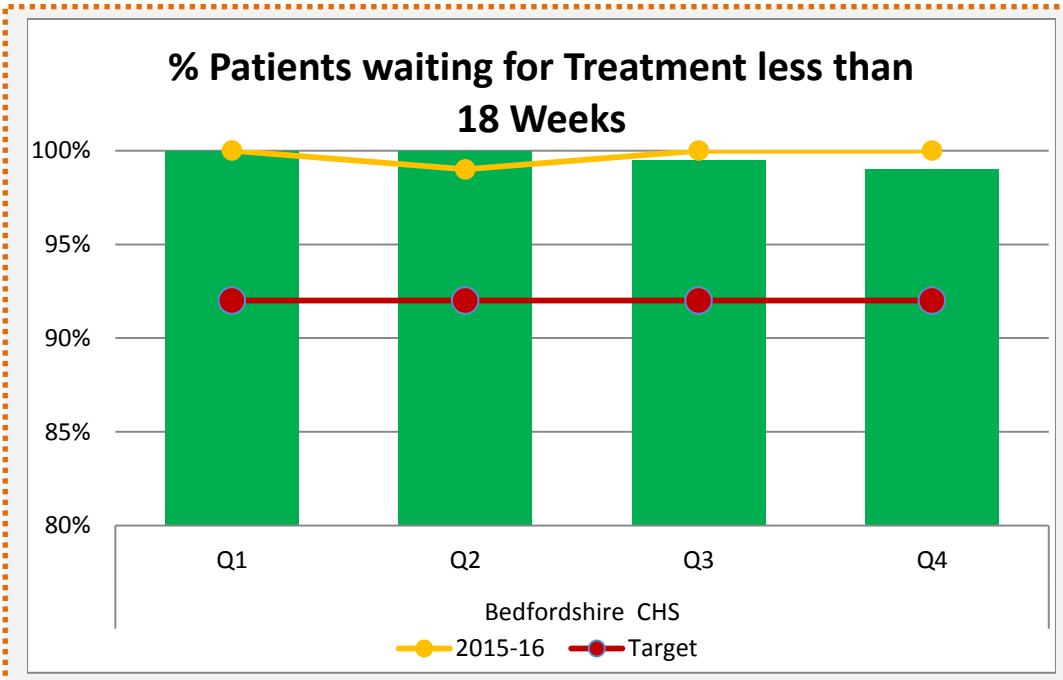
This indicator was introduced in Q4 2015/16 to measure the percentage of referrals for people with a first episode of psychosis who are treated within 2 weeks. From Q1 2016/17 it was enhanced to include compliance with NICE packages of care.

South Essex Mental Health Services are not currently commissioned to provide NICE compliant packages of care.

## Delayed Transfers of Care (DTOCs) (MH & LD)

This indicator is calculated as the % of inpatient beddays lost to DTOCs due to either NHS or Social Care related issues for both mental health and learning disability services. The target which has been carried forward from the NHSI Risk Assessment Framework is less than 7.5%. This target has been achieved consistently throughout 2016/17.






## % Patients waiting for treatment less than 18 weeks

This indicator measures the treatment waiting times for patients on non-admitted consultant-led pathways. The maximum waiting time is 18 weeks and the target is 92% of those still waiting. This target has been consistently achieved throughout 2016/17.

Only Bedfordshire CHS has a GP to consultant referral pathway for Paediatrics.

## *Section 3.5: 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 3.3 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 team managers with regular reports which detail the results from the Surveys for their team. 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 | SEPT Overall Scores 2015/16 | SEPT Overall Scores 2016/17 | Increase / decrease between 2015/16 and 2016/17 scores |
|---|---|---|---|
| To what extent did you feel you were listened to? | 9.3 | 9.3 | ➡ |
| To what extent did you feel you understood what was said? | 9.4 | 9.4 | ➡ |
| To what extent were staff kind and caring? | 9.6 | 9.6 | ➡ |
| To what extent did you have confidence in staff? | 9.5 | 9.5 | ➡ |
| To what extent were you treated with dignity and respect? | 9.6 | 9.6 | ➡ |
| To what extent did you feel you were given enough information? | 9.4 | 9.4 | ➡ |
| How happy were you with the timing of your appointments? | 9.3 | 9.3 | ➡ |
| How would you rate the food? | 6.7 | 6.9 | ⬆ |
| To what extent would you say the ward/clinic was comfortable? | 8.8 | 8.8 | ➡ |
| To what extent would you say the ward/clinic was clean? | 9.3 | 9.3 | ➡ |

A total of 10,081 responses were received to the Survey in 2016/17. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).

Food continues to show the lowest satisfaction rating although this has increased over the year. It should be noted though that responses in this particular category are very low. The Food Task & Finish Group originally set up last year developed a Food Strategy for the Trust - as part of that, another complete audit of the food service (including tasting) was undertaken by the Patient Experience Team. Further audits continue to be undertaken and will continue into the future.

## Other Key Patient Experience Engagement Activities

**Mystery Shopper Programme**: Mystery Shoppers are patients and carers who give anonymous feedback about their actual experiences of using services, naming the staff they have had contact with. The feedback is monitored by Directors and Team Managers. Individual staff receive feedback in supervision sessions with their manager on how their practice has been perceived by patients and carers. The feedback received has a direct impact on patient and carer experience and outcomes, systems and quality. Mystery Shoppers can opt to give feedback via completing questionnaires, email and telephone. Feedback specifically about issues they may have encountered in accessing or using SEPT services which relate to the Equality and Diversity protected characteristics is also captured.

**SEPT On the Spot:** These events were set up last year to incorporate the previous "Take it to the Top" and "Let's Talk About "events that took place across the Trust. The aim of these events was 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 SEPT. These were held across all localities, and included different presentations from teams relevant to the locality as well as updating everyone on the trusts planning process and the merger with NEP. Feedback was generally positive although attendances did vary considerably from locality to locality.

**Stakeholder Forums**: Service users, carers and staff are invited to discuss services in their area and share feedback with the Trust. Forums are chaired by an associate locality director who is supported by operational staff. These are well received and some smaller forums were also held more as discussion groups. These all include patients, carers and local voluntary organisations.

**Service User/Carer Involvement:** One of the Trust's priorities has been to involve service users and carers more to play a meaningful role not only in current services but also the future of Trust services. A service user and carer reference group was set up to discuss the merger and begin co-production work on the clinical model for the new Trust.

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

The following are just a few examples of 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:

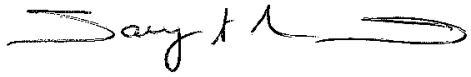
- Specific changes on how we communicate with patients and service users (eg appointment letter content, answerphone messages).
- Clearer information leaflets regularly updated.
- Staff introducing themselves appropriately continuing the "Hello my name is" campaign.
- Greater involvement of carers in the care of those they look after.
- Service user involvement in staff training giving the lived experience viewpoint.
- Adaptations to clinical areas.
- Varying the number and location of local forums in response to those who were either experiencing difficulties to attend or who had not been engaged with before.
- Strengthening and expanding the "Buddy" scheme, where service users and carers are "buddied" up with a student nurse ensuring the lived experience contributes to the trainees learning.

## CLOSING STATEMENT FROM SALLY MORRIS, CHIEF EXECUTIVE

I am proud to present our quality achievements for 2016/17 in our final year as SEPT. 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.

As I mentioned earlier, SEPT merged with NEP on 1 April 2017 to become Essex Partnership University NHS Foundation NHS Trust (EPUT). Throughout the year, our Interim Board of Directors will receive monthly reports on progress against the new organisation's quality goals. These meetings, as well as various other Trust meetings, are open to the public. I would like to encourage you to attend our monthly Board Meetings and other public events. At every meeting there is an opportunity for you to ask any questions of the local staff and managers responsible for care in your area. Details of all these meetings are available on our website https://eput.nhs.uk/

2017/18 will be an exciting time for the new Trust and I hope that you will be able to come to future meetings to be involved. We look forward to seeing you.



**Sally Morris**
**SEPT Chief Executive 2016/17 /**
**Chief Executive of the Interim Board of Directors, EPUT from 1 April 2017**

If you have any questions or comments about this Quality Report or about any service previously provided by SEPT (now provided by Essex Partnership University NHS Foundation Trust), please contact:

Faye Swanson
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Email: faye.swanson@eput.nhs.uk

## ANNEXE 1 – Comments on the Quality Report / Account

We sent the SEPT Quality Report / 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.

TO BE INSERTED INTO FINAL DOCUMENT FOR PUBLICATION

## ANNEXE 2 - Statement of Directors' Responsibilities for the Quality Report / Account

***Please note, due to the timing of the Quality Report production and the merger of SEPT and NEP to form EPUT, this statement has been signed by the Board of Directors of EPUT in May 2017.***

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 2016/17 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 2016 to May 2017
    - papers relating to quality reported to the board over the period April 2016 to May 2017
    - feedback from commissioners dated *{XX May 2017}*
    - feedback from governors dated *{XX March 2017}*
    - feedback from local Healthwatch organisations dated *{XX May 2017}*
    - feedback from Overview and Scrutiny Committees dated *{XX May 2017}*
    - the Trust's complaints report *(appertaining to 2016/17)* published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated *{XX May 2017}* and presented to the Board of Directors in May 2017
    - the 2016 national patient survey published on 15th November 2016
    - the 2016 national staff survey published on 7th March 2017
    - the Head of Internal Audit's annual opinion over the trust's control environment dated *{XX May 2017}*
    - CQC inspection report dated 19th November 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report 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 Report.

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

By order of the board

Date: {DATE} Signature to be inserted on approval (Acting Chairman of the Interim Board of Directors, EPUT)

Date: {DATE} Signature to be inserted on approval (Chief Executive of the Interim Board of Directors, EPUT)

## ANNEXE 3 - Independent Auditor's Report to the Council of Governors on the Annual Quality Report

**TO BE INSERTED ON PUBLICATION OF FINAL REPORT**

| GLOSSARY | |
|---|---|
| **CAMHS** | Child and Adolescent Mental Health Service |
| **CIPs** | Cost Improvement and Income Generation Plan |
| **CCG** | Clinical Commissioning Group |
| **CHS** | Community Health Services |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **CPA** | Care Programme Approach |
| **CQC** | Care Quality Commission |
| **CRHT** | Crisis Resolution Home Treatment |
| **CQUIN** | Commissioning for Quality and Innovation |
| **DoH** | Department of Health |
| **DTOC** | Delayed Transfer of Care |
| **DVT** | Deep Vein Thrombosis |
| **EIS** | Early Intervention Service |
| **EPUT** | Essex Partnership University NHS Foundation Trust |
| **FT** | Foundation Trust |
| **GP** | General Practitioner |
| **HOSC** | Health Overview and Scrutiny Committee |
| **HRA** | Health Research Authority |
| **IAPT** | Improved Access to Psychological Therapies |
| **IT** | Information Technology |
| **KPI** | Key Performance Indicator |
| **LD** | Learning Disabilities |
| **LTC** | Long Term Condition |
| **MDT** | Multi-Disciplinary Team |
| **MEWS** | Modified Early Warning System |
| **MHS** | Mental Health Services |
| **MHRA** | Medicines and Healthcare Products Regulatory Agency |
| **MHU** | Mental Health Unit |
| **MRSA** | Type of bacterial infection that is resistant to a number of widely used antibiotics |
| **MSK** | Musculoskeletal |
| **NCAPOP** | National Clinical Audit Patient Outcome Programme |
| **NCB** | National NHS Commissioning Board |
| **NEP** | North Essex Partnership NHS Foundation Trust |
| **NHS** | National Health Service |
| **NICE** | National Institute for Clinical Excellence |
| **NIHR** | National Institute for Health Research |
| **NHSI** | NHS Improvement (previously Monitor), the health sector regulator |
| **NPSA** | National Patient Safety Agency |
| **NRLS** | National Reporting and Learning System |
| **NRES** | National Research Ethics Service |
| **PICU** | Psychiatric Intensive Care Unit |
| **POMH UK** | Prescribing Observatory for Mental Health UK |
| **QIPP** | Quality Innovation Productivity and Prevention |
| **RCA** | Root Cause Analysis |
| **REC** | Research Ethics Committee |
| **SEPT** | South Essex Partnership University NHS Foundation Trust |
| **SI** | Serious Incident |
| **SUTS** | Sign Up To Safety national campaign |
| **UTI** | Urinary Tract Infection |
| **VTE** | Venous Thromboembolism – blood clots |