		Agenda Item No: 8b
SUMMARY REPORT	BOARD OF DIRECTORS PART 2	30 October 2019

Report Title:	**PHSO and HSE Steering Group Assurance Report**					
Executive/Non-Executive Lead:	Alison Davis, Non-Executive Director / Chair of the PHSO Steering Group					
Report Author(s):	Nigel Leonard, Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the PHSO and HSE Steering Group. This is a Task and Finish Group established by the Board to oversee the work relating to the PHSO and HSE requests for information.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the summary of the meetings held on 25 September 2019 and 16 October 2019.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Provide comments on the draft response to the HSE attached at Appendix 1.

Summary of Key Issues

The PHSO & HSE Steering Group met on 25 September 2019. The following items were discussed:

- Action Log
- Final PHSO Action Plan
- HSE Investigation

In addition, an extra ordinary meeting was held on 16 October 2019 to discuss the draft response to the HSE on 21 October 2019.

Since the meeting on 16 October 2019 an extension for submission has been agreed with the HSE until 4 November 2019. The revised draft response to the letter of 12 July 2019 is attached at Appendix 1. The Original HSE letter is attached in Appendix 2. This incorporates all of the comments received to date. The PHSO and HSE Steering Group will also review this response at an extraordinary meeting prior to submission on 4 November 2019.

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

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

3: Empowering	✓

Relationship to the Board Assurance Framework (BAF)	
Are any existing risks in the BAF affected?	Yes
If yes, insert relevant risk	BAF 18
Do you recommend a new entry to the BAF is made as a result of this report?	No

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			✓
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications:			Nil
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed?	**YES/NO**	**If YES, EIA Score**	No

Acronyms/Terms Used in the Report			
PHSO	Parliamentary and Health Service Ombudsman	HSE	Health and Safety Executive

Supporting Documents and/or Further Reading
None

Lead
Prepared by: **Nigel Leonard** **Executive Director Strategy & Transformation** On behalf of: **Alison Davis** **Non-Executive Director / Chair of the PHSO & HSE Steering Group**

Part 2 Agenda Item: 8b
Board of Directors
30 October 2019

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PHSO and HSE STEERING GROUP

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of PHSO and HSE Steering Group. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisations objectives are being managed effectively.

EXECUTIVE SUMMARY

PHSO & HSE Steering Group 25 September 2019
The PHSO & HSE Steering Group met on 25 September 2019. The Steering Group had a robust and thorough discussion on a number of key areas. The following matters were considered:

1. **Action Log**
   Updates were received. Slippage has been noted in respect of the Trust being an early implementer of the new NHSE/I SI Framework. However, it was noted that this is not within the Trust's control and we are awaiting further information on the National launch date.

2. **Final PHSO Action Plan**
   As noted in part 1, further to the Ombudsman receiving the policies they had requested they informed the Trust that they had passed the Action Plan to their clinical advisers to assess whether any further work was required. The Trust is waiting to hear whether any further action is required.

3. **HSE Investigation**
   Updates were provided in respect of the work being undertaken to respond to the HSE's recent correspondence. The Legal Services Team are continuing to collate documents and meet with key leads to obtain information to send to the Trust's legal representatives to prepare a response.

4. **Risk**
   The key risks identified related to the volume of work and the timescales required, and these items were included within the overall BAF risk. It was agreed that the Group would meet again on 9 or 16 October 2019 to review the final draft.

PHSO and HSE Steering Group extraordinary meeting on 16 October 2019

The Group met on 16 October 2019 to review the draft document to be submitted to the HSE. Initial comments were taken from those in attendance and it was agreed that these would be incorporated and then an updated version would be sent to all Group Members for their review and final comments in order that the response could be finalised.

In addition, the Group were informed that following responses to queries regarding:
1) key worker allocation when staff are on annual leave, and
2) a review of the actions detailed in the action plan by the service lead to ensure implementation and effectiveness.

The PHSO's clinical expert also commented very favourably on the policies presented as part of the Trust's action plan response. The Board will be pleased to note the PHSO have now closed the case and the Trust's focus is on completing the action plan.

Extension to HSE Deadline

Due to concerns over the advice provided on the approach to the letter of 12 July 2019 a second opinion was sought. As a result EPUT requested an extension to the original deadline for submission from the HSE. This request was agreed on 17 October 2019 and a revised date of 4 November 2019 was set.

The Project Team have co-ordinated a revised draft response including all comments received to date, including from our lawyers, Bevan Brittan. The response has been reframed to reflect the 2 areas of concern highlighted in the HSE letter dated 23 July.

The revised draft response is attached at Appendix 1 to this report. This response will also be reviewed by the PHSO and HSE Steering Group prior to submission on 4 November 2019. For information the HSE letter of 12 July is also attached at Appendix 2.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meetings held on 25 September 2019 and 16 October 2019.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Provide comments on the draft response to the HSE attached at Appendix 1.

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

On behalf of:
Alison Davis
Non-Executive Director / Chair of the PHSO & HSE Steering Group

Dear Mr [I/S]
We are writing in response to your letter of 12 July 2019 in relation to the Health and Safety Executive's (HSE) investigation into the management of risk at the former North Essex Partnership University Foundation NHS Trust (NEP) between 2001 and March 2015.

Background
In early 2017, the former NEP was dissolved by the Secretary of State for Health. On 1 April 2017, a brand new Trust, Essex Partnership University NHS Foundation Trust (EPUT), was established by the Secretary of State for Health, following a merger of the former NEP and the former South Essex Partnership University NHS Foundation Trust (SEPT). The senior leadership of EPUT is made up almost entirely from that of the former SEPT and, therefore, EPUT is very different organisation from that of the former NEP.

Unfortunately, as a result of the almost complete change in leadership noted above, EPUT does not hold sufficient information or organisational knowledge from the former NEP to provide full details of the history and basis for decision-making and actions taken by that Trust in the time period relating to the HSE investigation. However, we have provided within this letter submissions based on the information we do hold and the prior organisational knowledge we are able to access. This supplements the previous information shared with Police and yourselves.

EPUT has reviewed the potential breaches arising from the investigation into the former NEP and the summary of evidence provided in the appendix to your letter. Additionally, we have taken into full consideration the very significant concerns expressed in your letter and more widely, and the well-publicised service failures of the former NEP.

We strongly submit that a prosecution of EPUT for the failings of the former NEP would not serve as an effective nor proportionate response to the potential charges, nor would it be in the public interest. We request that the HSE, in coming to a decision regarding prosecution of EPUT in these circumstances, and particularly in considering the Full Code Test, should take into account our detailed submission.

In framing our response we have used the two points in your letter of 12 July 2019 to detail the work that has been undertaken by NEP (where known) and also by EPUT since merger. We have highlighted the work we have been able to identify pre-merger that was undertaken by NEP. This is followed by the work that EPUT has completed.

1. **The Trust was aware of the risks posed from fixed points of ligature within its inpatient ward environments and recognised these as a significant risk that required management. Evidence includes –**

    - **The Trust's own Environmental Standards documents.**
    - **The Trust's own Risk Management Strategy documents.**
    - **Department of Health Safety Alerts relating to the management of potential fixed points of ligature provided to the Trusts Risk and Governance Executive via the central alert system liaison officer.**

Former NEP
From Trust Board reports and minutes in 2015, we have noted that the former NEP introduced a number of new initiatives to support their safety and quality agenda:

- A revised quality report which drew together patient experience, clinical effectiveness, complaints and safety issues.

- Area Quality Panels were established to further develop the governance processes around the Quality Improvement Plan and Quality Framework, provide robust assurance, and generate a shared understanding of quality issues.
- The Quality, Audit and Area Teams reviewed the following year's quality audit plan to ensure a consistent and effective approach to audit and outcomes across the Trust.
- 'Quality Star' where each area/unit was asked to talk about their key strengths and areas for development in the context of each of the 5 CQC domains.
- Further work was also taken forward to included teams visiting each other to share perspectives on the inspection process and embedding the 'quality conversation' approach.
- Skills-Based Training on Risk Management for Suicide Prevention (STORM) which focussed on developing the skills needed to assess and manage a person at risk of suicide was made mandatory for all staff in acute inpatient and Crisis Resolution and Home Treatment (CRHT) services.
- The Trust's partnership with the Samaritans was relaunched to provide additional support for service users and carers.
- Training for A&E staff involving 5 Trusts in the East of England was delivered and a suicide prevention event was planned.
- A strategic review of estates management to highlight residual risks in the patient environment was undertaken.
- Staff induction was revised to include clear guidance on identifying patient and environmental risks, managing ligature incidents and the availability of ligature cutters.

From Trust Board reports and minutes in 2016, we have noted that the former NEP introduced a number of new initiatives to support their safety and quality agenda:

- The new Therapeutic and Safe Interventions (TASI) training.
- The Quality Improvement Plan was reformatted setting out more clearly the alignment to Executive Directors, Board Committees, and the Assurance Framework.
- A capital programme of approximately [I/S] was put in place to address ligature and single sex accommodation issues.
- A reduction in bed numbers at the Linden Centre (Finchingfield ward from 24 to 17 and Galleywood Ward from 24 to 18) to facilitate the move to single room occupancy and single sex accommodation.
- A robust risk assessment system regarding ligature removal, which would be tested by systems including Peer Review.
- A re-launch of the Patient Experience Board, providing an opportunity to improve engagement with those receiving care.
- An intranet alert system called ‘Safety Matters’ was introduced providing information on alerts received.

In 2016, the former NEP Trust Board of Directors noted, through the incident reporting system, Datix, that more incidents were being recorded, which was a positive indicator of moving towards a more open culture. The NEP Board of Directors was informed about a recent thematic report from the CQC regarding suicides and avoidable deaths in care, looking across the NHS. The former NEP had been invited to participate in the study, and no specific findings were reported about any Trust.

Minutes from former NEP’s Board of Directors illustrate that safer staffing discussions were held regularly throughout 2015, 2016 and in 2017 prior to merger. In addition, mandatory training was discussed and it was noted that there were challenges to improve the take up rate. Initiatives were put in place and these included staff email reminders and this initaive was reported as effective.

In 2016, the Care Quality Commission (CQC) inspection rated the former NEP's community mental health services as "good" and Child and Adolescent Mental Health Service (CAMHs) as "outstanding" for caring, one of the very few services to achieve this rating nationally. Throughout 2016, safety works and risks were discussed at the weekly Executive Management Team Meeting of the former NEP and progress monitored.

Merger

Since the merger of the two former organisations EPUT has in place in a number of different mechanisms to ensure the issues highlighted in the CQC report are not replicated. This includes strong governance on national alerts, utilising experts and pecialist companies, learning from best practice in other organisations and working closely with frontline staff and, where appropriate, people with lived experience.

The rationale for merger was that greater public and patient benefits would be realised by the establishment of a new merged organisation in the medium to long term, than by both former continuing to operate as completely separate organisations. The Full Business Case (FBC) submitted to NHS Improvement (NHSI) to support the merger proposal noted that the proposed new Trust would possess fresh impetus to work in a transformative way, using the consequent economies of scale and resources to deliver significantly improved care for local people and to protect NHS frontline services from increasing financial pressures.

The main drivers for the merger were:

- **Clinical Quality:** the Trusts began the journey to merger in very different places in terms of assessment of the quality of services and culture. Bboth Trusts were committed to delivering the highest quality possible and to exploit in full the synergies offered by merger;
- **Demand:** the level of health and social care needs of the people of Essex was increasing;
- **Strategic Context:** commissioners' priorities were changing to meet demand more effectively, Nearer To Where People Live: Providers Have To Change How They Provide Care To Meet These Priorities, Offering Better Clinical Services;
- **Human Resources:** services could nott improve without the right workforce, and skilled, experienced staff were increasingly at a premium;
- **Finances:** providers can only deliver those changes to services if they are financially sustainable.

Table 1 details the financial position of both former organisations from 2013 pre-merger.

[I/S]

EPUT

Ligature and Safety Works

At the point of merger in April 2017 the CEO of EPUT requested that a ligature re-audit (inspection) of all acute, secure and specialist mental health in-patient services was carried out across the whole new Trust. This was completed in parallel to the routine/regular ligature inspections already in place. This inspection identified that the ligature inspection process that had been in place needed strengthening and action was taken promptly by EPUT to do so. By the end of September 2017, 8 wards (at the Linden Centre and the Lakes) had been subject to an Executive led review, priority safety improvement works identified and funding released to undertake recommnendations.

All obvious potential ligature risks identified by the CQC in the inspections carried out in November 2017 were addressed. In some cases, actions taken were interim measures until longer term solutions could be implemented. This was to ensure patient safety by immediately removing identified risks whilst a longer term option was researched and commissioned.

In January 2018, the CQC published the findings of its unannounced inspection of the majority of the Trust's in-patient services in November 2017. The CQC acknowledged that progress had been made in mitigating potential ligature risks but identified that further work was still required. The CQC conclusions aligned to the Trust's survey work.

EPUT has a clear record of all works undertaken and any that remain for each ward was developed, maintained and monitored by the Estates Task and Finish Group. The programmes were shared with ward managers so that they are able to demonstrate progress made and have an understanding of future plans and mitigate their own risk areas. This also provided the opportunity for this information to be shared with staff or any regulator or commissioner inspection team.

EPUT's environmental ligature work investment programme for 2017/18 totalled £330,000.

Since April 2018, a wide range of activities were undertaken. These included the development of a new Trust policy and procedure, developing and implementing a training package, and reviewing the Trust's Observation and Engagement procedure. This work has continued and is aligned with our risk reduction agenda.

There was a review of the Ligature Audit Sign Off Group in November 2018. This group had been in place since 2014 in former SEPT and had continued to meet on a quarterly basis since merger in April 2017. The group's terms of reference were reviewed and the frequency and name changed to become the Ligature Risk Reduction Group (LRRG). The group now meets on a monthly basis. The group is chaired by the Executive Chief Operating

Officer/Deputy CEO. The group is a sub-committee of the Health Safety and Security Committee (HSSC). It is responsible for ensuring:

- ligature risk assessment inspections are robust with appropriate control measures in place;
- the Trust remains compliant with all regulatory or legislative requirements and Safety Alerts;
- risks are identified, managed and escalated as required;
- that systems are in place internally and externally to provide appropriate assurance;
- governance structures in respect of this agenda are appropriate and effective.

The Trust receives the following alerts via the Central Alerting System which are managed by the Trust's Medical Device Safety Officer (MDSO):

- Medical Device Alert (MDA)
- NHS Patient Safety Alerts
- NHS Estates Alerts
- Department of Health (DOH) Alerts
- Field Safety Notices direct from the manufactures

All forms of alerts received are recorded onto the Datix Safety Alert system and are managed by the Risk Management Department. Datix is used to cascade all alerts to the relevant leads who are required to action as appropriate and respond for their respective areas.

The MDSO or their nominated deputy is responsible for monitoring the content of their email box to identify safety alerts on a daily basis (Monday – Friday 9-5). Out of hours alerts are received by the Trust's Contact Centre and actioned on the advice of the manager/director on call.

When an alert arrives the MDSO or nominated deputy acknowledges receipt within 1 working day. The MDSO or nominated deputy carries out the first assessment of the alert and its relevance to the Trust and its operations. They then decide who the alert is to be sent out to in conjunction with the member(s) of the Medical Device Sub Committee & Resus Committee as necessary. Specialist advice is sought where appropriate e.g. medication, estates etc. The MDSO determines, dependent on the risk assessment of the alert received, whether to include it on the Trust's risk register.

The MDA is distributed via the Datix alert system. The alert is sent to identified leads and it is their responsibility to action/cascade the alerts to the team leaders in their areas of responsibility, as directed on the alert.

Each contacted lead has the responsibility to cascade, action and sign off the alert on Datix and to provide written confirmation that the action described within the alert has been complied with. Details of any local plans with associated implementation timescales must be included where relevant. Should no action be required then a negative return must be recorded on Datix. Timescales for alerts are given when sent via Datix. A reminder will be sent to recipients, compliance will be reported via the risk management report presented to the HSSC.

The MDSO produces a monthly report on activity to various governance committees as appropriate and commissioners where requested.

The Trust now operates an approach based on risk stratification to prioritise capital and revenue investment. This involves the use of a risk priority scoring table, with a score of 1 being the top priority, national guidance takes overall priority as a must do as these are based on national themes and trends. Risk Stratification has been agreed by the Board and is led by the Estates and Compliance Expert Reference Group.

Risk stratification of all inpatient environments identified replacement of all non-moulded toilets in forensic, adult acute, CAMHs, learning disability and functional older peoples inpatient environments and installation (in the same services, where there were none previously) of a minimum of 4 door top alarms to bedrooms (and bathrooms depending on unit) where patients assessed as at risk would be admitted.

The Trust has an Estates Task and Finish Group. This group meets fortnightly to oversee the agreed environmental improvement programme. The appointment of a single specialist contractor has been completed to carry out all required works and improve the Trust's ability to address identified issues. The Trust has also appointed a dedicated Estates Project Lead to oversee the programme of works.

Line of sight audits were undertaken in all inpatient environments and parabolic mirrors installed as requested by individual clinical teams to improve observation of patients in all areas of the ward.

As noted a Ligature Risk Assessment and Management Policy and Procedure was developed and approved by the HSSC in February 2019. Prior to the policy launch in April 2019, environmental ligature requirements were part of the Preventing Suicide Policy which was an adopted policy following merger.

The policy includes a working document to confirm the standards for reduced ligature fixture and fittings and the requirement and function of the red tabbed wallets introduced in 2018. These wallets hold key information to manage ligatures within all inpatient mental health wards. The policy has, as an appendix, the ligature risk assessment tool, which is continually being reviewed and developed as knowledge is learnt from communication forums andrequests made by either HSSC, LRRG, or related meetings and as a result of alert/incident event learning.

The risk assessment tool is updated by the Health and Safety Specialists within the Risk Team with a version control system in place. The tool is shared for agreement at the LR RG and the HSSC.

All ligature risk assessments carried out since April 2017 were reviewed by the Risk Team with the Estates Team and local clinical leaders to ensure that they reflected current risks and mitigation plans were realistic.

The Ligature Risk Assessment tool in use has been subject to rigorous reviews with consideration of relevant Health Building notes (HBN 03-01), NHS Estates Safety Notices (SN 01 January 2002, NHSE 10 2004, DH 08 June 2007) and reported incidents. The tool is designed to identify, mitigate or eliminate risks. Photographs of potential risks are included in the assessments and heat maps (floor plans of wards identifying locations of potential fixed ligature points) developed by ward teams as a result.

All ligature risk assessments were re-issued to every ward. They are stored with the heat maps in a red wallet in the nursing station/ office, in a visible place.

All mental health inpatient wards (and health based place of safety suites) have had ligature risk assessment completed since April 2017. The re-issue of ligature risk assessments and

development of heat maps and hot spots encouraged constructive discussion within ward teams of the potential risks and enabled staff to better describe how they manage potential risks in the area that they work.

A process was established to carry out risk assessment of potential ligature risk in community mental health clinics. Whilst these are public buildings; used by people living with mental ill health in their communities and those who have physical health conditions; staff recognising that there are potential fixed ligature points and considering these in the risk assessment of patients is part of EPUT's holistic approach to patient safety.

Similarly, people experiencing mental health crisis attend acute general hospital accident and emergency (A&E) departments. Risk assessments are now carried out in all 5 local A&E departments.

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

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

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

Action required following a ligature risk assessment are recorded on the Datix actions module, which is monitored by the Risk Management Team. Any overdue actions are reported to the LRRG on a monthly basis as well as HSSC.

The Risk Team has introduced a quarterly ligature scrutiny audit during Q2 2019. This is completed on a rolling basis of all mental health inpatient wards to ensure compliance and gain assurance regarding:

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

Audit results will be presented to the HSSC and risks/hotspots escalated to the Quality Committee.

A development planned for 2019 is the introduction of experts by experience into the ligature risk assessment process (with appropriate safeguards). Volunteer assessors are being identified and an information/ training package and protocol are being developed.

Two estates and facilities alerts (EFA) have been issued since April 2018.

EFA/2018/005 Assessment of Ligature Points
The alert was issued in September 2018 requiring all providers to review the ligature risk management arrangements in place. An action plan was developed which has been monitored by the HSSC. The alert was presented to the HSSC for monitoring and progress updates were provided at meetings in 2018 and 2019. The Quality Committee was advised of progress via the HSSC assurance report in October and December 2018 and February 2019.

EFA/2019/003 'Anti-ligature' type curtain rail systems
The alert was issued in March 2019. It identified potential risks from incorrect installation or modification of anti-ligature type curtain rail systems. The alert also included two previous alerts issued relating to cubicle curtain tracks (EFA 2010 003) and flush fitting curtain rails (EFA 2010 009). This alert is monitored by the LRRG and the HSSC.

As detailed above alerts are presented to the HSSC for monitoring and progress updates are provided at subsequent meetings. The Quality Committee was advised of progress via the HSSC assurance report in June and October 2019.

As noted EPUT carries out works using a risk priority scoring table, with a score of 1 being the top priority, national guidance takes overall priority as a must do as these are based on national themes and trends. Risk Stratification is led by the Estates and Compliance Expert Reference Group.

The Trust uses two types of standards, the type of environment and the type of fixtures and fittings. This enables a consistent approach to prioritising the investment programme using a risk based approach.

The following room standards have been agreed as private areas as they are deemed to be a higher risk due to patients potentially spending time alone in these rooms.

Private areas must have reduced ligature fixtures and fittings; rooms include:

- Bedrooms
- Bathrooms
- Ensuite
- Seclusion Rooms

Communal areas with high footfall, where patients are generally in the company of others and have unrestricted access, these rooms include:

- Lounges/Sitting Rooms
- Some Corridors
- Dining Rooms
- Reception Areas

These rooms are risk assessed so decisions are made based on the level of observation and footfall and the need to have ligature resistant fixtures and fittings. Where there is not a reduced ligature fixture or fitting the risk must be included in the hot spot photos and heat map, and management of the risk is included in the patients risk assessment. This could then result in a higher level of service user observations.

As noted each mental health ward has an A3 Red Tabbed Ligature Wallet, which is kept in the ward office and all staff are made aware of its requirements and contents which included:

- Ligature Cutters
- Current Ligature Risk Assessment Report
- Laminated copy of the 'Emergency Procedure - use of ligature cutters
- Laminated Heat Map - floor plan of the ward showing high risk areas and potential ligature anchor points
- Hot Spot Photos (gallery of potential ligature anchor points)
- Procurement and Maintenance of Ligature Cutters information sheet
- Copy of the most recent ward Ligature inspection report.
- A Signage Sheet
- Ligature cutter poster

Supervised areas where patients are supervised by staff and locked when not in use areas include clinic/treatment rooms, assisted toilets and bathrooms, therapy rooms, gymnasia, laundry, kitchen and store rooms. The rooms must be included in the hot spots and heat maps and staff aware of the requirements and covered by the wards General Workplace Risk Assessment (GWPRA).

The Trust's fixture and fitting standards are agreed via the LRRG and recommended for inclusion into the policy and onto the risk stratification programme to the Estates Expert Reference Group. A number of standardised fixtures, fittings and furniture with products of a reduced ligature design have been agreed through this process and included in the Ligature Risk Assessment and Management Policy and Procedure.

In relation to Health Building Note (HBN) 03-01 and NHS Estates Alert November 2004 (NHSE (2004) 10 and the Estates and Facilities Division Alert October 2006, the standard adopted by EPUT to date has been to ensure all window handles are of a ligature resistant design and for windows to be replaced with a 'Polar' window for all mental health inpatient wards but excluding older adult organic (dementia) wards and long term rehabilitation units. As an interim measure window handles were removed and windows sealed closed where they were not of a ligature resistant design. This temporary arrangement has reduced the risk of ligature.
A task and finish group was put in place with representatives from Operational Mental Health teams, Property and Projects, Facilities Management and Risk Management to review the detailed audit results and to confirm the recommended course of action required. The wards were placed into one of three categories to determine the urgency of works to be undertaken – P1 sites being mental health acute wards, P2 sites being older adult functional (and organic where appropriate) wards and P3 sites being mental health specialist services wards.

From a priority perspective related to programming the works wards in groups 1 and 3 are where patients are of the highest risk of ligature and therefore windows be replaced before those in group 2, except where the numbers of window units involved are less than 5.

The Trust has spent time assessing and taking advice on the best design options available for each ward/service. Orders have already been placed for the 33 windows at The Lakes and at the Linden Centre totalling £91,870. These will be installed from mid-November 2019. Orders have also been raised for another 12 windows at Peter Bruff; Rainbow Unit; Christopher Unit; and Henneage ward at an estimated cost of £40,000. It is expected that these will be installed in early January 2020.

The wards at the Basildon Mental Health Unit (MHU) have been deferred until 2020/21 financial year for implementation due to the number of window units involved, the complexities associated with replacing windows as potentially part of the eliminating dormitories project and also some uncertainty on the future use of two of the existing dormitory wards. The costs associated with replacement windows at the MHU are expected to be higher than those in other locations.

The continuation of the 2019/20 programme will replace a further 75 windows required at the group 1 sites of Poplar ward; Cedar ward; and the Assessment unit which we would want to deliver during this financial year. It would also be beneficial to accelerate the orders for replacement windows for Larkwood and Longview wards for 15 windows.
The total estimated spend in 2019/20 is [I/S] with 135 windows being replaced. Based on an estimated cost of [I/S] per unit the total spend for 2020/21 could be [I/S]

By following this programme of window replacements as set out above the Trust should be in a position by the end of Q3 of 20/21 to have reduced the ligature risk associated with windows across the whole of our owned portfolio.

In relation to NHS Estates Safety Notice SN(01), NHS Estates Alert November 2004 (NHSE(2004)10, Estates and Facilities Division Alert June 2007 DH(2007), Estates and Facilities Alert March 2010 EFA/201 0/003, and The Department of Health "Never Events" List 2011 /12 (DH),all EPUT inpatient mental health wards have shower rails and bedroom and bathroom curtain rails that are designed to collapse under the application of a predetermined load. The Trust has identified the following 2 systems:

- A magnetic collapsible plastic hold connector system (Kestrel) in Adult Acute, Older Adult Functional wards
- A fixed anti-ligature rail system with bespoke glider system (JTrac) in CAMHs, PICU and Low and Medium Secure wards

A new Trust wide maintenance contract for all collapsible rails is currently being commissioned to be carried out by a contractor who is independent of the original suppliers. The investment programme for 2019/20 is based on the risk stratification programme agreed by the Executive Operational Steering Committee.

In relation to NHS Estates Alert November 2004 (NHSE (2004)10, the Department of Health Estates and Facilities Alert March 2010 and HBNs and HBN 03-01, all sites have been assessed against this standard. A solution has been identified to minimise the risk from ceiling fittings. Proposals are being developed to implement the agreed solution across all sites which will take up to a year to complete. The programme of works will be based on risk with high risk areas being completed first and details of our approach are included in this response.

Estates and Facilities Division Alert - Doors as ligature points of October 2006, EPUT has inherited a number of properties of differing designs and ages following merger. All sites have been reviewed for compliance on ligature points for doors. Our ligature assessment process ensures compliance with alerts on a routine basis to ensure that any replacements or changes at ward level are reviewed against this checklist.

National Reporting and Learning Service based on 8 incident reports issued a specific "signal" in September 2009 and Estates and Facilities Alert- Self-harm with wardrobes 24 November 2010 and HBN 03-01, similarly, predecessor organisations have invested in changes to bedroom areas in relation to wardrobes. We are compliant in relation to the alert on wardrobe handles, again wardrobes and shelving assessments are included in the ligature assessment process for EPUT.

2. **The Trust recognised the need to audit the risk from these fixed points of ligature but at a senior level failed to act with sufficient speed and resource to address these risks or learn lessons from serious and fatal inpatient ligature injuries on the Trust's wards.**

EPUT

Governance

Since the merger of the two former organisations EPUT has in place in a number of different mechanisms to ensure the issues highlighted in the CQC report are not replicated.

EPUT delivers a wide range of mental health services in Essex and Suffolk, and specialised mental health services and community health services in Essex, Bedfordshire and Luton. From an inpatient perspective the Trust has 14 acute adult mental health wards (251 beds), 10 older adults mental health wards (179 bed), 1 rehabilitation (11 bed) unit, 2 nursing homes (70), 6 physical healthcare wards (121). In addition we provide low and medium secure inpatient facilities and 3 inpatient CAMHs wards.

The governance structures established in EPUT are largely those that were in place in former SEPT. These were subject to an independent review by Grant Thornton and NHSI and confirmed to be effective as part of the merger assessment process. They are therefore well embedded and perceived to be strong and valued by the Board of Directors.

The EPUT Board of Directors consists of 8 Non-Executive Directors (NEDs) and 7 Executive Directors. 6 out of 7 of the Executive Directors have been in post since the merger, having been members of the interim Board and Executive Directors in the former organisations (5 former SEPT and 1 former NEP). 3 out of 8 NEDs were members of the Boards of the former organisations (2 former SEPT and 1 former NEP); 5 NEDs, including the Chair have been appointed since 2017 bringing new skills and experience into the Board dynamic.

EPUT has a comprehensive Director and Governor Service visit programme. The CEO has carried out 49 recorded service visits in the past 12 months, including unannounced visits at night. 213 recorded service visits were carried out by EDs and 51 by NEDs. In addition joint ED, NED and Governor Service visits take place monthly.

The Board of Directors has delegated decision making responsibilities to six standing committees: Audit, Quality, Strategy and Planning, Finance and Performance, Remuneration and Nomination and Charitable Funds. Each standing committee is chaired by a Non-Executive Director. Assurance reports confirming discussion, decisions and potential risks are provided to the Board of Directors following each meeting. All standing committee meetings take place regularly, are minuted, receive written reports and have action logs to take forward actions agreed.

There is a comprehensive sub-committee structure supporting the standing committees of the Board. The sub-committees cover a wide range of activities and/ or functions. All meetings are chaired by Executive Directors or other members of the senior leadership team and have identified reporting requirements including responsibility to take forward actions and manage risks identified by the standing committees. Directorate specific Quality and Safety Committees are in place to support the quality agenda.

The Executive Directors are supported by an effective and stable medical, operational and corporate leadership team, consisting of Clinical Directors, Directors, Deputy/ Associate

Directors. Bi-monthly Senior Leadership meetings/ workshops take place and each month the senior leaders participate in an extra-ordinary meeting of the Executive Operational Sub-Committee to finalise the operational, quality and financial performance of the Trust.

The efficacy of the governance structure in place is reviewed annually. The last review was completed in Q3 2018 when some minor changes were made to the Committee structure. The Finance and Performance Committee is responsible for overseeing the governance arrangements in place in the Trust.

The Trust carries out an internal Well Led assessment each year, assessing compliance with the CQC/NHSI Well Led Key Line of Enquiry (KLOES) and identifying opportunities for continued improvement. The most recent assessment was completed in March 2019.

In line with NHSI requirements to commission an independent developmental Well Led review at least every three years, Deloitte LLP were commissioned in March 2019 to carry out a review of the Trust's well led arrangements. The final report of findings and recommendations were considered by the Board of Directors in July 2019 and an action plan was approved to respond to the findings. Deloitte found:

- Leadership visibility is high.
- Governance arrangements are a significant strength, with clarity of roles and responsibilities at all levels.
- Risk management arrangements follow many areas of good practice.
- Focus on leadership is to be commended.
- Performance management arrangements are well embedded.

A Governance Development Plan is in place to continue to strengthen governance arrangements. This is monitored every 6 months and reviewed annually to incorporate opportunities for further improvement.

The CQC noted in their well led inspection of the Trust in July/August 2019 that EPUT has a clear and robust governance structure to oversee performance, quality and risk. Governance spanned the entire organisation, with local managers discussing issues at service level in team meetings. The CQC saw a variety of minutes and papers from meetings during the inspection which demonstrated staff reviewed risk, quality and performance. Local managers knew the reporting structure for sharing information and escalating concerns and could describe the ward to board governance structure. The CQC stated that the Trust uses a variety of tools to monitor and assess risk, and that the Trust had a programme of internal audits to review and monitor aspects of their services, linked to the risks identified on the board assurance framework. Frameworks and action plans set out the ways the trust intended to reduce risks identified. The Trust received a rating of 'outstanding' for the domain 'caring'.

Risk Management
The risk management and assurance arrangements in place are set out in the Risk Management and Assurance Framework which is reviewed annually. The Board Assurance Framework (BAF) identifies potential risks. Action plans are in place or in development to mitigate potential risks on the BAF. Each acition plan is assigned to a standing Committee of the Board and reviewed quarterly to ensure that action is appropriate. The BAF is considered by the Board of Directors at each meeting (ten times each year). The Corporate Risk Register (CRR) is reviewed quarterly by the Board of Directors. Directorate risk registers (DRR) are in place to capture service specific risks. Risks are escalated and downgraded to and from the BAF, CRR and DRR. At every meeting within the governance structure, agendas provide for identification and escalation of potential risks (or hotspots).

The risk management arrangements are subject to oversight by the Audit Committee and an annual independent audit. The last independent audit provided significant positive assurance, confirming that that the arrangements in place are mature and more developed than similar organisations which were compared with EPUT.
There is a programme of independent internal audit in place linked to risks identified on the Board Assurance Framework. During 2018/19, nine internal audits were undertaken (fire safety, key financial systems, segregation and seclusion, serious incidents, policy implementation, violence and aggression, cyber security, GDPR and data quality). In addition, EPUT has a further ten internal audits taking place or planned during 2019/20 covering (for example) CQC action implementation, ligature risk reduction processes, observation and engagement, health & safety).

During 2018/19 42 locally identified clinical audits were undertaken. The Trust participated in 14 national clinical audits. An annual report is produced each year and a programme of 38 local audits has been agreed for 2019/20.

There is a positive incident reporting culture in the Trust, and the latest (22nd) NRLS Summary Report which was published on 26 September 2019 and provides information on Patient Safety Incidents reported for the period 1 October 2018 to 31 March 2019. EPUT's cluster benchmark for this reporting period is 53.2 incidents per 1000 bed days, EPUTs reporting rate is 70.6. As of the end of September 2019 our reporting rate is 49.1, which equates to 6, 935 reported patient safety incidents, this is expected to increase as incidents are signed off by managers and audited by risk management. The total number of incidents for the Trust is 12,337.

All incidents are required to be signed off by managers; follow up action recorded and any lessons learnt taken forward. Incident data is routinely produced to drive the patient and staff safety improvement agenda via many of the Trust's sub committees, including a detailed report produced each month for the HSSC that provides an overview of incident trends across Trust services and activities. All incidents reported are triaged by the Risk Management Team to ensure any significant incidents are correctly reported and therefore followed up appropriately. All incidents rated as having moderate harm (or greater) are subject to review by the Moderate Harms Group to ensure that the appropriate level of investigation is carried out. All incidents meeting the NHSI Serious Incident reporting threshold are subject to detailed independent internal investigation.

The Trust has a robust policy development, review and control process in place. There are approximately 340 policies and procedures in place, approved by standing committees of the Board of Directors. The majority of policies in place in the former organisations were merged/ harmonised within 12 months of merger (commented on in the 2018 CQC Comprehensive Inspection). All policies are available to staff on the Trust intranet. Review processes are closely monitored to ensure that policies remain up to date and that appropriate consultation has taken place before approval takes place. During 2019/20 there is a focus on establishing a policy implementation assurance framework to confirm that policy is being implemented (or not) through collation of findings from various monitoring mechanisms. In response to a recent action plan submission to the Parliamentary and Health Service Ombudsman (PHSO) the Ombudsman complimented EPUT on the policies submitted to them being among the best they have seen.

Quality Strategy
The Trust Quality Strategy sets out clear priorities for improving the safety, experience and effectiveness of services. EPUT's priorities are:

- Continued reduction in harm (particularly restraint, suicide/ unexpected deaths)

Our aim for 2019/20 is to decrease harm by 50% with an ambition to move towards zero in pressure ulcers, avoidable falls, medication omission, physical health of mental health patients, and early warning systems for deteriorating patients.

In addition, we aim toimprove and reduce the use of restraint and restrictive practices the Trust is using the principles of 'No Force First' a restrictive intervention reduction programme that seeks to transform the experience of people who use our services. Our achievements will be measured by our ability to change the culture of care within our services and transform the care narrative from 'containment' to 'recovery.' The Trust has secured two places on a national restrictive practice collaborative, run by the Royal College of Psychiatrists, and will use the opportunity presented by this to drive this agenda.

The Trust is moving towards an ambitious target of zero suicide. Critical to achieving this priority is the development of a 'Just Culture' encouraging our staff to speak up when things go wrong and to learn from incidents, feedback and outcomes. This is in addition to our clinical transformation strategy that aims to improve access to services provide new models of care and develop the skills and capabilities of the workforce will enhance our abilities to meet our targets.

- Collective leadership

Embedding a collective leadership culture, shared leadership at team level is being developed bringing to life the Trust's values of openness, compassionate and empowering. Alongside a 'Just Culture' the Trust is making a promise to learn and a commitment to act. The Trust has successfully secured support from NHSI to build collective leadership across STP footprints to deliver system wide service transformation. Working with members of our transformation board and system partners support will be given to conceptualise and introduce new models of delivery that will improve quality and outcomes of care for our populations.

- Continuous improvement

To develop the principles and methodology of quality improvement across all teams and services and empower all staff and service users to identify areas for improvement and undertake actions that will enable the organisation to move to 'Outstanding'. Improving patient safety and the quality of the services we provide is at the core of our business model. By supporting staff to be open about mistakes it will allow valuable lessons to be learnt therefore preventing errors being repeated in the future. The Trust Board has been selected to undertake a Board level programme aimed at embedding a culture of improvement and will use the learning from this programme to embed a system approach to improvement.

- Increasing the use of technology

The utilisation of new electronic systems and tools and maximising the use of those in place is a priority to inform and improve quality. To capture real time quality data, the Trust has procured Perfect Wards that will enable the organisation to acquire, receive, understand and analyse patient safety and quality data. Increasingly, the Trust will produce quality dashboards that will tell the story of our quality priorities and the outcome of actions taken towards improving standards of care.

In addition, an exciting innovation project due to be piloted during Q3 within the Trust is Oxehealth. Oxehealth's Digital Care Assistant is an innovative solution improving safety and

experience on inpatient mental health wards. It uses an optical sensor to pay attention to a room; it can see movement and measure vital signs. There is no device connected to the patients and the solution works even in total darkness. It supports ward staff working on inpatient wards and has been proven to reduce patient risks as well as enable a better patient experience relating to better sleep, feeling safer and a greater sense of privacy at night.

In addition, the Digital Care Assistant provides staff with objective data for reporting purposes, to learn from serious incidents or near misses, for auditing / assessment purposes. A number of NHS Trusts have deployed the Digital Care Assistant in seclusion rooms to increase physical health monitoring, especially post rapid tranquillisation to reduce restrictive interventions and improve adherence to physical health monitoring policies. The Digital Care Assistant also alerts to 'no activity' in an occupied seclusion room, alerting staff earlier to potentially life-threatening incidents.

Two reports have been published by NHS Trusts (Coventry & Warwickshire Partnership NHS Trust / Oxford Health NHS Foundation Trust) on the real-world evidence of the Digital Care Assistant. They state that deploying Digital Care Assistant delivered the following benefits:

- 33% reduction in falls at night.
- 56% reduction in A&E demand.
- 71% reduction in enhanced observations; 7,800 clinical hours saved annually.
- Staff reported improved patient safety and confidence.
- Carers reported greater peace of mind.
- Rated as an example of outstanding practice by the CQC.
- Patients reported feeling safer, sleeping better and greater privacy.

The Trust will be piloting this new technology on Peter Bruff ward and Hadleigh ward. The pilot will take place for 3-6 months from the date of commencement.

Ligature and Safety Spend
EPUT's Estates Strategy confirms the commitment to providing services in fit for purpose premises. Building on the previous investment by former NEP since April 2017 there has been a particular focus on ligature risk reduction (investment of c£2.2m since April 2017); improvements to seclusion facilities in CAMHs and Learning Disability inpatient services and relocation of the Cumberlege Intermediate Care Centre (Community Health Services). Whilst the majority of inpatient services offer single bedroom accommodation, three adult mental health inpatient wards have dormitory style bedrooms. In June 2019 the Board of Directors approved investment of £6.4million and a programme of works to eliminate remaining dormitory accommodation by 2021. One ward (older people, functional mental health) was re-provided to provide single bedroom accommodation in 2019. The financial plan 2019/20 includes a commitment of a further £2.3m for patient safety related improvement works and £1.4m backlog maintenance.

As noted, EPUT is continuing to develop a standardised approach to replacing fixtures, fittings and furniture with products of a reduced ligature risk design. The Design in Mental Health Network (DIMHN) conference held in May 2019 was attended by an EPUT Estates representative. It was confirmed at the conference by the Director and Head of Profession NHS Estates and Facilities NHSE/I (NHS England/Improvement) that they are currently working on a Health Technical Memoranda (HTM) for fixed point ligatures risks. HTMs give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare. It is hoped the ligature HTMs will be made available to Trusts by year end.

In June 2019, the DIMHN published a draft consultation document; a design guide for products installed and used within buildings and facilities for mental health care – test methods and performance categorisation criteria. This document has been shared with the Estates Expert Reference Group for consideration.

EPUT is fortunate as at present a former inpatient ward is vacant at Thurrock Hospital which is being held pending the planned conversion / redevelopment to form a new Integrated Medical Centre (IMC) on the site. This presents the Trust with the opportunity of being able to test various potential solutions to ligature issues in a safe environment, free from patients and ward staff, but representing a similar environment that would be found on an operational ward. EPUT has been testing options for ceiling mounted fixtures to reduce ligature risk on the vacant ward and will be using the space to test fittings for dispensers in bathrooms and toilets.

The test ward enables destructive testing to take place on a variety of ligature reduced fittings to ensure that they meet our standards and where such destructive testing can be undertaken in a safely managed environment. Use is to be made of load testing equipment to establish at what applied weight a fitting comes away so that this replicates an attempted ligature, and it is important to establish that a potential solution would work in practice and both works as designed in normal use but would fail if a ligature attempt was made.

This is a recent development for the Trust, which is invaluable during the process of establishing which options work best. In addition, the Trust will be hosting a regional meeting for Estates leads from NHS Mental Health Trusts to discuss the removal of ligature risks and share learning and ideas with other Trusts to increase patient safety across the NHS.

Financial Position

EPUT's financial position at the end of 2017/18 and 2018/19 is detailed in Table 2:

Table 2

[I/S]

Table 3

Patient Safety Spend

General Patient Safety	[I/S]
Anti Ligature Soap Dispensers	
Sight Lines	
Anti Ligature Showers & WC's	
Anti Pick Mastic	
Door Top Alarms	
Anti Ligature Doors	
Anti Ligature Windows	
Anti Ligature Curtain Tracks	
Anti Ligature Loft Hatches	

Safer Staffing

In addition to the works to reduce ligatures, the Trust has or will be taking forward a number of initiatives to further improve patient safety.

On an annual basis the Trust undertakes an establishment review that is focused around nursing levels on inpatient areas. This year the Trust is focusing its establishment review on the triangulation model shown in Figure 1 that sets out the principles of safer staffing.

During September 2019, all inpatients units have collated acuity data against either the Mental Health Optimal Staffing Tool (MHOST) or Salford acuity tool for a period of 20 days. This has given an initial impression of individual ward acuity and staffing requirements. Alongside this a meeting has taken place with ward managers, matrons, senior clinical leads and a member of the nursing directorate to review the data collated against establishment and planned activity to explore staffing pressures associated with acuity. The triangulated data will be collated for appraisal and discussion with the Executive Operational Sub Committee during October 2019 for presentation at Trust Board in November 2019.

Areas identified with high acuity will continue to use the dependency tool to inform evidence based decision making prior to the 2020/2021 financial year. This is being triangulated with incident data/complaints incorporating professional judgement.

Figure 1: Principles of safe staffing



On a daily basis, clinical areas take part in a SitRep to discuss established versus planned versus actual staffing levels. The Trust has a dashboard in place that allows operational management from Executive Director to ward manager to have access to details regarding the current situation on the wards, including

staffing levels, bed occupancy, skill mix, and training. It also details the particulars of the client group i.e. observation levels in place. This dashboard was already in place in former SEPT and has now been rolled out across all EPUT sites. This is shared twice daily with all Executive Directors.

Significant progress has been made over the past two years in managing mental health inpatient capacity/ demand which does pose risk to the quality of our inpatient services, the experience of patients, system resilience and has financial implications. As noted SitReps take place, twice daily to manage flow and capacity. An OPEL status is determined as a result and escalation actions taken as necessary internally and with system partners as necessary. A flow/capacity inpatient ward occupancy dashboard, developed as part of winter planning 2018/19 provides real-time data to support much improved bed management arrangements; red to green weeks have taken place, weekly Delayed Transfer of Care (DTOC), SitReps occur and patient pathways reviewed.

EPUT has in place an out of hours Site Coordinator role which is key to ensuring that services are coordinated and managed in a clinically effective and safe manner. It is also critical in ensuring that all untoward and significant incidents are dealt with in accordance with Trust policies and procedures. The Site Coordinator provides senior oversight and assurance across a given site/locality and is the first point of contact for the management of issues pertaining to that area of responsibility. At the start of each shift, they ensure that all wards are appropriately staffed to meet clinical need; which may include the redeployment of staff as appropriate. They oversee the appropriate management of all instances of seclusion as per policy. They participate in the daily weekend SitRep process and Safer Staffing Calls in order to ensure the coordination of flow and capacity in keeping with Trust Bed Management procedures and protocols and ensure that all planned ward based therapeutic and recreational programmes are maintained.

The Trust has been working on improving access to mental health services for people in crisis. One area of improvement is within Acute Hospital where the Trust has introduced a Mental Health Liaison services into each of the 5 Acute Trusts across Essex. These services have received transformation funding to ensure that they are able to achieve specified staffing levels. The South Essex services have established Mental Health Liaison services whereas the 3 North localities are in the process of implementing increased staffing to meet 24/7 service provision. Whilst part of the focus of the service is to provide improved quality of care for individuals with physical health problems there are significant numbers of people who present to the Accident and Emergency Department with mental health presentations. The Mental Health Liaison service is able to provide a rapid assessment and diversion to mental health service where needed.

Ward Initiatives

The Trust has introduced performance stations in all inpatient units. These provide information to staff on the ward's performance in a number of metrics for discussion including safety items such as number of incidents, complaints and compliments, vacancy rates and KPI's relating to ward occupancy. Where performance drops in a number of areas deeps dives are completed to understand if there is an underlying issue which may require a change. Any significant hotspots identified may result in a Rapid Response Task and Finish Group being established to support the ward's underperformance and return them to the required standard.

The Trust has also introduced safety huddles across all inpatient wards. They are short multidisciplinary briefings, held at a predictable time and place, and focused on the patients most at risk. Safety huddles involve agreed actions, which are informed by visual feedback of data and provide opportunities for staff to celebrate their successes in reducing harm. They enhance teamwork through communication and co-operative problem-solving, share

understanding of the focus and priorities for the day and improve situational awareness of safety concerns.

EPUT has implemented matron meetings trust wide which enable the sharing of learning from incidents and from other organisations to ensure best practice is in place.

The Trust has prioritised, in line with national guidance, physical health care assessments for people with mental health conditions as it is recognised that this client group may have greater physical health needs particularly in relation to cardio-vascular and diabetes.

Quality Initiatives
In May 2019, a Quality Conference was held providing a professional development and sharing of good practice opportunity for Quality Champions and staff eager to be engaged in the process. At each Board of Directors meeting, staff are invited to present and showcase an improvement project. In recent months, the substance misuse service has described the improvement journey following the CQC requires improvement rating in 2018. A service user presented the co-production initiatives taking place in secure mental health service; Enable East demonstrated significant positive outcomes in getting mental health service users into and keeping them in employment and training and the community learning disabilities team showcased the award winning work that they have carried out to improve dental health of people with a learning disability in partnership with community dental practices.

EPUT holds an annual Quality Awards to highlight and share learning and new initiatives. In addition, our Quality Academy has been in place since 2017. It supports and facilitates staff to develop and share best practice using a common language for improvement. Around 670 Quality Champions have received Quality Improvement (QI) training through the Academy. Each training cohort consists of five sessions. The QI Framework confirms the EPUT model for improvement, which includes a range of tools and skills that staff will be equipped with. Four senior leaders have participated in the NHSI QSIR (Quality Service Improvement and Redesign) College programme that provides the opportunity to develop quality and efficiency improvement capability to rapidly build up a local skills base through the EPUT Quality Academy. They are accredited to run the programme internally.

370 QI projects, of varying scope/ scale have been registered by the Quality Champions who have been through the Academy. There is a repository of projects on the intranet and a resource hub.

Building on the success of the establishment of a Quality Hub within secure mental health services, these are now being rolled out to all divisions. Quality Hubs consider service specific issues and the priorities for QI projects that Quality Champions are assigned to take forward. A Trust wide QI forum is now in place.

EPUT is participating in national improvement collaboratives to share the Trust's good practice and to learn from others in the following areas:

- Recruitment and retention
- Falls
- Restrictive practice
- Observation and engagement
- Sexual safety

The quality of some Trust services has received external accreditation:

- AIMS Grangewaters Ward

- AIMS Assessment Unit
- Quality Network for Inpatients (QNIC)
    - Larkwood Ward
    - Rainbow Unit
    - Poplar Unit
- ECT Accreditation Scheme (ECTAS) – Basildon MHU
- Memory Services National Accreditation Programme (MSNAP) – Dementia Services (North East)

In addition to the internal quality recognition programme, the Trust encourages and supports staff and teams to make applications for local and national awards. Recent recognition includes:

- NHS Parliamentary Awards: Enable East team have entered the Heads Up (Employment Support Programme) and the applications have been supported by a local MP
- LD Nurse of the Year: two LD nurses were presented with the award at the National LD and Autism awards for their work with dental practices
- Mentor of the year: two LD nurses were presented with the award by Hertfordshire University following nomination by a student
- NHS@70 awards: one of the Heads of Physiotherapy was recognised for his leadership by the Nigerian Healthcare Professional UK organisation from a shortlist of 207.
-

Queens Nurse Awards: two nurses (from the LD and Memory Assessment Services) achieved this honour.

Staff Training

The Trust has in place training programmes linked to patient safety, which depending on their job role are mandatory for staff and must be repeated within a set time. All training courses are reviewed at least annually with the subject lead to ensure they remain relevant and up to date with current standards and best practice.

In the past year (to 31 August 2019) 828 training courses were delivered covering 23 mandatory/ essential training subjects and 8447 staff completed the training provided. Compliance with mandatory training is also monitored locally via a "tracker" on the intranet and by the Board of Directors each month. Trust compliance at the end of August 2019 was 93.5%. Compliance with essential training was 94% (where the target is 90%) and 93% (where the target is 85%).

All staff working within an inpatient setting are required to complete the ligature awareness on-line training package (launched in March 2018) "Preventing Suicide by Ligature" on an annual basis. The training package details:

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

The training package was last reviewed during July 2019 in line with policy developments and the two Estates and Facilities Alerts detailed above. The new training package went live on 2 August 2019; it will be reviewed on an annual basis.

Other mandatory safety related courses which inpatient staff must complete are:

- Falls prevention - 3 yearly
- Restrictive practices – annually
- Security (Secure Services) – annually
- Safeguarding - 3 yearly
- Care Planning (care co-ordinators only) - 3 yearly
- Infection prevention - 3 yearly

Learning Lessons
EPUT has in place a Learning Lessons Oversight Sub Committee which reports to the Quality Committee. The role of the Sub Committee is to provide assurance to the Quality Committee that learning identified through different work streams has been reviewed and taken forward across the Trust with processes and controls in place to ensure learning has been embedded into clinical practice. The Sub Committee is responsible for monitoring effective systems and processes that:

- review and discuss learning in aggregate including from serious incidents, complaints and patient experience;
- identify any trends or themes for further actions to be taken forward
- identify and manage any clinical risk issues and provide assurance on the arrangements to mitigate future risk
- agree evidence required to assure that learning has been embedded into clinical practice.

In order to ensure key messages are cascaded to staff EPUT has introduced “Five Key Lessons” which re communicated each month electronically and via poster format and available on the learning lessons section on the intranet. In addition the Trust publishes a Quality Matters Newsletter, and holds a Quality Conference and Nursing Conference to support development and sharing of good practice.

EPUT commissioned a review of Serious Incidents by Professor Appleby (who leads the National Suicide Prevention Strategy for England) in 2018. The recommendations led to task and finish groups focusing on Clinical Practice and ‘At Risk’ Groups being set up, changes being made to the Trust’s root-cause analysis reports, and the clinical policy being redrafted which will be completed by the end of December 2019.

EPUT has an Adverse Incidents Policy and Procedure which details the process to be followed when an incident is reported. A key aim of the incident reporting and learning process is to reduce the risk of recurrence, where the original incident occurred and elsewhere in the NHS. EPUT recognises that the timely and appropriate dissemination of learning following an incident is core to achieving this and to ensure that these lessons are embedded in practice. Team leaders and managers regularly review their own incidents singly and collectively to identify lessons learned. As noted Matron Meetings are in place which allow details of incidents and learning to be shared and discussed for cascading to teams to ensure improvements are implemented.

All Serious Incident investigations aim to identify lessons learned, and make SMART recommendations that relate to the findings. Action plans are developed, implemented, and compliance is monitored by the responsible directorate. Lessons learned are fed back to the

Risk Management Department via the Datix reporting form, once approved by the sign off panel and the relevant CCG.

Critical Incident action plans are developed by the responsible directorate once the internal investigation report is signed off. In addition, the relevant sub committees receive the learning and recommendations from the final reports. The Serious Incident Team monitor the progress for compliance on times and evidence submitted.

As noted the Trust's Risk Management Team coordinate regular analysis of incident statistics, including as a minimum: trends, severity and locations and report these monthly to the HSSC, who are responsible for incident analysis. The analysis includes both qualitative and quantitative data. Any lessons learnt/service changes made as a result of incident analysis will are outlined in the monthly analysis report. Outcomes discussed as part of the HSSC and the Clinical Governance Sub Committee are cascaded by members to their sub committees and directorate meetings.

The Risk Management Team provides monthly statistics to the Performance Department to enable the organisation to monitor effectiveness against key performance indicators and report to the Board of Directors.

Coordinated analysis is undertaken a minimum of 6 monthly and will include both qualitative and quantitative data. Any lessons learnt/service changes made as a result of the coordinated analysis will be outlined in the 6 monthly report. This analysis is provided to the HSSC, Clinical Quality Sub Committee, Learning Oversight Sub Committee and Senior Management Teams. Any risks identified through the coordinated analysis are sent to the relevant directors for assessment and potential inclusion on the risk register.

Following a serious incident investigation the report, findings and recommendations are shared with the team(s) involved to enable them to be discussed with the team and involve the team in their implementation. Lessons learnt or service changes made following investigations and incident trend analysis are shared with those involved in the incident and other staff members this is completed via:

- The intranet
- Reports to the HSSC
- The Clinical Quality Sub Committee
- Annual reports
- Performance reports
- Debriefs with teams involved

Trust staff elected EPUT's Principal Freedom to Speak Up Guardian. The Principal Guardian is supported by 20 Local Guardians. The Principal and Local Guardians actively support staff who identify and report poor practice, clinical risk and issues affecting them. The guardian service aims to facilitate discussions with the Leadership Team to address the concerns raised by staff.

The Principal Guardian meets with Local Guardians regularly and with the Executive Director of People and Culture and a Non-Executive Director who champion the agenda and discuss issues requiring escalation or organisational attention. In addition, the Principal Guardian meets with the Chief Executive and Trust's Chair of the Board of Directors on a quarterly basis. The Principal Guargian also presents to the Trust Board and has direct links with the National guardian. Thirty concerns were reported through the F2SU process during 2018/19.

Technology

The Trust is always considering how technology can be further utilised to support us with patient safety. The EPUT Lab provides a forum for clinicians to discuss their ideas for technical innovation and for suppliers to present potential technical solutions for quality related issues. The Lab has been responsible for development of the IAPT App which provides remote treatment options and self-referral if required to the Trusts "Therapy For You service. Two further Apps are in development: medication reminder and early intervention.

As noted the Trust is currently rolling out Perfect Ward. This is an app-based, real time inspection and reporting tool for healthcare inspections. Questions, answer options and guidance can be customised for different areas or types of organisation. Feedback of the product is very positive, in July 2018 PwC announced their investment in the business and recent CQC inspections have commended organisations for using the app to inform and drive forward the quality agenda.

Perfect Ward typically halves the time it takes to do a manual audit and as soon as an inspection is completed, the results are immediately available for everyone to see. Live, transparent reporting enables front-line clinical staff to make improvements straight away, empowering clinical staff to take an active part in continual quality improvement. Perfect Ward has been found to have a big impact on quality, patient experience and allows staff to spend more time with patients and less time on administration. The feedback from wards that undertook a trial was that the product was quick and easy to use.

The features of Perfect Ward are as follows:

- Capture inspection results in-app eliminating paperwork
- Real-time automated reporting for inspections
- Capture photos and free text comments to exemplify inspection findings
- Transparent reporting with drill down capability to see underlying results
- Remote access to all historical reports
- Immediate notification of inspection results
- Automated alerts for inspections due/overdue and on failed questions
- Compare performance between areas, inspectors and by decision or site
- Customised for different audits, questions, answer options and guidance
- Automated monthly reporting for each area and organisation-wide.

Benefits include:

- Reduce time spent inspecting. Typically, you can halve inspection time
- Eliminate administration time in writing reports and analysing results
- Quickly identify issues across the organisation
- Compare performance and identify the best and worst performing areas
- Ensures inspection evidence is captured with clear audit trail
- Gain assurance from being able to track performance
- Ensure the Trust's inspection regime is comprehensive covering all areas
- Ensures inspection results are robust with consistent inspecting
- Access key information including staffing, management and location
- Ensures consistent inspections with automated updates.

The Trust has recently invested in SafeCare with implementation commencing in September 2019. SafeCare is an extension of HealthRoster (e-rostering) that enables staffing to be planned in line with patient acuity. The implementation plan has been developed to facilitate implementation of four wards at a time. Full implementation will be achieved in July 2020.

Conclusion

As stated at the beginning of this letter, unfortunately EPUT is unable to address, in detail, the matters set out in the appendix to the HSE letter of 12 July 2019. However, we do not in any way underestimate the importance of these matters or, more generally, the deep concerns expressed more widely regarding aspects of patient safety at the former NEP.

As outlined in this response EPUT takes patient safety risks seriously, and those relating to ligatures extremely seriously indeed. Improving patient safety has been EPUT's top priority since the Trust launched in April 2017 and it will continue to be so for the foreseeable future. We would ask you to consider the prosecutor's Full Code Test and, in particular, the public interest element. We would ask, in light of the matters set out above, for the HSE to take particular account of the relevant parts of paragraph 4.14b of the Code for Crown Prosecutors:

"b) What is the level of culpability of the suspect?

- *The greater the suspect's level of culpability, the more likely it is that a prosecution is required.*
- *Culpability is likely to be determined by:*
  i. *the suspect's level of involvement;*
  ii. *the extent to which the offending was premeditated and/or planned;*
  iii. *the extent to which the suspect has benefitted from criminal conduct;*
  iv. *whether the suspect has previous criminal convictions and/or out-of-court disposals and any offending whilst on bail or whilst subject to a court order;*
  v. *whether the offending was or is likely to be continued, repeated or escalated;*
  vi. *the suspect's age and maturity (see paragraph d below).*
- *A suspect is likely to have a much lower level of culpability if the suspect has been compelled, coerced or exploited, particularly if they are the victim of a crime that is linked to their offending.*
- *Prosecutors should also have regard to whether the suspect is, or was at the time of the offence, affected by any significant mental or physical ill health or disability, as in some circumstances this may mean that it is less likely that a prosecution is required. However, prosecutors will also need to consider how serious the offence was, whether the suspect is likely to re-offend and the need to safeguard the public or those providing care to such persons."*

Whilst it is acknowledged that criminal liabilities from the former Trusts did pass to EPUT as part of the technical legal process, as is referred to in the third paragraph of your letter, it is submitted that EPUT's culpability should be assessed on the basis it is not the organisation against which the factual case is put.

That said, the public disquiet in respect of ligature-related deaths at the former NEP is well known and publicised and EPUT fully recognises that transparency and public accountability are vital when considering the appropriate action to address this. We also fully acknowledge the distress of the families involved.

These issues have already been the subject matter of a report from the PHSO, '*Missed opportunities: What lessons can be learned from the failings at North Essex Partnership University NHS Foundation Trust*'. The HSE can be assured that these issues and the action EPUT has taken and continues to take to address them, are subject to close and public scrutiny by senior national regulatory bodies for the NHS, with powers to take significant measures against EPUT should the Trust's remedial actions be found to be insufficient in any way.

Finally, the financial position of EPUT is a matter to be considered carefully, as with all NHS Trusts. As the 'Patient Safety Spend' diagram on page 18 demonstrates, EPUT has a substantial direct spend on patient safety with well over half being spent on anti-ligature measures from 2017 to date. It is important to re-emphasise that the financial and other resources spent by EPUT relate to problems and failures that existed prior to the new Trust's existence.

EPUT is not a new Trust in name only. It is run by a different Board of Directors, primarily drawn from the former SEPT, with a different senior leadership team and a very different way of operating. EPUT's funding covers not only the former NEP's sites and staff, but also those of the former SEPT. It is expected of EPUT to run services not on the combined budgets of both these former Trusts, but on a lower overall budget as a result of savings achieved through mergerdue economies of scale of merging corporate functions.

Should the prosecution being considered by the HSE result in a conviction and sentence for EPUT, this would, potentially, place a significant financial burden on a Trust which is not, in practical terms, culpable for the failures of a former Trust. This will reduce EPUT's capacity to provide the public and patients with essential care and services. Additionally, in respect of resources and staff which came to EPUT from the former SEPT, it should be taken into consideration that these staff may be affected by a financial penalty and had no involvement whatsoever in the matters set out in the HSE's 12 July 2019 letter.

Paragraph 4.10 of the Code for Crown Prosecutors recognises that:
"It has never been the rule that a prosecution will automatically take place once the evidential stage is met. A prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour."
We submit, notwithstanding the serious nature of the concerns, that given EPUT's reduced culpability as a new organisation, the significance of the work the Trust is doing to address ligature risk and the Trust's financial position, it is not in the public interest nor a proportionate response to prosecute EPUT, but it would be more appropriate for the HSE to continue to work with and monitor the Trust, alongside close scrutiny by the national regulators, to ensure that EPUT continues to provide the best and safest possible service to the communities we serve.

We appreciate your consideration of our lengthy submission.

Signed etc.