Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Teams Live Event
Wednesday 26 May at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Teams Live Event

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
	PRESENTATION: Parent Infant Mental Health Service and Family Group Conferencing Dr Ellen Auty, Consultant Clinical Psychologist Clinical Lead of Parent Infant Mental Health Service & Perinatal Psychology			
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 31 March 2021	SS	Attached	Approval
4	**ACTION LOG AND MATTERS ARISING**	SS	Attached	Noting
5	Chairs Report (including Governance Update)	SS	Attached	Noting
6	CEO Report	SS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	SS	Attached	Noting
(b)	NHSI Self-Certification	JD	Attached	Approval
(c)	Freedom to Speak Up Report 2021	YM	Attached	Noting
(d)	Complaints Annual Report 2020/21	SL	Attached	Approval
(e)	Equality and Inclusion Report Annual Report 2020-21	SL	Attached	Noting
(f)	Learning from Deaths - Mortality Review Summary of Q3 2020-21	NH	Attached	Noting
(g)	Patient-Led Assessments of the Care Environment PLACE	TS	Attached	Noting
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2021/22	NJ	Attached	Approval
(b)	Standing Committees:			
	(i) Audit Committee	JW	Attached	Noting

	(ii) Finance & Performance Committee	ML	Attached	Noting
	(iii) Quality Committee	AS	Attached	Noting
	(iv) People, Innovation & Transformation Committee	ARQ	Attached	Noting
9	**RISK ASSURANCE REPORTS**			
	(i) COVID-19 Assurance Report	NJ	Attached	Noting
	(ii) EU Exit	NL	Attached	Noting
	(iii) Ligature Risk Management Year End Learning Report 2020-21	NJ	Attached	Noting
10	**STRATEGIC INITIATIVES**			
(a)	Mental Health & Community Health Services Transformation	AG	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
(a)	CQC Update	NJ	Attached	Noting
(b)	Safe Working of Junior Doctors Annual Report covering 1 April 2020 to 31 March 2021	MK	Attached	Noting
12	**OTHER**			
(a)	Use of Corporate Seal	JD	Not Used	Noting
(b)	Correspondence circulated to Board members since the last meeting.	SS	Verbal	Noting
(c)	New risks identified that require adding to the Risk Register or any items that need removing	ALL	Verbal	Approval
(d)	Reflection on equalities as a result of decisions and discussions	ALL	Verbal	Noting
(e)	Confirmation that all Board members remained present during the meeting and heard all discussion (S.O requirement)	ALL	Verbal	Noting
13	**ANY OTHER BUSINESS**	ALL	Verbal	Noting
14	**QUESTION THE DIRECTORS SESSION** A session for members of the public to ask questions of the Board of Directors			
15	**DATE AND TIME OF NEXT MEETING** **Wednesday 28 July 2021 at 10:00**			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 29 September 2021 at 10.00 Wednesday 24 November 2021 at 10.00			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 31 March 2021
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof. Sheila Salmon (SS)	Chair
Paul Scott (PS)	Chief Executive Officer
Alex Green (AG)	Executive Chief Operations Officer
Prof. Natalie Hammond (NH)	Executive Nurse
Nigel Leonard (NL)	Executive Director of Strategy & Transformation
Trevor Smith (TS)	Executive Chief Finance Officer
Sean Leahy (SL)	Executive Director of People & Culture
Alison Davis (AD)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Janet Wood (JW)	Non-Executive Director
Rufus Helm (RH)	Non-Executive Director (via the audience)
Loy Lobo (LL)	Non-Executive Director (via the audience)

In Attendance:

James Day (JDa)	Interim Trust Secretary
Chris Jennings (CJ)	Assistant Trust Secretary (Minutes)
Tina Bixby (TB)	Assistant Trust Secretary
Clare Sumner (CS)	Trust Secretary Administrator
Jo Debenham (JDe)	Head of Staff Engagement
Caroline Thomsett	Interim Director of Communications and Marketing
Charlie Bosher (CB)	Quality Health (For 27/21)

SS welcomed everyone to the public Board meeting. SS welcomed LL to his first Board meeting as a newly appointed Non-Executive Director and advised that for technical reasons he would be joining and contributing to the meeting from the audience section. Processes were underway to ensure the right accessibility join the meeting fully.

025/21 APOLOGIES FOR ABSENCE

Apologies were received from Dr. Mateen Jiwani, Non-Executive Director.

026/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

027/21 PRESENTATION: STAFF SURVEY RESULTS

SS introduced a presentation regarding the encouraging staff survey results for the Trust. SS advised that CB was also having difficulty joining the meeting and therefore the presentation would be delivered initially by JDe.

JDe advised that the presentation focused on results of the Staff Survey 2020, which staff would have completed in September – November 2020. JDe provided details of the staff survey needing to be facilitated by an external provider and the Trust had engaged Quality Health for this purpose for a number of years.

JDe advised that the results of the staff survey are used by NHS England and the CQC to assess the performance of the Trust and is a requirement for the Trust to participate as a healthcare provider. The Trust also uses the results internally to measure the experience of staff across a range of areas, such as staff engagement, patient experience and patient outcomes. There had been some changes to the survey due to the Covid-19 pandemic, relating to feeling safe at work and some questions that allowed results to be broken down by elements of the pandemic (i.e. working on a Covid-19 ward), however, the majority of questions had remained the same. A statement was provided made by the staff survey coordination centre acknowledging the context of the Covid-19 pandemic and being aware that it was the context in which staff were completing the survey.

JDe advised that the Trust response to the Staff Survey was 46.5%, with the majority of responses online, but some completed by paper. The response rate was slightly below average for the Trust sector of mental health and community services, which was disappointing, but still a good response rate overall given the context of the pandemic.

JDe provided a number of key results identified by the staff survey, including:

- The Trust engagement score was 7.17 which was a slight increase from the previous year. This score was measured across the themes of Advocacy (recommending the Trust as a place to work), Motivation (staff motivation to work) and Involvement (staff ability to contribute towards improvements at work).
- The Trust scores had not changed significantly overall, but the following had improved scores from last year:
    - Care of patients / service users in my organisation is a top priority.
    - I would recommend my organisation as a place to work.
    - If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.
- Where the scores had improved it was not considered a significant change within the sector.
- Health & Wellbeing showed there had been significant improvement from the previous year. The Trust taking positive action on health & wellbeing improved by 9% and the Trust was better in than the sector overall.
- The number of staff reporting coming to work when feeling unwell has declined, which is significant given the pandemic and the potential for staff to feel more pressured to come to work.
- Equality, Diversity and Inclusion showed slight improvements from the previous year, but was still significantly worse within the sector.
- More staff had experienced musculoskeletal issues in 2020 and this was being investigated.
- The number of BAME staff experiencing bullying and harassment has reduced, however, there has been an increase in BAME staff experiencing bullying and harassment from other staff. There was also some concern around career opportunities and staff personally experiencing discrimination at work from managers and colleagues.

CB joined the meeting

CB thanked JDe for delivering the presentation in his absence and advised he had experienced technical difficulties when trying to join the meeting.

CB advised that the overall results of the staff survey for the Trust was fantastic as the overall trend across the NHS was downward, particularly around the quality of care. The Trust had seen some sweeping improvements and CB was pleased to see such improvements, having worked with the Trust on the staff survey for a number of years. CB advised there were one or two areas the Trust would need to review, such as equality and diversity. CB advised that discrimination was a particular areas of interest for the CQC, especially when it is reported as happening from an internal source.

Bullying and harassment was a trend across the NHS and therefore the Trust should potentially focus on where it is happening internally.

CB provided some recommendation made by Quality Health, based on the results, but advised that these were the opinion of the organisation and should simply be considered by the Trust.

CB advised that the issue relating to musculoskeletal was a theme across the NHS and it was due to the nature of working during the pandemic. CB also advised that the scores for staff morale were good, but there was a low score around feeling involved in changes about the way staff work, which could have been affected by the pandemic and the re-deployment of staff.

CB reiterated the point that the overall scores have declined in many Trusts, but there has been broad improvement in EPUT which is something that should be celebrated with staff. Communication had also been reported a poor in many organisation during the pandemic, but there were great scores in EPUT which suggests senior managers are communicating well.

SS thanked JDe and CB for the presentation. SS felt the scores were very positive, especially having experienced the toughest of years in the NHS. There were areas that needed to be reviewed, but was proud of the overall scores received. SS invited questions or comments from members of the Board.

SL congratulated the organisation on the efforts borne out by the results of the Staff Survey. He gave particular thanks to the Staff Engagement and Human Resources teams for their efforts. SL acknowledged there were still significant improvements required and these were being addressed, especially relating to bullying, harassment, diversity and inclusion. SL advised there were plans in place to address these and he was happy with the scores for 2020 and looked forward to good scores in 2021.

PS felt that the results were a validation on the approach being taken in relation to staff engagement within the Trust. PS advised that the survey was important as it was a primary scientific source of data on staff engagement and wellbeing. There was lots of qualitative data throughout the year, but the data in the staff survey acts as punctuation mark to see if staff engagement is working. PS agreed there was a need to focus on equality, diversity and bulliyng, but also included the element of staff being involved in changes in their workplace as this was an important part of the new Safety Strategy. PS hoped to see improvement in these areas once the safety strategy is implemented and will be a measure of whether the strategy is right.

SS thanked JDe and CB for the presentation and looked forward to welcoming them back next year when new staff survey results are published.

CB left the meeting.

028/21 MINUTES OF PREVIOUS MEETINGS

The minutes for the Board of Directors meeting on the 27 January 2021 were agreed as an accurate record.

029/21 ACTION LOGS AND MATTERS ARISING

The action log for the 27 January 2021 was reviewed and noted that all actions had been completed.

030/21 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

SS presented a report as circulated providing a summary of key activities and information to be shared with the Board and stakeholders, including an update on governance developments in the Trust.

SS advised that this was the last Board meeting for AD who would be leaving the Trust to become the Chair of Milton Keynes University Hospitals Foundation Trust. SS thanked SS for all the hard work within the organisation.

SS advised that her report included information about the staff survey results, covered in the presentation and further information was included in the CEO report. However, SS advised it was pleasing that the Trust was in the top ten high performing mental health Trusts

SS asked the Board of Directors to note the content of the report and invited any questions.

The Board of Directors received and noted the report.

031/21 CEO REPORT

PS presented a report as circulated providing a summary of key activities and information to be shared with the Board of Directors. PS advised that the report was split into two, with information that he believed was important to share as the CEO and the other being an update from individual Executive Directors for their areas of operation.

PS highlighted the following areas from the report:

- Staff survey results which had been the subject of the earlier presentation and reflection session.
- The anniversary of the Covid-19 lockdown, with the report noting it had been the “worse of times and the best of people”.
- The remembrance service that had been held to mark the anniversary of the lockdown and the fact that had been well-received by colleagues. PS thanked Reverend Paul Walker for the service. The service had highlighted that it had been a difficult year for everyone, but everyone’s experience of the pandemic had been different. It was therefore important to understand what people may currently be experiencing and to continue to be kind to each other. PS hoped that this was reflected in the behaviour of the Leadership Team throughout the year.

PS advised that the report noted an increase in vaccinations in March, but later identified a decrease in vaccinations at the end of March. PS advised that these were both true statements and reflected the volatility of the vaccination programme. There had been an increase in vaccination supply for March, but it was forecast there could be decrease in supply from April. However, assurance was provided that people would still be protected and would still get the vaccinations for the slots that had been booked.

PS advised that each Executive Director would provide am update for their respective operational areas.

NH highlighted the following areas from the report:

- The Trust had fully embraced the Safety Strategy, which now had some key deliverables attached which gave the strategy form and function within the organisation. NH highlighted the process being undertaken in relation to the quality improvement partner completing a diagnostic on inpatient wards, which had been met with enthusiasm and energy by staff. NH felt it was important to recognise the enthusiasm that staff still have for delivering high quality safe care, despite the ongoing circumstances of the pandemic.
- The Trust was close to signing-off the Patient Safety Incident Response Framework (PSIRF) and noted the large amount of work that had been undertaken to ensure the Trust remained on track. NH advised that early indications have suggested that the PSIRF was being met with greater responsiveness within the organisation and with system partners. System partners had shown a keenness to learn from the Trust as it becomes an early adopter of the PSIRF.

AG advised that the Trust had remained stable in relation to operational performance and highlighted the following areas from the report:

- There had been an increase in the number of areas achieving its targets in February (25) comparted to January (23).
- There had been improvement in an area of focus for the Trust relating to people being seen within 12-months. Focus work had been completed, using an organisation called Meridian and reviewing outpatient data to understand the true breaches in this area. The position had improved significantly, but it was still being kept on the agenda to ensure the Trust reaches the desired outcome.
- There was a continued pressure on mental health inpatient capacity. The position had improved in February 2021 with services spending one-day Opel-4, compared to six-days in January 2021. However, there were still too many out-of-area placements and demand was very high. There had been an increase in the level of acuity and the organisation was trying to understand the existing and new pressures, with modelling work being undertaken nationally. The Trust had been working with the regional team to discuss how Opel status is recorded and there would be a dashboard methodology developed from the 19 April 2021.
- There was pressure on CAMHS Tier 5 beds and an unprecedented level of acuity, with a number of patients requiring high level observations (Levels 3 & 4). However, the positive was that there were different conversations happening locally and regionally regarding the pressure and the importance of bridging the gap between Tier 3 and Tier 4 services to provide the best services for young people.

MK advised that he was joining the board meeting from the new Topaz Ward, which was waiting to receive its first new patients once AG had visited and approved the environment. MK highlighted the following areas from the report:

- Patients with autistic spectrum disorder where finding it difficult during the pandemic, with a number of patients being admitted to CAMHS and Learning Disability services. This was being raised with Commissioners in terms of having a better service provision for patients with autistic spectrum disorder.
- Work was being undertaken in relation to outpatient services (as highlighted by AG) with the number of patients not seen in 12-months being narrowed down to 40-50 patients and information was not being sought for each patient to how and when they were last seen.

TS advised that the Trust was at the “sharp-end” of end of year preparations as well as planning and budget setting. TS highlighted the following areas from the report:

- There were a number of areas being managed as part of the year-end preparations as a result of the adapted financial regime and some large technical issues locally. These were being managed with the External Auditors. TS thanked ML and JW for their support as Chairs of the Finance & Performance and Audit Committees respectively for their time and support in managing these matters. TS also thanked system and regional partners for their

support in aiming to achieve break-even even with revenue at year-end and maximising investments on capital programmes, such as the investment made in Topaz Ward.
- Guidance had been published in relation to financial planning, but more detail was awaitied in terms of national planning. Once received, this would be reviewed and fed-into budget planning. A further update would be provided in Part of the Board meeting.

SL highlighted the following areas of the report:
- The significant achievement in relation to the Staff survey results. SL thanked the teams within his directorate for going above-and-beyond during the pandemic.
- In relation to the mass vaccination programme, the Trust had hired just under 4000 people, which was a mix of qualified and unqualified staff. The Trust had also hired 3000 volunteers, which showed a large amount of recruitment had taken place. The Trust had been given permission to hire 50 international nurses and was working through how the process would be managed. The Trust is also in the process of hiring a further 200 healthcare workers and had already brought in over 60 people.
- The Trust was busy with the Kick Start initiative, which was an initiative introduced by the government earlier in the year. The Trust was managing the initiative for the region and already had 60 people on board within the process.
- Sickness levels were at an all-time low and this should be something the Trust is proud of as staff felt confident to come to work.
- Mandatory Training was something still being driven forward. There had been some slips, but work was being undertaken to ensure it was being taken forward as appropriate.

SS thanked everyone for the detailed updates and invited any questions or feedback from the Board for any of the updates provided.

The Board of Directors received and noted the report, including the specific updates provided by Executive Directors.

032/21 QUALITY AND PERFORMANCE SCORECARD

PS presented a report as circulated providing a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHS Improvement (NHSI) key operational performance metrics. PS advised that the updates provided as part of the previous item had highlighted any significant areas from the scorecard, so would not present the report in detail and instead invited any questions from the Board.

SS thanked PS for the report and was happy that the updates provided as part of the previous item made the connection with the Quality and Performance Scorecard and provided assurance that Executive Directors were taking full ownership of the respective areas.

The Board of Directors received and noted the report.

033/21 NHS PEOPLE PLAN UPDATE

SL presented a report as circulated providing an update on progress in the delivery of the NHS People Plan. SL advised that the People Plan would need to be reviewed in consideration of the Covid-19 pandemic given the demands on staff and the workforce significantly changing over the past 12-months, including the embracing of the digital era. The review would be combined with the results of the staff survey for the areas that require improvement.

SL advised he had employed an external consultancy to review how the Trust needed to engage with the modern workforce and delivering services to the workforce itself. SL emphasised the providing of services to the workforce, in relation to helping, supporting and guiding staff.

AS agreed that the plan needed to be reviewed from a Covid-19 perspective, but wanted to reflect that the plan appeared to be well-structured and had more detail than NHS England expectations. As felt that the plan was more relevant to the Trust and it could be measured monitored.

NH agreed there was a need to complete a deeper look at the plan in relation to the pandemic to understand the stress and anxiety of people with protected characteristics, which had grown over the last 12-months. NH highlighted the need to consider the vaccination programme in terms of staff, including understanding some of the anxieties and what it means for the organisation continuing to deliver care. NH was enthused by the plan, but felt further depth was needed given the events of the preceding 12-months.

ML advised he felt there were two areas within the plan which appeared to be underdeveloped. The first related to recruitment best practice. ML advised that feedback received, including from Staff Governors, suggested the administrative systems for getting staff into post quickly were not at optimum and was not as strong as other Trusts, which meant the organisation could be missing potential candidates. ML asked how this would be incorporated into the plan.

SL advised that he had received some feedback that the recruitment process was slow, laborious and not engaging. He had asked for a review of the recruitment process to be undertaken to ensure it is quicker, more engaging and focused on the candidate. SL advised that the process was currently focused more on what the Trust needed to do, rather than the candidate and highlighted the previous comments around providing services to staff.

ML advised the second area related to a lack of detail in relation to the Associate Practitioner roles the Trust was looking to create to fill some of the clinical gaps. ML felt there should be more detail around how the Trust intended to recruit to the clinical roles.

SL advised that one of the programmes for Associate Practitioners had been approved by the University. It would be possible to recruit individuals as there was a desire from individuals to join the NHS, but it was important to see why individuals wanted to specifically join EPUT and these needed further detailing in the plan.

ARQ asked what was meant by Schwartz rounds included in the plan. NH advised that Schwartz rounds engage the clinician in the emotional experience of what may have been a tragic incident, traumatic event or another topic in which the clinician had engaged emotionally. It was a compassionate conversation, facilitated by a Schwartz facilitator and multi-disciplinary panel. Other individuals in the room are encouraged to join the conversation and describe any similar experience they may have had. NH felt that the Schwartz rounds were valuable as the best and most important changes are made when an individual is emotionally engaged and it links with patient safety.

ARQ agreed with the comments made in relation to recruitment as this was something the Trust needed to address, but was happy this was being taken forward. ARQ asked about the new ways of delivering care section of the plan. She felt that the move towards integrated care was more about multi-disciplinary training, such as having mental health / physical health trained staff, with the idea being that one person could complete multiple assessments, rather than referring to others and delaying treatment. ARQ felt that the plan did not contain anything about the dynamic way in which the Trust would need to utilise this potentially scares source of staff.

SL confirmed that the Trust now had around 55 dual qualified nurses starring on training programmes and lots of work was being undertaken in terms of new technology to assist staff. SL

advised that the work being undertaken needed documenting and this would be brought to the People, Innovation and Transformation (PIT) Committee once complete. ARQ felt that the work being undertaken should be detailed in the People Plan rather than in an external format. SL agreed to include details in the People Plan.

TS advised that the Executive Team were fully aware of how important the People Plan was for the organisation as people are the biggest asset. Therefore, it was important to get the recruitment, deployment and experience of staff right. This included retention of staff and it was important to ensure effort, energy and investment was made to ensure the Trust is the best place to work.

The Board of Directors received and noted the report.

Action:

1. **People Plan to be updated to include:**
    a. **Review of the recruitment process to ensure staff can be recruited into post more quickly.**
    b. **Details of the plans to introduce the role of Associate Practitioner.**
    c. **(SL)**

034/21	NHS WORKFORCE DISABILITY EQUALITY STANDARD MID-YEAR PROGRESS REPORT

JDe presented a report as circulated providing an update on progress on the Workforce Race Equality Standard (WDES) for the first six-months of the reporting year (October 2020 – March 2021). JDe advised that the report focused on the experience of the Trust's disabled workforce compared with the non-disabled workforce.

JDe advised that the results of the staff survey feed into aspects of the WDES and all but one of the WDES indicators had improved. This included bullying & harassment, feeling valued and the engagement score. The only area that did not improve was around staff feeling pressured to come to work and this was something that was already being taken forward with the staff Disability & Mental Health Network.

JDe advised there had been good engagement with the Disability & Mental Health Network and more disabled staff had completed the staff survey. This showed that the engagement was working. JDe advised more work being undertaken including having disabled individuals as part of interview panels and the establishment of a long-Covid support group for staff.

ARQ noted that the report asked for senior leaders to attend the Disability and Mental Health Network. ARQ said she would be happy to attend the network. ARQ commented that the summary report presented could have included a summary of the key focus areas, both positive and negative, to allow the Board to be aware of where it should be focusing, However, she felt the substance of the report was great.

SL congratulated the Disability & Mental Health Network and the Staff Engagement Team for the work they do and the improvements that had been made.

The Board of Directors received and noted the report.

035/21	BOARD ASSURANCE FRAMEWORK 2020-21

PS presented a report as circulated which provided an overview of the Board Assurance Framework (BAF) and Corporate Risk Registers (CRR) 2020/21 as at the 31 March 2021, which covered a two month period of February – March 2021.

PS advised that the Executive Team continued to focus on the BAF as an important part of the oversight of the organisation. He advised that the document contained a number of amendments to the BAF and Corporate Risk Register (CRR) which he asked the Board to approve.

PS advised that the focus of the Executive Team was on refreshing the BAF and bringing this into line with refreshed Strategic Objectives. The report contained a timetable for how this would be achieved, which will include engaging with the Board and Senior Managers over the next two-months to review risk appetite and the focus on risk. PS advised that the aim was to present the new BAF to the Board in July 2021 at the same time as the Strategic Objectives.

JW queried CRR 76 in relation to an issue around the receipt of inferior quality towels and bedding from its contractor which had a risk score of 20. JW asked for assurance regarding how the risk score would be reduced and the risk managed. NH advised that urgent work was underway to review the linen supply to inpatient units. The risk emerged following a change in contract and it was determined, through incident reporting and clinical conversations, that there was a level of risk to patient safety caused by the inferior linen. NH advised that Estates and Facilities were undertaking rapid work to address the risk. AG confirmed that conversations with the linen supplier had already taken place and it had been made clear that the quality of the linen was not acceptable. The rapid work was being overseen by the Risk Reduction Group, providing assurance that the situation was being closely scrutinised.

ML noted that there were a number of big risk areas on the BAF, including Covid-19, mass vaccination, recruitment and financial challenges, with other operational risks such as CAMHS and out of area placements. ML asked how the Executive Team would be able to manage the breadth of the risks identified in terms of intervention and management.

PS agreed that there was a lot of breadth to the risks, but provided assurance that mechanisms were in place to manage these. This included a weekly Executive Team meeting, a specific Executive risk group and a bi-weekly BAF meeting. Each Executive Director also has their own governance processes, such as Senior Management Team meetings which work through all the risks for their particular areas. However, PS advised that the Trust was currently not in a place to manage the intensity of some of the risks and therefore the future will look at ensuring delegated authority is place through an accountability framework, streamlining Executive governance to ensure it is there to support and enhance, rather than be a process in itself. The alignment of the BAF with the Strategic Objectives would also provide greater ability to manage the breadth of risks. PS advised that in the next few months there should be changes which will give people the ability and empowerment to manage the risks.

ARQ queried the meaning of the abbreviation ECTAS. MK advised that it is an accreditation from the Royal College of Psychology that it is expected that all ECT services nationally achieve which provides assurance on the quality of the service provided. MK gave assurance that one of the Trust ECT suites already had the ECTAS accreditation and the remaining two have been registered for the accreditation.

ARQ queried risk CR56 reflecting that if EPUT continues to operate global restrictions in mental health inpatient services, patient experience will be compromised. ARQ asked whether the Trust was still implementing global restrictions or had this stopped. NH confirmed that there are still some global restrictions in place relating to patients testing positive for Covid-19 on admission and requiring a period of isolation. NH advised that the Trust has a rapid testing process in place, but the restrictions are national requirements that the Trust must follow. NH advised that the Trust is required to follow the national road map which will see some restrictions eased, however, there are still requirements such as visiting restrictions that are still in place. NH felt that the Trust had been as flexible and individualistic as possible for approaches to visiting, but national guidance had to be

followed. ARQ asked whether there were any other global restrictions followed outside of the Covid-19 restrictions. NH confirmed there were no further restrictions.

AG agreed with the points made by NH and gave further examples of where compassion and care have been prioritised in terms of allowing flexibility with visitation for individuals on an end of life pathway and flexibility on leave when it is part of a patients therapeutic plan. AG advised that there has been a focus on infection prevention and control, but also on compassionate care.

ARQ queried the closure of BAF46 in relation to EPUT being unable to secure low secure and other placements for young people with complex care needs when an increase in restraints and assaults may be seen resulting in potential harm to patients and staff. ARQ noted that earlier conversations had referred to an increase in the complexity of CAMHS patients and issues with capacity and wondered whether this risk reflected this or was something different.

PS advised that BAF46 was a very specific risk and the issues referred to by ARQ relate to a broader risk within CAMHS. PS advised that the report confirmed a new risk was being finalised around this and would be included in the next version of the BAF.

The Board of Directors received, noted the report and:

1. **Noted the rollover of BAF and risk registers to align with the proposal to agree new strategic objectives at the Board of Directors in July 2021.**
2. **Approved the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its February meeting.**
3. **Approved the BAF risk escalations, closures and amendments iterated in the report.**
4. **Approved the CRR risk escalations, closures and amendments iterated in the report.**
5. **Noted the Q4 Key Performance Indicators.**
6. **Noted the CRR March summary table including actions taken by EOSC at its February meeting.**
7. **No further risks were identified for escalation to the BAF.**

Action:

1. **Refreshed Board Assurance Framework to be presented to the Board of Directors in July 2021 in line with refreshed Strategic Objectives. (PS)**

036/21 STANDING COMMITTEES

(i) Audit Committee

JW presented a report as circulated providing assurance to the Board that the duties of the Audit Committee, which include governance, risk management and internal control have been complied with.

JW advised that the report was split into two parts, with the first providing assurance regarding the meeting of the Audit Committee in March 2021. JW advised she had received questions from Pippa Ecclestone, Public Governor, West Essex & Hertfordshire, which she had responded to via email.

JW advised the second part of the report provided a slightly amended Terms of Reference for approval. JW advised that following discussion with the Chair she would like to propose that the membership of the Committee remained at four members (the attached document amends to three) as this is in line with other standing committees. JW also advised that one member should be either the Chair or Vice Chair of the Quality Committee which was currently only listed in the “in attendance” section.

JW advised that the amended Terms of Reference had proposed the removal of Local Security Management Specialists (LSMS) from the function of this Committee as this reported to the Quality Committee and was therefore removed to avoid duplication.

JW confirmed that the Terms of Reference were circulated to the Council of Governors and any comments incorporated into the amendments presented.

SS asked for assurance from the Trust Secretary that the amendments noted by JW in addition to the report had been captured. JDa confirmed that he had captured the additional amendments and would circulate to JW after the meeting for full clarity.

The Board of Directors received, noted the report and approved the Audit Committee Terms of Reference, with additional verbal amendments.

Action:

1. **Provide additional amendments made to the Audit Committee Terms of Reference at the meeting to JW to ensure these are accurately recorded. (JDa)**

(ii) Finance & Performance Committee

ML presented a report as circulated providing assurance to the Board that the duties of the Finance and Performance Committee have been complied with.

ML advised that as AG had provided an update regarding operational performance and TS had provided an update regarding financial performance, there was nothing further to add further to the assurance report.

The Board of Directors received and noted the report

(iii) Quality Committee

AS presented a report as circulated providing assurance to the Board that the Quality Committee is discharging its terms of reference and delegated responsibilities effectively and that the risks that may affect the achievement of the Trust's objectives and impact on quality are managed effectively.

AS advised that Page 5 of the report provided details of a deep dive that was undertaken of three performance hotspot areas. AS advised that the Committee had considered the benefit of completing a deep dive of hotspots and found that the process was useful where hotspots had been reported on a number of occasions to receive additional assurance.

AS advised that the deep dive for CPA identified the Trust was reviewing the procurement of an app which would support caseload management in relation to his KPI and she was looking forward to the app being demonstrated to the Committee.

The Board of Directors received and noted the report.

(iv) People, Innovation & Transformation Committee

ARQ presented a report providing the Board providing assurance that risks that may affect the identification and / or achievement of the organisation's objectives are being managed effectively.

The Board of Directors received and noted the report.

037/21 RISK ASSURANCE REPORTS

i) Covid-19 Assurance Report

PS presented a report as circulated providing assurance in relation to the actions taken in response to the Covid-19 pandemic. PS said that the report is reminder that whilst the Trust works to continue to deliver services during the pandemic there were losses in the community as a result of the pandemic that should always be remembered. This was especially important as restrictions eased and the prevalence reduces, understanding that the threat has not gone away and there was a need to consider how to live with it for the future.

PS advised that the intensity of the workload has dropped in relation to the pandemic, such as the reduction in the number of Gold / Silver / Bronze Command meetings, however, it should be noted that the intensity of workload remains in terms of maintaining social distancing, use of PPE and national reporting requirements which continue.

The Board of Directors received and noted the report.

ii) EU Exit

NL presented a report as circulated providing an update on the Trust's position in regards to the EU Exit and highlighted any risks. NL advised that there were some areas that are currently being taking forward with Human Resources, as whilst it may appear the EU Exit has been completed, there are still some areas that need to be resolved.

NL highlighted the EU Settlement Scheme, which is a scheme to allow EU nationals to continue to stay and work in the UK, including the NHS. NL advised that there are currently 110 staff that have not yet applied for the scheme and this would need to be completed by June. NL advised that the staff were known at the figure included 45 permanent staff and it was important to support these staff through the settlement process.

SL advised that individual support would be given to the staff needing to complete the EU settlement application as the process can be quite daunting. JW asked for assurance asked for assurance that the staff referred were engaged and what would happen if by June the staff had not gone through the process. SL advised that he did not have an answer to hand and would review urgently and provide an update to JW.

The Board of Directors received and noted the report.

Action:

1. **Provide assurance that staff members that had not applied for the EU Settlement Scheme had been engaged and provide details of what happens if by June those staff had not been through the process. (SL).**

038/21 MENTAL HEALTH & COMMUNITY HEALTH SERVICES TRANSFORMATION

AG presented a report as circulated providing an overview of transformation service lines, progress on 2020/21 spend & forecast, issues & risks and next steps, with points to note for 2021/22.

AG advised that a significant amount of transformation had been provided in mental health and community health services of the past 12-months, despite the impact of Covid-19 and the need to deliver the mass vaccination programme. AG advised that there had also been a significant amount

of learning from this, which has been incorporated into transformation programmes and would inform transformation going forward.

AG highlighted crisis care for mental health which was launched in three of the STP / ICS areas in April 2020 and has been an incredible initiative. Activity has grown month-on-month which shows there is a need for the service. The service is accessible via 111. The Trust had also worked with the voluntary sector very differently in terms of the patient pathway and this learning would be incorporated into future transformation programmes. AG advised that the crisis cafes had extended their hours and as we ease from the pandemic there is a mix of virtual and face-to-face interventions. The service has been implemented in all three areas, which allow it to remain locally agile, whilst having the same principles in relation to working with the voluntary sector.

AG advised that for Personality Disorders / Complex Needs the progress has been different in each of the STP / ICS areas. Essex Mid & South is in place, North East Essex will be commissioned from the 1 April 2021 and discussions are still ongoing in West Essex. AG / MK are currently completing close work on a focused model to reduce the dependency on inpatient admission and providing a system-wide approach to managing personality disorders / complex needs.

AG highlighted Dementia / Older People's Care as a success as a result of transformation and during the Covid-19 pandemic. There has been a reduction in admissions and community services had raised their threshold in terms of acuity and are managing people in a very different way as part of the Dementia Intensive Support model. AG advised that in North East Essex it is aligned with the redevelopment of the Clacton-on-Sea site and this has yet to be implemented fully. In West Essex, the model is integrated with physical health urgent response, which addresses people's holistic needs. AG advised that dementia prevalence is still an issue, but the Trust is not an outlier in this area.

AG advised there is great work happening in community and primary care, including West Essex being an early implementer and work in Thurrock around psychiatry appointments within primary care centres, rather than the traditional outpatient model. AG advised the focus for 2021/22 is around integration between community and primary care. There is a challenge in trying to bring the transformation plans forward to deliver two-years within one-year. Recruitment remains a challenge, but the Trust has been able to recruit 70% of the staff required for transformation, but there was still a challenge. AG said this was also about looking at dual roles and peer support programmes. AG said that there was a once-in-a-lifetime opportunity with the investment in mental health, but also a challenge in ensuring the Trust can demonstrate the investment it has made.

AG advised that for community health services the Covid-19 pandemic has meant that services are being provided very differently. AG advised that South East Essex has its joint venture with Provide and NELFT. EPUT has led the way in relation to discharge to assess model and this has been implemented across the MSC system, which has reduced bed dependency and getting people home from hospital as quickly as possible.

There has been great work undertaken in relation to urgent care, regarding the opening of the Care Coordination Centre in South East Essex and work has been undertaken with Mid and South West Essex colleagues to remove variation and ensure everyone is working to the same specification.

AG advised that services for Mountnessing Court and Cumberlege Intermediate Care Centre (CICC) were being delivered very differently from Brentwood at the beginning of the pandemic. CICC has now moved back to the Rochford Hospital site. Mountnessing Court staff remain at Brentwood Community Hospital and work was underway with partners to determine the beds configuration which are right locally and link with the transformation work around home first.

AG advised that West Essex has a new community contract which links to the out of hospital care model and specific areas, such as primary care alignment, specialist services, care coordination centre and re-enablement & urgent care services.

AG advised that recruitment remains an ongoing challenge, but is confident there are robust workforce plans in place and will continue to work closely with CCG colleagues.

SS thanked AG for the report and said it showed the substantial amount of work that is currently taking place. ARQ agreed with the sentiment of the chair and hoped that the work would continue in the same way going forward.

ARQ commented that the report refers to the primary care centres and putting mental health services in the primary care network. ARQ commented that this raised the importance of dual trained staff, rather than having separate physical and mental health staff. AG agreed with the importance of dual trained staff and this had been discussed earlier as part of the people plan discussions. However, AG noted the importance of support workers outside of professional training and the ethos that needs to be taken forward is people working at the top of the licence. This will mean that as part of their visit to patients they will be able to do a number of things which will reduce the needs for additional contacts. The work undertaken in West Essex Dementia is a good model and will now need to implemented rapidly for mental health. Specialist roles will always remain

ARQ commented that it was important to ensure that the joint venture work being undertaken across the system is truly integrated and the only thing achieved is reduced hand-offs between services, rather than actual integrated care. The report seemed to suggest that the plans were around reducing hand-offs to allow people a clear path through, but did not address the issue of needing to handover to different organisations which means people would still see different people at different points of the patient journey. ARQ asked how this would be incorporated to ensure the number of people / organisations the person would have to deal with would be reduced.

AG advised that for the joint ventures there was a system piece of work which will look at certain things only being done once. This would relate to smaller services such as Speech & Language Therapy, Specialist Nursing and may have a single team under a single leadership. Where it becomes more challenging is where we are working with primary care across the different localities, with the focus being working as a local MDT approach. AG advised that she would be leading a piece of work on overarching principles so there is consistency, but do not create a scare in the local community as the local work is currently underway.

MK advised that the focus was on having a seamless service within primary and secondary care. MK advised there were already links in place with the primary care networks, but now it was about how to get multi-skilled staff aligned and other things such as record keeping systems. Different PCN's were at different levels and therefore it was important to link with their needs as well as our own. In terms of the joint ventures, there was currently a piece of work to look at the variations between the different organisations in terms of how they deliver services. This will allow us to ensure that we can deliver uniform accessible services.

ARQ commented that she had noted for a number of months references to STP recruitment challenges and looking to get alternative recruitment structures agreed with commissioners. ARQ asked whether these had now been agreed as this seems to have been an ambition for a number of months.

AG advised that all of the business plans for mental health transformation have been pulled together into a workforce plan that has been costed and deliverability is being looked at at the moment. However, there is a need to have a contingency plan in place as we struggle with some of our

specialist roles and may need to think differently. The plans need to be linked with the people boards in their respective areas and link to the voluntary sector.

SL advised that the Trust was looking at augmented reality in terms of looking at one member of staff that can feed back into multiple specialists is an option that needs to be considered. Discussions were already underway and it was uncertain how this would be delivered, but it is high on the agenda of considerations.

AG felt that the transformation that has taken place has been achieved through joint working between clinical staff, corporate staff and system partners. AG now felt the important part was to be able to articulate the lessons learnt from new ways of working during the pandemic to incorporate into any future transformation plans.

The Board of Directors received and noted the report.

039/21 CONSTITUTION REVIEW

SS presented a report as circulated providing the Trust Constitution for approval. SS advised that the Trust was required to review its Constitution annually, with the last review taking place in February 2020.

SS advised that the Council of Governors considered the amended Constitution on the 18 February 2021 and this was approved for presentation to the Board of Directors. SS advised that a Task and Finish Group took place to review the Constitution, which consisted of nine governors, two NEDs, one of the Assistant Trust Secretary's and the Interim Trust Secretary.

SS advised that there were three amendments set-out in the report, relating to the staff constituency (Section 8.0), the Deputy CEO (Section 30.5) and significant transactions / mergers (Section 49.2). SS advised that there were other discussions held which did result in a change to the Constitution.

The Board of Directors received, noted the report and approved the amended Trust Constitution.

040/21 ENGAGEMENT STRATEGY

SL provided a verbal update in relation to the Engagement Strategy. SL advised that the needs, demands and expectations of the population and workforce are significantly different now. There is also a need to embrace the impending new website, reviewing the channels for communication and developing dynamic communication. SL asked for agreement from the Board that the Engagement Strategy would be reset and brought to the next Board meeting.

The Board of Directors noted the verbal update provided.

Action:

1. **Engagement Strategy to be reset and presented to the next Board of Directors meeting. (SL)**

041/21 CQC COMPLIANCE UPDATE

PS presented a report as circulated providing an update on the activities that are being undertaken within the Trust and information available to maintain compliance with the CQC standards & requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.

PS advised that the Trust remained fully registered with the CQC. PS advised that there had been no new inspections completed and the action plan has been completed following receipt of the Warning Notice, which has been reported back to the CQC. Assurance of the completion has been gained through a visit by the Compliance Team and a positive visit by the Commissioners.

PS advised that work had been undertaken to ensure action taken from previous inspections had been embedded. There had been some gaps identified, with action being taken to ensure these are resolved.

PS advised that there was no new guidance from the CQC, but there were two consultations underway in relation to strategic direction, which was looking at the CQC being more data focused and more frequently updating ratings to make these more meaningful to service users.

PS advised that CQC visits were being restarted following their suspension during the pandemic and the Trust was ensuring staff were refreshed and prepared for any CQC inspections that may take place.

The Board of Directors received and noted the report.

042/21	**USE OF CORPORATE SEAL**

Not used.

043/21	**CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING**

None.

044/21	**NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING**

None.

045/21	**REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS**

SL felt that equality was at the heart of everything we do and the agenda had been very inclusive.

AG advised that the crisis service mentioned during the meeting was really aimed at addressing inequality because of its accessibility. The question now was about understanding whether it is addressing inequalities and take action. Scoping work has suggested that the service was mainly being accessed by younger and middle aged people, so work may be needed to understand why older people are not accessing the service as much.

AD felt one of the big issues was around interviews and representation. It was important to get people into the roles that have lived experience as this can help change the culture and it was good to see this was actively being pursued in the Trust.

PS reflected that at the beginning of the meeting it was acknowledged that the experience of BAME staff working in the organisation was worse than others and it was important to acknowledge and make a commitment to improve in this area. PS felt it was important as unitary Board to hold itself accountable for this and take action to ensure it is improved.

PS also felt that there was something that was not on the agenda today, but should be considered going forward around health inequalities. The pandemic has exposed some of these inequalities and how they affect health outcomes and there appeared to be much more information to allow this to be explored. This was an important part of the work being undertaken by AG in terms of transformation.

SS agreed that health inequalities was a central item across the NHS and was considered one of the top priotrities by Simon Stevens. SS advised that a Board Development session was being planned with Governors which could incorporate this.

046/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

SS noted that MK had to leave the meeting due to a fire alarm sounding at his location, but had indicated when he had re-joined the meeting. NL had also had to leave the meeting and this would be recorded in the minutes.

JDa noted that LL and RH had joined the meeting via the audience due to technical difficulties. This meant they were present during the meeting.

047/21 ANY OTHER BUSINESS

None.

048/21 DATE AND TIME OF NEXT MEETING

26 May 2021, 10am via Microsoft Teams Live.

049/21 QUESTION THE DIRECTORS SESSION

Questions from Governors submitted to the Trust Secretary prior to the Board meeting and also submitted during the meeting via the 'Live Chat' function are detailed in Appendix 1.

Appendix 1: Governors / Public / Members Query Tracker (Item 049/21)

Governor / Member / Public	Query	Response provided by the Trust
John Jones, Lead Governor, Bedfordshire, Luton and Rest of England	(a) On the matter of student clinical placements, I am impressed that the number has risen to 200 per annum. Financially, is there a cost to the Trust, or does this generate a surplus? (b) On page 41, why does the discharge of 22 long stay patients result in an increase in the ALOS Adult MH figure to 53.8 (compared to the NHS target of 31.6, which has never been achieved in the last two years)? (c) On the PICU, the ALOS position is worsening with the current figure (126.8 days) around three times the target of 42. What is being done to address this continuing problem	(a). Natalie Hammond – Agreed that it is very good news that the number of student nurse placements has risen to 200 per annum and this links with earlier conversations at Board regarding the workforce challenges. The Trust receives £15 per day for each student, which generates income that is immediately reinvested to improve the student placement by bringing in student facilitators to support the students, equipment, induction and laptop loans. The laptop loans have been provided over the past 12-months to ensure students can continue to engage and have a positive placement experience during the pandemic. (b & c). Alex Green – This relates to the current patient complexity and longer recovery periods than expected. This has been seen particularly in the PICU group. This is being reviewed nationally and locally to understand the complexities of patients to determine if these are new patients presenting or existing service users with an increased level of acuity. This is being discussed regularly in meetings with commissioners. In addition to existing patients having a longer stay, there have also been delays experienced with discharging people to certain locations, which has been Covid-19 related, including cessation / temporary closure of the destinations. This does not mean that the Trust can do nothing and internally there is continuous review of the inpatient flow and work was underway to complete a fresh look at purposeful admission to ensure that at the point of first presentation it is clear what the expectations are of the service, the patient and the therapeutic plan. Dr. Milind Karale – It should be noted that when a long stay patient is discharged from a ward it can skew the figures and create peaks for a specific ward.

Stuart Scrivener, Public Governor, Essex Mid & South	4.9.1 Patients on Medical Caseload South Essex (Inc. Memory Service) not seen / no contact by a Medic for over 12 months I read 4.9, waiting Lists as showing 21.6% against a target of 0%. I am concerned that we are missing people's issues in this time of ultra-high need. Are you comfortable with the way the Trust is addressing this? What actions can you recommend or take to tackle this?	Milind Karale – A number of patients that are waiting in the outpatient clinics have been seen by other members of staff, which means there are 40 – 50 patients that have not been seen by any member of staff and as mentioned in the meeting, details have been requested on these patients to see what action has been taken and whether they need to be discharged or seen. Data is being refined to include teleconferences as these had not previously been included as an outpatient appointment, whereas some clinics have now moved onto video / teleconferences. It was also important to identify patients who are within inpatient units as these do not need to be on the outpatient caseload as they are being seen more frequently by the doctors whilst an inpatient. Work is being undertaken to review the patient record keeping systems interact for outpatients (QFlow) and inpatient (Mobius) to ensure the right data is being collated. An external company, Meridian, are currently completing an analysis of the capacity and productivity of the clinics. The review has found that the slots are being used well so there is a need to look at the capacity of the clinics. This issue should be resolved once the transformation work has been completed regarding linking with the primary care services, which will mean the patient will be seen as and when required. The current outpatient model does not provide a true picture as the individual may have been seen by a number of other clinicians whilst waiting.

Signed: …… Date: ……

Pippa Ecclestone, Public Governor, West Essex & Hertfordshire	DATA SHARING Having asked this question on more than one occasion in the past....and having received the response that there was not a problem for staff to access records on either PARIS or MOBIUS... .....I was concerned to be reading reports for a Manager's hearing this week when **both** the Responsible Clinician's (Basildon - Mobius) and Care Co ordinator's (Harlow -Paris) report writers wrote ***that they could not access their patient's records on the 'other' system....*** *this cannot be an isolated case in times where patients are often transferred to and from different parts of the trust.*	Natalie Hammond – Please could the details be provided to Natalie to put out a direct support to the clinicians. Assurance provided by Jan Leonard, Director of ITT has confirmed that Health Information Exchange is fully operational alongside a targeted training package for its use. By understanding the specific case it would be possible to understand whether focused training was required or a further review of what caused the statements to be made.
	KPI 4.9.3/4. ?Greater clarity needed.....?patients on non medical caseload...2 graphs North & South but different scale gives a false picture.? What is "non medical" in this context?	Non medical will relate to the community mental health team including psychlology. With regards to the performance difference between Paris and Mobius teams, the perception is that the recording of this activity in Paris is more straight forward and therefore not prone to the variety of data quality issues experienced in Mobius. This is being pursued to address the recording issues.
Dianne Collins, Public Governor, Essex Mid & South.	When you let the staff know of the improvements that have been made will you also let the staff know of the areas that you want to improve and will be focusing on in the coming year.	Yes our strategy will indicate all areas for improvement, when we have concluded a final strategy we will hold an all staff meet to congratulate and elaborate on our direction of travel
Anonymous	KPI "waiting lists" ? APPOINTMENTS OFFERED/ DNA	Unable to provide a reply as – clarification required, please advise the Trust Secretary's office using epunft.Trust.secretary@nhs.net

Signed: …… Date: ……

Paula Grayson, Public Governor, Essex Mid & South	Please can we have some indication of the financial and clinical risks continuing to exist from the red score on efficiency programmes.	No financial risk identified. It has been agreed that due to a sustained improved position, the CPN on CPA was removed at the end of March. The First Response Team within 28 days issue relates mainly to Southend and was due to staffing issues which have been addressed and we are now seeing improved performance .
	F&P: What financial and/or clinical issues might arise from the two Contract Performance Notices please?	Update to follow

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 27 March 2021)

Lead	Initials	Lead	Initials	Lead	Initials
Alison Davis	AD	Sean Leahy	SL	Amanda Sherlock	AS
Alex Green	AG	Nigel Leonard	NL	Janet Wood	JW
Natalie Hammond	NH	Manny Lewis	ML	James Day	JD
Rufus Helm	RH	Alison Rose-Quirie	ARQ		
Mateen Jiwani	MJ	Sheila Salmon	SS		
Milind Karale	MK	Paul Scott	PS		

Requires immediate attention /overdue for action	
Action in progress within agreed timescale	
Action Completed	
Future Actions/ Not due	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 033/21	People Plan to be updated to include: 1. Review of the recruitment process to ensure staff can be recruited into post more quickly. 2. Details of the plans to introduce the role of Associate Practitioner.	SL	July 2021	This action has formed part of the HR review which is due for completion in June 2021.	Open	
March 035/21	Refreshed Board Assurance Framework To be presented to the Board of Directors in July 2021 in line with refreshed Strategic Objectives.	PS	July 2021		Open	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
March 040/21	Engagement Strategy to be reset and presented to the next Board of Directors meeting.	SL	~~May 2021~~ July 2021	Part of the HR review which will be completed in June 2021.	Open	
March 037/21 (ii)	EU Exit - Provide assurance that staff members that had not applied for the EU Settlement Scheme had been engaged and provide details of what happens if by June those staff had not been through the process.	SL	May 2021	We have 4 permanent staff who we have tried to make contact with in terms of status and have not been able to establish contact and they have not returned messages etc. – these are being followed up with their managers in terms of ensuring they are aware if the scheme and how to apply – however please see below individuals do not have to inform us of their status and legally we do not have to obtain this to continue to employ them beyond 30th June. We have 29 bank/locum workers who we have tried to make contact with re status and have not been able to establish contact with. I have attached the full breakdown report that I did provide however not sure if this was provided alongside the narrative. Home office guidance states that the onus on applying for settlement status rest on the individual and not the employer and the following is set out for existing employed staff • there is no legal obligation for employers to communicate the EU Settlement Scheme, however, we may wish to direct employees to the information that the government is providing. • it is the responsibility of the individual to make an application to the EU Settlement Scheme. There is no requirement for the individual to inform their employer, that they have applied or the outcome of their application. Likewise, you should not check that an employee has applied.	Complete	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
				The purpose of the communication we have been carrying out is awareness of the scheme and to support individuals with applications if they were struggling. The purpose was not to check up on if individuals have applied or not applied – Individuals do not need to share outcome of settlement status with us this is entirely their decision to do so we are lucky that many of our staff have engaged with this process and have willingly shared their status with us following application We do not need to do anything come 30th June – if individuals do not apply for settlement status then we will have a statutory excuse for their continued employment and will not be liable for any legal action if the individual has failed to obtain settlement status		
September 117/20 (1)	Workforce Disability Equality Standard (WDES) Update on Action Plan to be presented to BOD in January 2021	SL	~~January 2021~~ March 2021	Report being presented at Board	Completed	
May 064/20 (1)	Freedom to Speak Up Report NHS England and NHS Improvement Self Review: review two actions agreed to bring the Trust into compliance with the self-review tool at a future Board Seminar Session.	SL	September	Due to time constraints (Covid-19) the report received from the National Guardian Office along with accompanying slides was circulated to the Board outside of the Seminar session. SL also discussed the report at the August People, Innovation and Transformation Committee.	Completed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
July 092/20 (1)	Review of BAF41 wording and mitigation in light of recent conversations held at F&P Committee, where challenges in delivering recurrent CIPs were discussed.	TS	September	Wording updated.	Completed	
July 094/20 (1)	Phase 3 Reset and Recovery Planning to be included on agenda for Board Development Session for discussion.	TS	September 2020	Added to the Board Seminar Agenda for November 2020	Completed	
May 068/20 (1)	Board Assurance Framework – Review BAF9 risk in light of review of data for Q1	NH	July 2020	Risk reviewed. Satisfied that progress is being made to mitigate. No Force First Assurance report provided to Board on the 29th July.	Completed	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Chair's Report (Including Governance Update)**					
Executive/Non-Executive Lead:	Professor Sheila Salmon, Chair					
Report Author(s):	Angela Horley, PA to Chair, Chief Executive and NEDs					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	None
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	Yes/ No
Are you recommending a new risk for the EPUT BAF?	~~Yes/~~ No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides a summary of key activities and information to be shared with the Board and stakeholders and an update on governance developments within the Trust.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Request any further information or action.

Summary of Key Issues

The report attached provides information in respect of:

- Coronavirus / Covid-19
- Covid-19 Vaccination Programme
- Board Changes
- Board Champions
- Collaborative Working

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Professor Sheila Salmon **Chair**

Agenda Item: 5
Board of Directors
26 May 2021

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

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

2.0 CHAIR'S REPORT

2.1 Coronavirus / Covid-19

The situation regarding the Covid-19 pandemic continues to be dynamic; the Trust has continued to put in place the necessary provisions to protect patients and staff in this regard. Nationally, the guidance for healthcare staff is continually updated as the situation develops further. The Trust is fully engaged with system, regional and national planning to stay firmly aligned. The Non-Executive Directors and I have been kept very well briefed during this extraordinary time by the Chief Executive and Executive Team. The Executive team are adjusting the reset plans to achieve best fit as the crisis continues to ease. I and the Board continue to extend our thanks to our dedicated staff and our volunteers who have continued tirelessly and with exemplary resolve to provide services to our patients and service users in light of tremendous challenges and uncertainty.

2.2 Board changes

I am delighted that Loy Lobo has now joined us as a Non-Executive Director. Loy is an experienced innovator in healthcare, over the past decade taking a number of healthcare innovations from concept to market. Loy is a Fellow of the Royal Society of Medicine in London where he serves on its Digital Health Council as President Elect and is a Visiting Researcher at Imperial College Business School. Loy has also served on a number of high profile government panels and academic collaborations to promote the adoption of technology and decision science in healthcare. Prior to working exclusively in healthcare, Loy accrued significant senior executive experience followed by more than a decade of management consulting experience at a top tier consulting firm, leading technology enabled transformation projects. Loy brings a wealth of corporate, commercial and entrepreneurial experience and knowledge to the Board of Directors.

2.3 Board Champions

I am pleased to confirm that following the departure of Alison Davis, Dr Mateen Jiwani has taken the Mental Health Act NED lead and Alison Rose-Quirie has taken the Veterans champion role. The outcomes of a full review of Champion roles will be confirmed at the July Board of Directors.

2.4 Collaborative working

EPUT is working proactively across three integrated care systems and regionally to influence and engage as a strategic partner within newly emerging collaborative structures. One such collaboration is developing and functioning across the Mid and South Essex ICS, taking into account Southend Borough, South East and South West Essex, Thurrock Unitary area, Mid Essex (including Maldon and Braintree Districts and Chelmsford City), and has brought EPUT together, with NELFT and Provide in a voluntary contractual joint venture, with the full support of the MSE commissioning arm. An advisory Board has been established involving the three sovereign bodies and I am delighted to be supporting ongoing development in the role of rotating Chair for the coming six months. EPUT is similarly involved in equally important

collaborations, including specialist models in mental health care (regional), North East Essex (within the SNEE ICS) and West Essex (within HWE ICS) on integrated responses, out of hospital care and better connected community services.

Finally we are embarked upon an exciting collaborative joint venture with our main academic partner Anglia Ruskin University, embracing multi-professional teaching, learning, innovation and applied research. We will be reporting in more detail as this gathers pace and bears fruit.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

- **Health Management & Policy Alert**
  Please see the link below for a copy of the policy on identifying corruption risks in UK public procurement for the COVID-10 pandemic. **For Information: Link**

- **Clinical Commissioning Policy: Sodium Oxybate For Symptom Control Of Narcolepsy With Cataplexy (Children And Adolescents Aged 7 Until 19 Years)**
  Please see the link below for a copy of the policy published on 15 April 2021 stating that Psychology support can come from within the sleep services, or externally such as local child and adolescent mental health services (CAMHS). **For Information: Link**

- **Can A Parent Be Displaced From Court Of Protection Proceedings Involving Their Child?**
  Please see the first link below published on 26 April 2021 relating to a parent that was discharged by the Judge without notice. **For Information: Link**

- **DNACPR Notices: CQC Publishes Final Report**
  Please see the first link below for a copy of the final report published on 28 April 2021, the second link is a copy of the background and the third link is a copy of the joint statement. **For Information: Link; Link; Link**

- **National Medical Examiner's Report**
  Please see the link below for a copy of the report published on 27 April 2021 showing the progress and activity of patient safety. **For Information: Link**

- **Concerning Increase In Children And Young People Contacting Mental Health Services**
  Please see the link below for a copy of the latest mental health services monthly performance statistics published by NHS Digital which contains various excel spreadsheets containing monthly statistics **For Information: Link**

- **Urgent Action Needed To Address Chronic Undersupply Of NHS Staff**
  Please see the link below as to why six organisations are calling for the government to take action and address the undersupply of NHS staff to include additional mental health support. **For Information: Link**

4.0 RECOMMENDATIONS AND ACTION REQUIRED

The Board of Directors is asked to:

1. Note the content of this report.

Report prepared by

Angela Horley
PA to Chair, Chief Executive and NEDs

On behalf of
Professor Sheila Salmon
Chair

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Chief Executive Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Paul Scott, Chief Executive					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	**X**	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
This report provides a summary of key activities and information to be shared with the Board.	**Approval**	
	Discussion	X
	Information	X

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Request any further information or action.

Summary of Key Issues

The report attached provides information in respect of Covid-19, Performance and Strategic Developments.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	

CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Paul Scott *CEO*

CEO Report – May 2021

1.0 Introduction

Since my last report in March I am relieved to see that the 3rd wave of Covid is firmly in retreat. I am sure we are all looking forward to some, if not full, contact with friends and family.

Undoubtedly this is a challenging time for all and we continue to do everything we can to support our patients and staff in this period. Many of our services are seeing unprecedented demand and we continue to work with our health and care partners to adapt our services so we can offer the most to the most. I am extremely grateful to our incredible colleagues who continue to offer their best every day in this period.

It is also a period where we can see great opportunity. I am so heartened to see and hear the enthusiasm of our staff to improve safety and embrace technology, as well as the willingness of our health and care partners to forge new ways of working. We haven't always got it right but I am confident that there is an appetite and willingness to learn and continuously improve how we support people in need.

Whilst Covid is in retreat we know it has not disappeared. We will maintain vigilance in how we deliver care and we will focus on how we support people with the effects of Covid. This may be in our "Long Covid" clinics, the mental health of the population, delivery of vaccinations to all parts of the population, the recovery of the health and care system or the economic recovery for the population we serve.

To this end I am delighted that we will be making, alongside all of our health and care partners, a public commitment as an anchor institution to support employment and businesses.

Our vaccination teams, including amazing volunteers, continue to deliver vaccinations for Covid across Essex and Suffolk. Their dedication and adaptability is fundamental to its success, as the supply of vaccine, and the timeframes for second doses, changes. Thank you to all involved.

2.0 Key Issues

HSE Prosecution

As detailed in my report in March 2021, the Trust has received notification that a court date of 16 June 2021 has been set for the HSE prosecution. The Trust extends it sincere condolences to the families of those involved. As with the independent Inquiry, the Trust is committed to learning from these tragic events and building them into our safety practice. I am very grateful to those families who have felt able to speak to me about their experience. Whilst I will never understand the full impact of losing loved ones in such circumstances, I am in no doubt that the pain and distress is long standing. I am determined to make sure services in EPUT can be trusted to be amongst the safest in the country.

Safety Investments

The implementation of our safety strategy continues to develop and is the key focus for the Executive team.

Our draft accounts show that we invested circa £10m in safer environments on our wards with a plan to spend a further £10m in 21/22.

As well as investing in our wards, we have agreed plans for an expansion of our community Mental Health teams and are planning to invest several £m to provide better support to people with mental health problems by providing more services and linking directly with GP's.

We have completed a full diagnostic of our ward safety which has meant spending a lot of time on wards and walking in the shoes of our front line staff to fully understand what can be done to improve safety. As a result of this work we will, in the coming months, be investing in more budgeted staff, continuing to roll out technology such as Oxehealth and CCTV, investing in clinical leadership, bringing patients and carers into decision making and implementing new ward metrics, with regular Executive team discussions with the services.

Delivering our Safety Strategy is our number one priority and we are also investing in capacity and capability to deliver the changes we want to make and to support our clinical teams. This will also give us the capability to report, in a detailed way, our progress.

More detail on how we are delivering our Safety Strategy is in the main content of the report.

Staff Engagement
Along with the rest of the Executive team I have invested a large amount of time engaging with staff from all over the organisation. We have over 500 engagement champions who have direct access to the Board at least once a month where they can raise concerns or propose ideas. All of this feedback has led directly to investment decisions and the changes set out above, as well as the changes we have planned in our safety strategy.

Independent Inquiry
As noted in my reports in January and March 2021, historical events relating to services in North Essex were debated in parliament resulting in the commissioning of an Independent Inquiry. The Trust is awaiting further details on the Independent Inquiry, which we will be fully cooperating with, ensuring learning is built into our safety practice. In the meantime, we are investing in a team, with independent scrutiny, to ensure that we have provided all the information we can to the inquiry.

3.0 Performance and Operational Updates

Improving Safety
Our ambition to provide the best and safest care possible for patients and become one of the safest organisations in the country is gaining momentum.

I am delighted that our safety strategy continues to harness excitement and interest. Our Safety First, Safety Always strategy sets out our ambition and our plans to continuously improve safety and build confidence in the trust as a safe organisation. As we are looking for some elements to have an impact quickly, it has been pleasing to note that our weekly Safety Executive Oversight Group has been tracking our progress already. We are making good headway in making change where it counts:

- Moriam Adekunle our new Director of Patient Safety commenced in post on the 4th May. Moriam is engaging with staff members across the organisation on what safety means to them and has promoted the role in a number of live webinars
- Our improvement partner Newton's have continued with their diagnosis analysis on safety in the wards and are now reaching conclusions and recommendations.
- Our work with post graduate students from Cambridge University looking at how we manage ligature risk is gaining momentum and will be a key presentation to the Mental Health Safety Improvement Programme national programme on how we, in collaboration and utilisation quality improvement methodology, reduce self-harm and suicide.
- Prioritised resource to support implementation

The rollout of Oxehealth is progressing to plan with 15 wards live and operational using the technology. In May, we will have two seclusion rooms and The Lakes 136 suite operational, with all other seclusion rooms and 136 suites completed by end of June. The work on the older peoples' functional wards is progressing with planned go-live dates in June and July.

Our ambition of our patients, families and carers feeling confident and safe in EPUT's care is in establishing a strong safety and learning culture and increasing patient involvement and co-design in our services. We formally implemented PSIRF (Patient Safety Incident Response Framework) on the 1st May 2021 following regional and national approval of the Trust's Patient Safety Incident Response Plan (PSIRP). We have received positive feedback from local commissioners and NHS E&I, including a request to use it as an exemplar.

We have commenced a Safe Staffing project to ensure that there is an appropriate number and mix of clinical professionals, with the objective to understand the staffing resource for safety and enhance substantive teams reducing reliance of Bank/Agency staff that are used across patient wards. Initial detailed planning of this project is nearing completion and the deliverables and timescales will be set in June.

With support from a specialist third-party (Newton), we are undertaking a diagnostic to look at ways to improve the safety and quality of our adult inpatient mental health services. The diagnostic approach is to understand the views and realities faced by frontline staff and to "walk in their shoes". Alongside frontline engagement, we have taken a data-focused approach to understanding factors and themes influencing current performance and then understand how these factors come together at an operational level. The findings and recommendations will be available in late May and will feed into our planning and projects portfolio.

We have a plan to engage the wider organisation, both with our people and our communities, this is an exciting communications strategy that will use of own staff and patient experiences to ensure everyone feels a part of our safety journey. We have also been explaining our approach to safety to our system partners, our commissioners, local authorities and acute care providers. Many of whom are keen to work across the system supporting the safety of our patients.

There are seven themes we are focussing on: leadership, culture, continuous learning, wellbeing, innovation, enhancing environments and governance and information. We continue with regular updates the Executive Safety Oversight Group weekly on the progress we have made.

As part of Safety Strategy, and starting with the Newton diagnostic work, we have implemented a new project management office (PMO) capability. This will ensure that we have the right level of project governance, controls and assurance for our projects and programmes. Over the coming weeks we will be expanding the PMO to support all of our key project activity. As part of the PMO activity we are producing an overall plan of all projects and programmes, both in-flight and planned over the next 24 months enabling us to plan, prioritise and resource our teams more effectively in the future.

Operational Performance

Our operational performance has remained stable and in there were 24 performance and quality indicators within target. The 5 areas of inadequate performance remain the same; there has been significant improvement in the numbers of patients not seen within 12 months and waiting list clearance plans in place for psychology. In addition, all 6 Clinical Associate in Psychology roles have been recruited to.

The pressure on inpatient adult mental health beds has continued resulting in a further increase in out of area bed days. Topaz ward is now operational and admitting patients in a phased approach. Social distancing caps on occupancy have also been reviewed with

support from Infection Prevention and Control and these have largely now been removed. We are repatriating patients and have an action plan in place to reduce out of area placements to 0 by September 2021.

There were 7 areas requiring improvement in April with IAPT and Essex STaRS continuing to experience COVID-19 related performance issues. Adult acute mental health readmission rates were at 10.3% against a target of 9.3%; the spike relating to 11 readmissions. Statistical control analysis indicates no cause for concern.

Our Tier 4 CAHMS pressures have sustained. We have been working with our system colleagues to develop a plan for the implementation of 2 x 72 hour admission beds to support better flow and capacity and improved outcomes for young people as well as working with regional colleagues on a number of medium term schemes.

Medical Directorate Update
A new ADHD services has been approved by Commissioners in the North East and West Essex areas and we are currently in the process of recruiting staff for that service to commence.

Four Overseas Clinical Fellowship positions appointed to and the first of the doctors should be ready to start work in June. We will be running another recruitment campaign to attract more overseas fellows to join the Trust with the expectation that with support and further training, these doctor's will join our consultant workforce within the next few years. Recruitment task and finish group met on the 13th May 21 to discuss the problems with recruitment to consultant roles and the plan is to review the current job description templates and general Trust content on website to try and make it more attractive for doctor's looking for roles.

Finance
The Executive Team Operational Committee have agreed for the Specialist Community Forensics Team to continue using the underspend from 20/21 beyond June 2021 to maintain the current service delivery until East of England Collaborative, fund as recurrent funds from 22/23.

Covid 19 Vaccination Programme
Delivery of the COVID-19 vaccination programme has continued at pace since my report in March. The programme continues to be rolled out progressively across the nationally identified priority groups. Nationally, and locally, vaccinations have now been offered to all people in the first ten priority groups (ie residents and staff in care homes for older adults, health and social care workers, the clinically extremely vulnerable, those in an at risk group and all those aged 40 years and over not included in one of the other priority groups listed). Recently vaccinations have started to be offered to those in priority group 11 - at the time of writing this report, those aged 38 and 39 had been invited to attend for vaccination.

Across Essex and Suffolk, colleagues in primary care, the hospital sector and EPUT have continued to work together to deliver the programme – via GP-led vaccination services, hospital hubs, community pharmacy vaccination services and large scale vaccination centres now in place across the two counties.

EPUT has now opened a total of 15 large-scale vaccination centres across Essex and Suffolk with the capability to deliver thousands of vaccines each week, and we have worked hard to ensure that our centres have been opened in line with the vaccine supply available to us at any given time. Throughout this time we have also focussed on delivering 2nd doses within the timescales set out by the national programme. Recently, those in priority groups 1 – 9 have been given the opportunity to move forward their 2nd dose appointment from 12 weeks to 8 weeks. We immediately took action to increase the capacity available within our

vaccination centres to provide earlier appointments that individuals could book into should they wish to.

A number of our centres have recently been assured by the national team to deliver more than one type of vaccine, enabling us to roll out vaccinations to the population as quickly as possible in line with the different vaccine supplies available to us. This has also enabled us to respond effectively to the national guidance of offering those under the age of 40 an alternative to the AstraZeneca vaccine. We are now working towards ensuring all our sites will be ready to start delivering different types of vaccine as they become available.

As well as delivery from our vaccination centres, we have continued to explore new ways of delivering the vaccine to local communities. We have extended our vaccination programme with pop up clinics for the homeless and other seldom heard groups across Essex and Suffolk to ensure the widest possible coverage of vaccination. We are planning to bring on line a vaccinating bus over the coming weeks to provide further opportunities for delivery of the programme across all parts of our community.

My thanks are extended to all those involved in the continued successful roll out of this unprecedented vaccination programme.

People
Recruitment Highlights and Workforce Planning

- **Healthcare Support Worker Recruitment Programme Update**. 64 candidates have been aligned to operational areas and necessary employments checks are underway. 13 candidates have commenced or have agreed start dates. There have been significant delays in the progress due to lack of engagement and support from the agency in completing pre-employment checks. Concerns have been raised with Health Education England and timescales for programme completion have been extended. EPUT are now managing the pre-employment check process.
  To support this programme all Bank healthcare support workers have been contacted to express interest in transferring to permanent positions in the Trust. 76 bank workers have been identified and we are currently in the process of transferring these workers into substantive positions.
- **Student Recruitment** – 72 student nurses have been offered employment in the Trust on completion of their nursing degree
- **International Recruitment Programme** is well underway, the first task and finish group was held on 4th May with monthly meetings in place moving forward. The Trust is also engaged in a variety of international recruitment meetings both across the ICS and East of England to support the recruitment 70 nurses this year.
- **Time to hire** has decreased as at April 21 (93 days) compared to last reported position in March 2021 (104 Days). However, it should be noted that included in this timescale is the authorisation to advertise stage. On average, it has been taking approximately 26 days to authorise. If we remove this from our monitoring for time to hire this reduces to circa 67 days.
- A focused piece of work has been undertaken to further reduce these timescales, which has included putting in place more robust Key Performance Indicators for the recruiting manager, recruitment and the chasing of candidates. We have also recently removed the finance authorisation stage, which was circa 20 days. We will now be reviewing recruitment processes and template documents with the purpose to modernise and streamline these.
- **Starters and Leavers** There were 102 staff members who joined the organisation in April 2021. This figure has increased from March 2021 when there were 60 starters. 47 staff left the Trust in April 2021. This figure is not dissimilar to the March 2021 when we had 50 leavers. The main reason as to why staff members left in April 2021 was due to promotion (10 staff) Vacancy and turnover figures remain under Trust's 12% target

Sickness

- Absence relating covid peaked in January 2021 at 710 staff reporting covid absence and has significantly declined February 299 staff and March 183 staff. As at 17th May 2021 we have 14 staff reporting Covid absence and a further 4 staff isolating/shielding not working.

Employee Relations Highlights

- 8 Formal disciplinary cases
- 3 suspensions
- 15 Grievances
- 8 Appeals
- 1 Whistleblowing investigation being supported by HR
- 3 Employment Tribunals
- The HR team held a session with members of the ethnic minorities committee where we discussed lived experiences in entering formal employee relations processes. The purpose of this session was to look at improving HR practices to support staff from ethnic minorities and reduce staff entering formal employee relations processes, it was a very thought provoking session and a further follow up session will be held on 15th June to agree actions to be taken forward.

Learning and Development

- Many of the Leadership Programmes are now restarting fully with all modules on offer. Mary Seacole cohorts are being rescheduled and will commence later this summer. The Management Development Programme (MDP) is offering the full programme again and some of the elective modules have commenced and all elective modules will be rescheduled to restart from June.
- Compassionate leadership/ culture workshops are being offered to all staff within the Trust
- The Edward Jenner on-line learning is now being integrated into the EPUT leadership pathway as an additional step on the learning pathway leading to the MDP.
- One of the recruitment incentives that is in development are three rotational posts for community mental health. The posts will allow these newly qualified staff to participate in a learning programme which involves formal learning and the chance to work across neighbouring providers .
- In support of the Health Care Support Worker recruitment the Workforce Development Department have recruited additional assessors who will work on the in-house Level 3 and Level 5 diplomas in health and care. These programmes are now going to provide options for staff wishing to train towards a therapy qualification as well as nursing.
- The Clinical Associate in Psychology programme has now recruited additional staff to assist with delivery and assessment. Applications are being processed and the course will commence within the next few weeks.
- Additional clinical placements have been created in the vaccination centres, taking advantage of the learning opportunities that they offer in terms of public health, infection control etc..
- The mandatory training team are continuing to train vaccinators for the SNEE and MSE systems.
- The accreditation for out TASID programme is progressing and we have had an initial inspection. The assessors were very impressed with the team following the observation, particularly the commitment to the reduction of restrictive interventions and the patient focused training and delivery. We have had to submit a few extra pieces of evidence for minor alterations. There will be a Panel on June 16th where EPUT will deliver a presentation and there will be the opportunity for questions. There is then a quality assurance process but we hope that accreditation will be granted from July 1st.

- Our applications for the September intake from the NHS Graduate Management Trainee Scheme have been submitted. This time we had 3 for general management in clinical services (West Essex Community, South Essex Community and Mental Health) and one from HR.
- The new Appraisal and Support Policy is going through the approval process. There is a new development pathway and objective setting template which will align to the Trust values and priorities for this year. An individual wellness plan has been created which will accompany the support 1;1 which will be part of the compassionate conversations which managers will have with staff.
- We have welcomed a Graduate Management Trainee for a flexi-placement in May and June. They are helping us set up the programme of Team Support Days that will be part of the Reset and Recovery work and also assisting us with the careers lounges for volunteers of the vaccination programme.
- Overseas Clinical Fellowship positions appointed
- Recruitment strategy for medical positions, BMJ supported advertisement and task and finish group set up to look at recruitment and retention, development of skill mix and introducing Physician Associate roles with supported funding from EoE
- Women in Leadership Events have been held for all staff
- Compassionate Leadership Sessions and Compassionate Culture sessions (Compassionate Leadership has now been accredited by CPD)
- Focused sessions for managers of managing effective teams virtually
- Developed and implemented career lounges for staff identifying talent pathways
- Coaching career conversations forming part of appraisal
- Health and wellbeing conversations taking the forefront in 1:1's /supervisions, wellness plan developed , EPUT represented in a regional working group for development

Staff Engagement:
Although we are currently on track to being released from lockdown the support required by staff is at an all-time high with an increasing need for team and individual support.

- Promotion of Staff Survey is ongoing, working closely with communications team to ensure promotion is focused in the lead up to 2021 NHS Staff Survey. Focus groups have now been completed with good attendance levels and positive feedback received Plans for future focus groups to discuss confidentiality and staff survey process in place.
- Staff Engagement Champions Network Meetings and Grills monthly with last event in May. Further plans to develop a newsletter, breakout smaller grills and mentors for each champion are underway.
- Continued Staff Engagement/Wellbeing attendance at local team meetings to strengthen staff support message.
- Plans to submit application for HSJ award for Staff Engagement Award & Menopause Support Group June 21.
- Staff Recognition Awards – now on to second round of winners to date over 300 nominations received.
- Recent survey on the Staff Engagement Team's effectiveness has seen some positive results and Staff Engagement Team been nominated for a Staff Recognition Award in the next round.

Wellbeing
- Wellbeing toolkit developed for managers, promotion planned
- Rest Nests included in staff calendars to encourage attendance
- Mental Health Awareness Week recently promoted
- Walk to Italy Competition still live to encourage physical activity
- Staff Fitness Classes have been running

- Wide promotion of the range of services available to staff including Facebook live videos, articles and events.
- Menopause support group operating well and has Guest Speaker in June (Prerana Issar Chief People Officer)
- 2 Wellbeing Leads in place providing support across the Trust and to the HSE Inquiry Team
- Close working with the ICS on wellbeing projects. Multiple seminars and events attended from NHS England and region
- First Long COVID support group held May 21 for staff.
- Long COVID webinar with Herts and West Essex planned for May 21.
- One to one wellbeing support and signposting provided to individuals
- Team wellbeing support provided collaborating with Here for You and the Organisational Development Team
- Personalised wellbeing toolkits developed for individuals and teams
- Management Development Programme and Leadership Development Pathway sessions will be delivered on wellbeing
- Compassionate conversation training and wellness plan being developed and recently showcased at the NHS Improvement Wellbeing Collaborative.

Equality & Inclusion

- Wellbeing and psychological support for those affected by the Derek Chauvin Trial and second wave of COVID-19 in India.
- Support for Vaccination services, including additional interpreting request to better support those who do not speak English accessing this service.
- Development of Race Awareness and Allyship training in collaboration with staff focus group and the BAME Staff Network.
- Statement written for Trust aimed at Ethnic Minority staff for the Sewell Report and the Trust's stance.
- Ongoing 1:1 "walk-in" support for staff members with questions relating to Reasonable Adjustments, Gender Identity and other E&I topics.
- Online stakeholder session to grade Equality Delivery System and propose new actions for 2021-22 EDS held in March, and a report has been submitted to the E&ISC with full results and future steps.
- Continuation of support telephone service for Black, Asian and Minority Ethnicity groups (in conjunction with HWE ICS) and "Here for You" service.
- Networking with the ICS Systems for collaboration on joint Equality and Inclusion Agenda, sharing good practice with other NHS organisations (i.e NELFT)
- Close working with Chaplaincy Services to ensure staff and patients' faith and spiritual needs are supported, including targeted work focusing on Ramadan.
- Finalising an updated E&I Induction / Staff OLM Training with new learning and covering important key points in E&I.
- Continued support for National Disability and Long Term Conditions Network for disabled staff, with initial meeting of all Networks after regional sessions.
- Development of a policy aimed at supporting transgender / non-binary patients & inclusion in the Same Sex Accommodation Clinical Guideline, plans to develop a full staff policy and procedure over the next six months.
- Continuation of LGBTQ+ Awareness Training for staff with positive reception in the Trust, this was also showcased at the Southend MHPF on request with positive feedback.
- Regular reviews of Intranet advice and guidance for staff, including additional resources for supporting Autistic Patients, Carers and Staff developed in collaboration with a staff member with lived experience.
- E&I Training provided to Staff Governors.
- New printable "Equality and Inclusion Update" designed to better reach frontline staff.
- Adherence to WRES and WDES with quarterly (Q2) update.

- Inclusion of Equality and Inclusion in Staff Appraisals in line with NHS Plan
- Sensory Loss Awareness Sessions available to all staff.
- Sunflower Lanyards Scheme implemented for Patients and Staff with hidden conditions and now embedded in Staff Intranet and Staff Induction
- Reverse Mentoring cohort continue to meet as part of reverse mentoring programme

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

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

Risk Assessment of Report	
Summary of Risks highlighted in this report	All inadequate and requiring improvement indicators.
State which BAF risk(s) this report relates to	BAF32 Quality Improvement BAF41 CIP's BAF42 Financial Plan BAF45 CQC Inspections and Learning BAF56 CQC Fundamental Standards BAF62 Staffing
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	Continued monitoring of Trust performance through integrated quality and performance reports.

Purpose of the Report		
The Board of Directors Scorecards present a high level summary of performance against quality priorities, safer staffing levels, financial targets and NHSI key operational performance metrics and confirms quality / performance "inadequate indicators". The scorecards are provided to the Board of Directors to draw attention to the key issues that are being considered by the standing committees of the Board. The content has been considered by those committees and it is not the intention that further in depth scrutiny is required at the Board meeting.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the reports.
2. Request further information and / or action by Standing Committees of the Board as necessary.

Summary of Key Issues

Performance Reporting

This report presents the Board of Directors with a summary of performance for month 1 (April 2021).

The Finance & Performance Committee (FPC) (as a standing committee of the Board of Directors) have reviewed performance in detail for April 2021.

Five inadequate indicators (variance against target/ambition) have been identified at the end of April 2021 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard. These remain unchanged from March 2021.

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity
- Out of Area Placements
- Clients not Seen, inc Patients with No Consultant Review within 12 months

There is one inadequate indicator which is an Oversight Framework indicator for April 2021.

- Out of Area Placements

There are no inadequate indicators in the EPUT Safer Staffing Dashboard for April 2021.

This CQC Reset action plan is now closed following confirmation from the CQC. The Trust continues to take forward an internal action plan using the CQC information, and developing it across the wider service, therefore there is no current CQC Action Plan to report against. The CQC are currently undertaking inspections of the Trust and a new action plan will be developed following these.

The Finance section sets out key financial headlines for M1 as reported to Finance & Performance Committee, RAG ratings have not been applied this month due to planning submission requirements.

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

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓

Data quality issues			✓
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
ALOS	Average Length Of Stay	FRT	First Response Team
AWoL	Absent without Leave	FTE	Full Time Equivalent
CCG	Clinical Commissioning Group	IAPT	Improving Access to Psychological Therapies
CHS	Community Health Services	MHSDS	Mental Health Services Data Set
CPA	Care Programme Approach	NHSI	NHS improvement
CQC	Care Quality Commission	OBD	Occupied Bed days
CRHT	Crisis Resolution Home Treatment Team	OT	Outturn

Supporting Documents and/or Further Reading
Quality & Performance Scorecards

Lead
Add signature **Paul Scott** **Chief Executive**

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
April 2021

Are we Safe? | Are we Effective? | Are we Caring? | Are we Responsive? | Are we Well Led?

Report Guide

Use of Hyperlinks

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

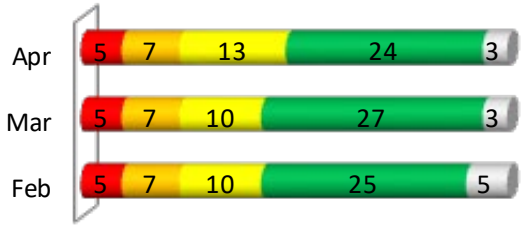
How is data presented?

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

Statistical Process Control (Trend Identification)					
Variation			Assurance		
					
Common Cause – no significant change	Special Cause or Concerning nature or higher pressure due to (H)igher or (L)ow er values	Special Cause of improving nature of low er pressure due to (H)igher or (L)ow er values	Variation indicates inconsistently hitting and passing and falling short of the target	Variation indicators consistently (P)assing the target	Variation Indicates consistently (F)alling short of the target
Assurance (How are we doing?)					
Meeting Target EPUT is achieving the standard set and performing above target/benchmark	Requiring Improvement EPUT is performing under target in current month/ Emerging Trend	Inadequate EPUT are consistently or significantly performing below target/benchmark / SCV noted / Target outside of UCL or UCL	Variance Trust local indicators w hich are at variance as a w hole or have single areas at variance / at variance against national position	For Note These indicate data not currently available, a new indicator or no target/benchmark is set	Indicators at variance w ith National or Commissioner targets. These have been highlighted to Finance & Performance Committee.

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

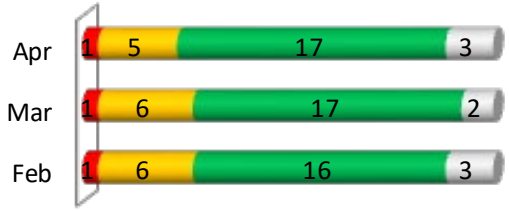


April Inadequate Performance

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Clients not seen, inc Patients with No Consultant Review within 12 months

Please note indicators suspended over COVID period and those that are for note are colour coded grey.

Summary of Oversight Framework Indicators



April Inadequate Performance

- Out of Area Placements

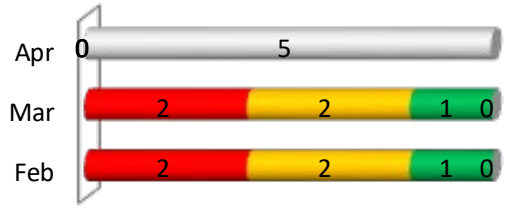
Summary of Safer Staffing Indicators

No risks identified within the Safer Staffing section.

Summary of CQC Indicators

The CQC Action Plan remains completed and closed.
The Trust is now taking forward an internal action plan using the CQC information, and developing it across the wider service, therefore there is no longer a CQC Action Plan to report against.

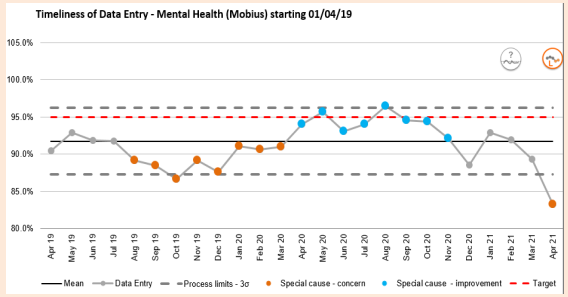
Finance Summary

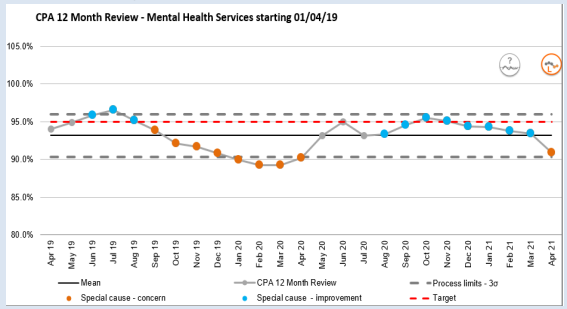
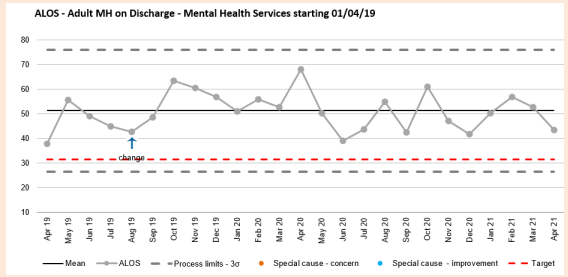


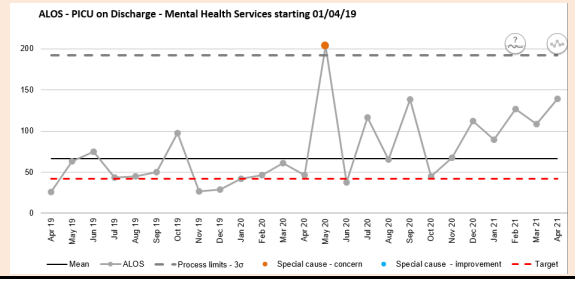
Items have not been RAG rated in April whilst budgets are still being approved.

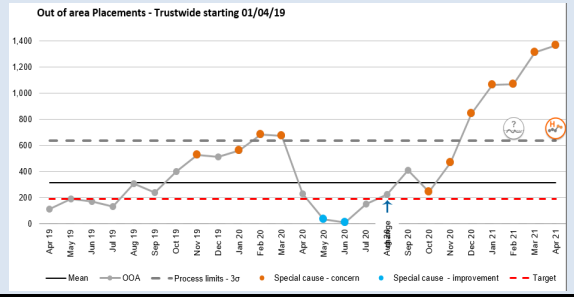
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

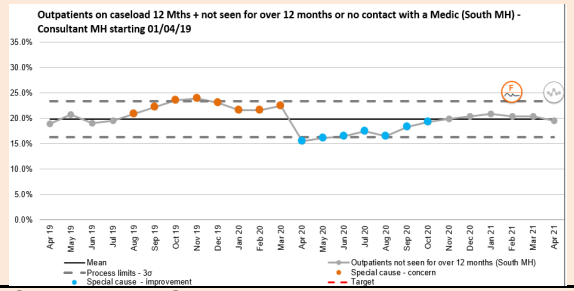
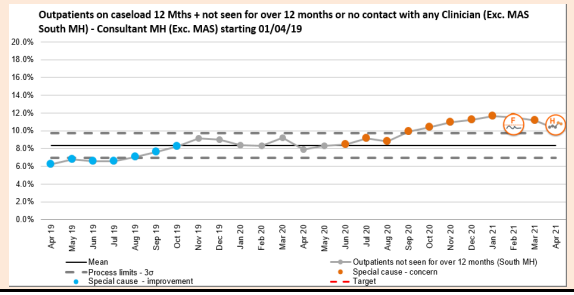
Effective Indicators

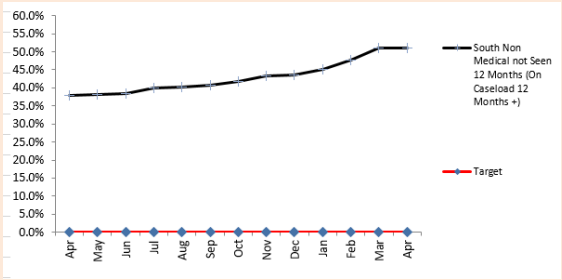
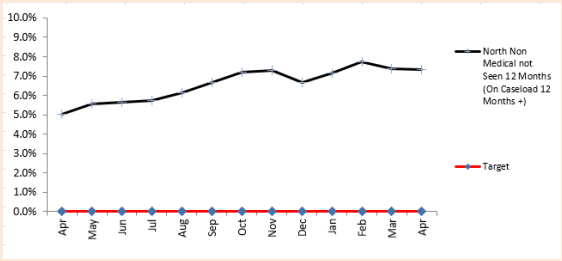
RAG	Ambition / Indicator	Position M1 Perf	Position M1 RAG	Trend	Nat RAG	Narrative	Recovery Date
2.1 Timeliness of Data Entry Committee: FPC Indicator: Local Data Quality RAG: Green	**Inadequate** Mobius MH performance has reduced further in April to 83.3% (95% target). Following refresh, February also remains below target. Paris and SystmOne continue to meet target. Late data entry can have a considerable impact on Trust reported performance against KPI's. As agreed at the previous Finance & Performance Committee, a review of the data included in the reporting of timeliness of data entry would take place with the Operational Director for Mid & South Essex to look at how the data is being presented. The first meeting has taken place and a break down of the data is being looked at by the Performance team. We are due to meet again at the end of this month to agree a more robust monitoring of this indicator. Early discussions have identified that a complete review of this indicator will take place. Currently the data only monitors Community contacts. <u>Data Entry MH services (on Mobius)</u> achieved 83.3% in April against a target of 95%. There were ten (out of ten) MH and two (out of two) Specialist MH Services below target). The following services were below 90%: • Assertive Outreach • Crisis Home Treatment • Early Intervention • Eating Disorders • First Response • Psychotherapy • Recovery Wellbeing • Other Teams (This includes but is not limited to services relating to Speech Therapy, Psychology, Psychotherapy, OT, and Day Care) • Forensic Community • Learning Disabilities Late data entry has a significant impact on Trust reported performance and internal figures being at variance with national figures.						
	2.1.2 Timeliness of data entry - Continuation Sheets Completed (Mobius) **Target 95%**	83.3%	●	Above Target = Good 	N/A	April performance : Mobius MH & Specialist Total : 83.3% MH Total : 83.3% Specialist Total : 84.0%	N/A

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: **Amber**	**Inadequate** Managers have instigated a process for receiving reports on service users not seen for 6 months to support the review of those on CPA that need to be discharged. As well as this, teams monitor their CPA review target on a weekly basis. The Operational Productivity team also send reminders to staff one month before the reviews are due and these are circulated twice a month. There does however continue to be a shortage of Medical staff in some areas which is resulting in an increase in medical reviews which are overdue. In April, overall performance fell again to 91% against a target of 95%. Performance against this indicator is regularly monitored by the Data Quality & Performance group.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	90.9%	●	Above Target = Good 	●	There were nine Teams in the South, one Team in Specialist Services, five Teams in Mid, five Teams in NE and four Teams in West below target.	
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** Adult & PICU Inpatient Capacity MH has been highlighted as inadequate due to parts of the indicator being at variance with EPUT ambition. 2.9.1 OPLE Status: There were three days at OPEL 4 in April (Three x North, 06/04/21, 07/04/21 & 08/04/21). 2.9.2 ALOS Adults: has reduced in April to 43.4 days and remains outside National Benchmark of <31.6. This is due to 98 discharges, 17 of which were long stays (60+ days). 2.9.5 ALOS PICU: remains outside target in April at 138.8 days against benchmark of <42 days, this is due to Six discharges, three of whom were long stay (60+ days).						
	2.9.1 OPEL Status	3	●	Three days at OPEL Four in April 2021	N/A		N/A
	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: 31.6**	43.4 days	●	Below Target = Good 	●	Consistently failing target 98 discharges in April (17 of whom were long stays (60+ days))	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: 42**	138.8 days	●	Below Target = Good 	●	Six discharged in April (three of whom were long stays (60+ days))	

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.5 Out of Area Placements ● Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	**Inadequate** OOA placement Occupied Bed Days has seen a significant increase since July 20, this is in part due to the requirement for social distancing on wards limiting occupancy levels. OOA placements are a key focus in the Phase 3 planning, with increased occupancy of Trust beds agreed to reduce the OOA impact and reinstatement of Topaz in March 21 to further offset any COVID surge demand. It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory. These beds are now in use and are being reviewed with regards to being considered appropriate OOA placements or not. There is currently an action plan in place to reduce inappropriate OOA bed days to 0 by the end of September 2021. In April EPUT placed 25 new clients out of Area (24 Adult and one PICU), 33 patients were repatriated in April (28 Adult & five PICU) and 38 remain (32 Adult and six PICU) OOA at the end of April. The total Occupied bed days for all out of area placements in April was 1,364. OAP's for locked Rehab patients have been excluded (2 patients) as EPUT do not provide these bed types, therefore these would need to be placed out of area.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA**	1,364 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative.	TBC

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
4.9 Patients Not Seen / no contact for over 12 months Committee: Quality Indicator: Local Data Quality RAG: **Blue**	**Inadequate** It should be noted that this is not a traditional waiting list, as referrals do not come directly to consultants from GP's. A task and finish group was put together to look at the construction of this indicator. This group has met several times and as a result a new consultant dashboard has been developed to make it easier for the consultants to monitor this activity and get the assurance they need that the information being presented to board is correct. There has been a major improvement in the numbers of patients waiting longer than 12 months and a final meeting will take place at the end of May to get the appropriate sign off on the quality of the data currently published. A full report of the findings will be presented at the Finance & Performance committee in June. In April all four indicators are breaching targets, however each one shows an improvement on March. There are currently 19.6% of clients on a consultant caseload who have not been seen by a consultant for 12 months, of these, 10% have not been seen by any clinician. 51% of clients on a South Essex non-medical caseload have not been seen and 7.3% on a North East, West, or Mid caseload have not been seen.						
	4.9.1 Patients with no consultant review within 12 months **Target 0%**	19.6%	●	On Target = Good 	N/A	The construct of this indicator has been reviewed and now counts the number of clients who have been on a medic caseload for 12 months + and have not been seen or had contact with a medic for 12 months + as at the end of the reporting period. (inc. telephone contacts / inpatients and contacts with any consultant)	
	4.9.2 Patients on Consultant Caseload South Essex not seen / no contact by any clinician for over 12 months **Target 0%**	10.2%	●	On Target = Good 	N/A	As above but excludes MAS Medic Caseload and includes any contact with another HCP.	

Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%**	51.2%	●	On Target = Good 	N/A	Work continues to validate and improve these indicators with breach and monitoring reports being supplied to the Operational Productivity team. These indicators will also continue to be monitored as part of the Data Quality & Performance meeting group. *SPC charts to be produced upon accrual of sufficient data.*	
	4.9.4 Patients on any North East, West or Mid caseload not seen / no contact by any clinician for over 12 months **Target 0%**	7.3%	●	On Target = Good 	N/A		

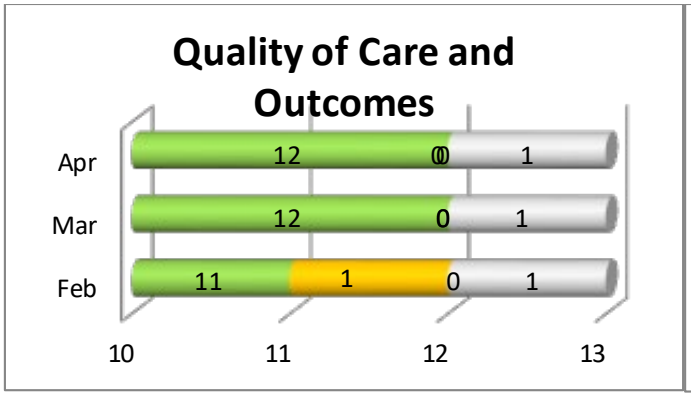
Additional Indicators	
RAG	**Narrative**
Waiting Lists	**Psychology**; Interviews took place to fill the six new posts under the Clinical Associate in Psychology (CAP) apprenticeship programme and all six have now been recruited to. These posts will be commencing on the 24th May, two in South West, and four in South East. This new resource will enable pick up of around 36 cases plus additional group interventions. There are waiting list clearance action plans in place across all areas. Wait times are as follows (as at March 2021): Rayleigh: there are currently 35 clients waiting and the longest wait is 18 months. Southend: there are currently 44 clients waiting and the longest wait is 28 months. Castle Point: there are currently 35 clients waiting and the longest wait is 28 months. Thurrock: there are currently 74 clients waiting and the longest wait is 35 months. Basildon: there are currently 112 clients waiting and the longest wait is 38 months. Brentwood: there are currently 46 clients waiting and the longest wait is 24 months. *Basildon has the longest waits due to being the largest area with the highest demand and density of need. At the previous Finance & Performance Committee it was agreed that the Director of ITT, Business Analysis & Reporting would meet with the Clinical Director of Psychological Services, to discuss being able to report from the Electronic Patient Systems the waiting lists and contacts with these patients whilst waiting for the appropriate service provision. This meeting has taken place and a further meeting with the clinical team is booked to look at how best to collect this data electronically.

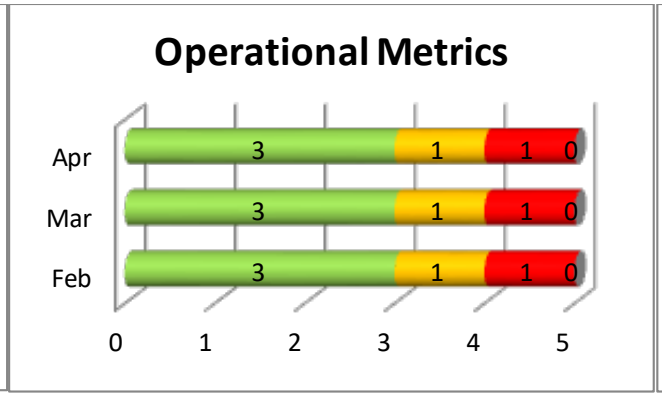
SECTION 3 – Oversight Framework

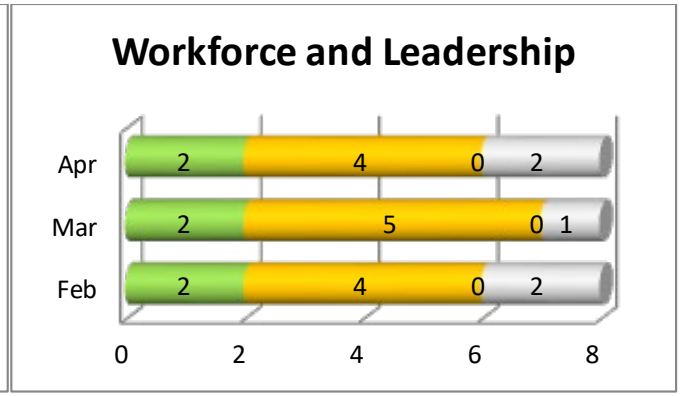
Click here to return to Summary

Summary

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





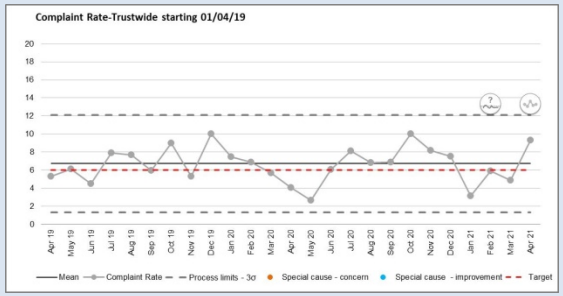


Inadequate

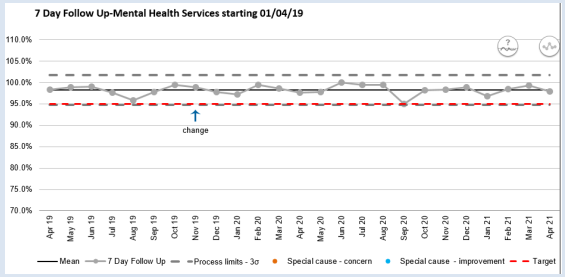
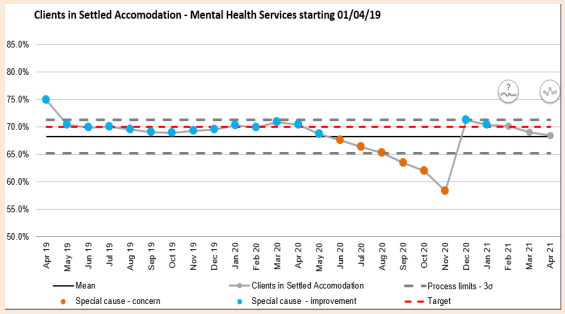
- Out of area placements

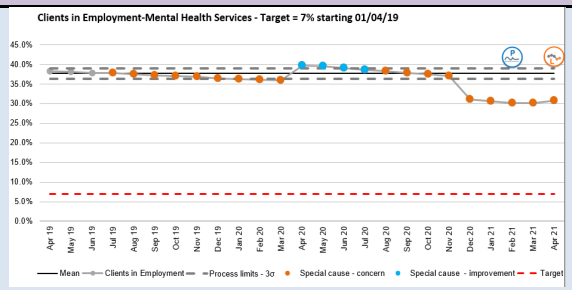
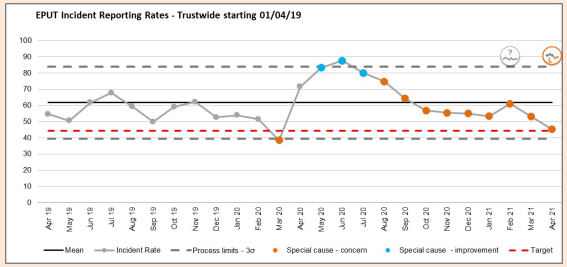
Requires Improvement

- IAPT Recovery Rates
- Staff Survey indicators x4

Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	CQC rating of Good or above (no target set)	Good	●	The Trust is fully registered with the CQC.			
4.1 Complaints Committee: FPC Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month	9.3	●	Below Target = Good 	●	Performance remains inconsistent and variation indicates inconsistently hitting and failing target.	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	Staff Friends and Family Test % recommended – care (extremely likely or likely to recommend) **Target 74%**		●		●	Indicator suspended nationally over Covid period	N/A
1.1 Never Event Committee: Quality Indicator: Oversight	0 Never Events 2019/20 Outturn 0	0	●	Year to Date 0	●		N/A

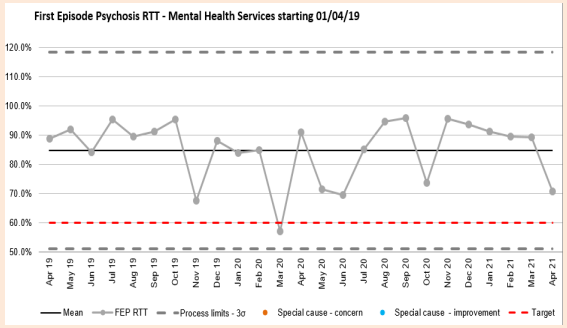
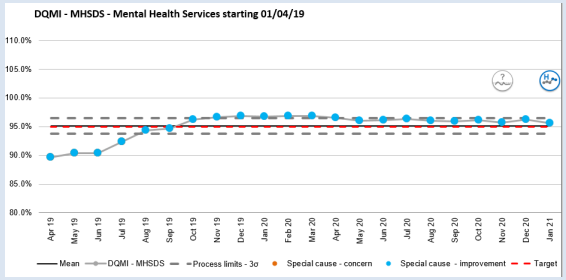
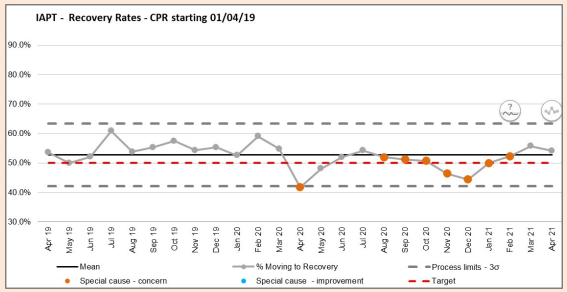
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Framework Data Quality RAG: **Blue**							
1.6 Safety Alerts Committee: Quality Indicator: OF Data Quality RAG: **Green**	There will be 0 Safety Alert breaches **2019/20 Outturn 0**	0	●	Year to date there have been no CAS safety alerts incomplete by deadline.	●		N/A
3.1 Patient MH Survey Committee: Quality Data Quality RAG: **Green**	Positive Results from CQC MH Patient Survey	●		EPUT achieved "about the same" in all 11 domains in the 2020 survey when compared with other Trusts.	●	Responses were received from 102 people at Essex Partnership University NHS Foundation Trust.	N/A
3.3.1 Patient FFT MH Committee: Quality Data Quality RAG: **Green**	Patient FFT MH response in line with benchmark **Target = 88.3%**	100%	●	Consistently achieving target.	●	37 total responses for MH 37 Very Good/Good	N/A
3.3.2 Patient FFT CHS	Patient FFT CHS response in	97%	●		●	32 total responses for CHS 30 Very Good/Good	N/A

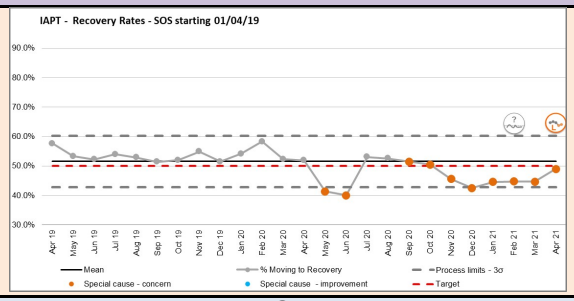
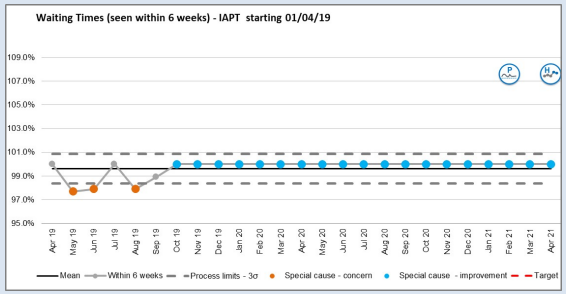
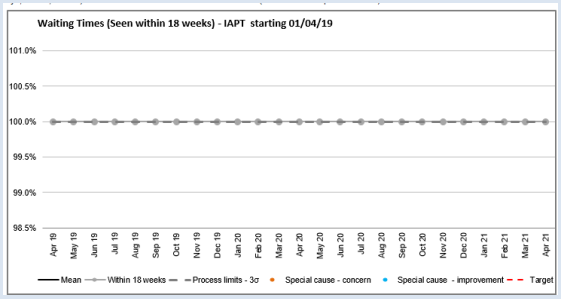
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Committee: Quality Data Quality RAG: **Green**	line with benchmark **Target = 96%**						
2.8.1 7 Day Follow Up Committee: Quality Data Quality RAG: **Blue**	95% of people on Care programme approach (CPA) are followed up within 7 days of discharge from hospital **Target 95%**	97.9%	●	Below Target = Good 	●	Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative.	N/A
2.4 Settled Accomodation Committee: Quality Data Quality RAG: **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	68.5%	●	Trend above Target = Good 	●	Paris 64.3% in April Mobius 79.8% in April	N/A
2.5 Employment Committee: Quality	We will support patients into employment **Target 7% (locally set)**	30.7%	●	Trend above Target = Good	●	Assurance indicates consistently Passing target.	N/A

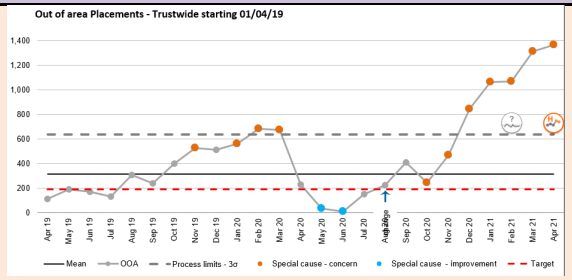
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**							
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Potential under-reporting of patient safety incidents **Target >44.33**	45	●	Trend above Target = Good 	●	Potential concern with seven months of reducing rate. However consistently above target. **Fewer incidents have been signed off by managers in time to be included in this report. This is due to the earlier production of performance reporting since November. The March data has not been refreshed this month. Both the March and April data will be refreshed in the May report.**	N/A
1.15 Under 16 Admissions Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in April	●		N/A

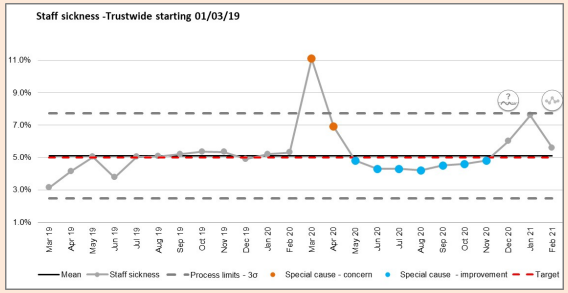
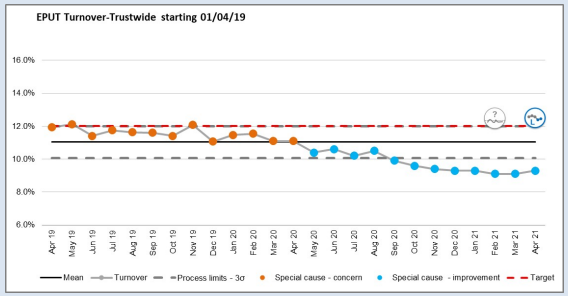
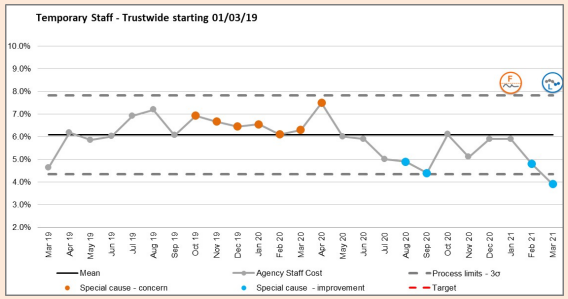
Click here to return to Summary

Operational Metrics

RAG	Ambition / Indicator	Position M1 Perf	Position M1 RAG	Trend	Nat RAG	Narrative	Recovery Date
4.6 First Episode Psychosis Committee: Quality Data Quality RAG: **Green**	All Patients with F.E.P begin treatment with a NICE recommended package of care within 2 weeks of referral **Target 60%**	70.8%	●	Trend above Target = Good 	●	April performance represents: 17 / 24 patients.	N/A
2.2 DQMI Committee: FPC Data Quality RAG: TBC **Green**	Data Quality Maturity Index (DQMI) – MHSDS dataset score above 95% **Target 95%**	95.6%	●	Trend above target = good 	●	Latest published figures are for January 2021	Dec 20 achieved
2.16.3/4 IAPT Recovery Rates Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT) /talking therapies 50% of people completing treatment who move to recovery **Target 50%**	CPR 54%	●	Trend above target = Good 	●	Slight decrease from last month but continues to meet target. Recovery rates had slowed in the last few months as service have seen an increase in numbers of patients dropping out of treatment, and worsening clinical presentations.	N/A
		SOS 49%	●	Trend above target = Good	●	Increase from the March positon. Decline has slowed but remains below target. Recovery rates had slowed in the last few months as service have seen an increase in numbers of patients dropping out of treatment, and	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						worsening clinical presentations.	
2.16.5/6 IAPT Waiting Times Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies b. waiting time to begin treatment: i) 75% within 6 weeks ii) 95% within 18 weeks	i) 100%	●	Trend above target = Good 	●	Consistently passing target	N/A
		ii) 100%	●	Trend above target = Good 	●		
4.5 Out of Area Placements Committee: FPC	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA by 2021**	1,364 Days	●	Below Target = Good	●	In April EPUT placed 25 new clients out of Area (24 Adult and one PICU), 33 patients were repatriated in April (28 Adult & five PICU) and 38 remain (32 Adult and six PICU) OOA at the end of April. The total Occupied bed days for all out of area placements in April was 1,364. OAP's for locked Rehab patients have been excluded (2 patients) as	N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Amber**						EPUT do not provide these bed types, therefore these would need to be placed out of area.	

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Data Quality RAG: **Blue**	Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**			Below Target = Good 		Data currently unavailable	N/A
5.2.2 Turnover Committee: FPC Data Quality RAG: TBC	Staff Turnover (Benchmark 2017/18 MH 12% / CHS 12.1%) **OF Target TBC** **Target <12%**	9.3%		Below Target = Good 		Special Cause of improving nature of lower pressure due to (L)ower values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staff Committee: FPC Data Quality RAG: TBC	Proportion of temporary Staff (Provider Return) OF Target TBC	6.8%		Below Target = Good 	N/A	Significant increase in temp staff expenditure in April with most directorates seeing an increase in either agency or bank spending.	N/A
5.5 Staff Survey	5.5.1 Outcome of CQC NHS staff survey 5.5.2 Support & Compassion, Team Work and	**Information from the 2020 Staff Survey** The Staff Survey ran from September to November 2020. The Trust was measured against 10 themes in the 2020 Survey. EPUT scored above average in one theme, in line with average on six themes, and below average against three themes.					

Committee: FPC
Data Quality RAG: **Green**

Inclusion

Support and compassion average rating of:
• % experiencing harassment, bullying or abuse from staff in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months
• % not experiencing harassment, bullying or abuse at work from managers in the last 12 months

Staff Survey 2020	EPUT	Average	Comments	
Safe Environment – Bullying & Harassment (high is better)	8.0%	8.3%	Below Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from managers (low is better)	11.9%	10.5%	Above Average	●
Well Being and Safety at Work – Harassment, bullying or abuse at work from other colleagues (low is better)	17.2%	15.5%	Above Average	●

Teamwork Average of:
• % agreeing that their team has a set of shared objectives
• % agreeing that their team often meets to discuss the team's effectiveness

Staff Survey 2020	EPUT	Average	Comments	
Q4h The Team I work in has a set of shared objectives	75.4%	74.6%	Better than average	●
Q4i The Team I work in often meets to discuss the team's effectiveness	68.5%	69.8%	Below Average	●

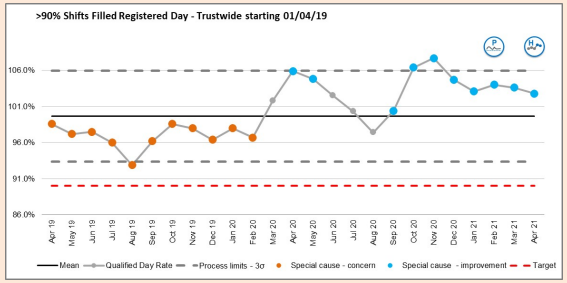
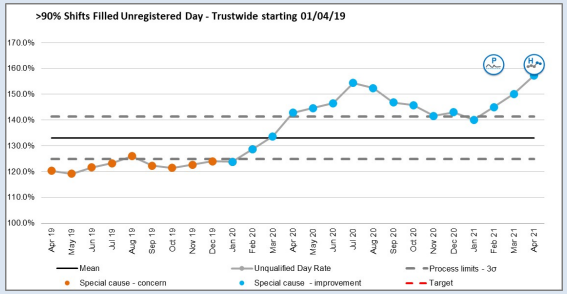
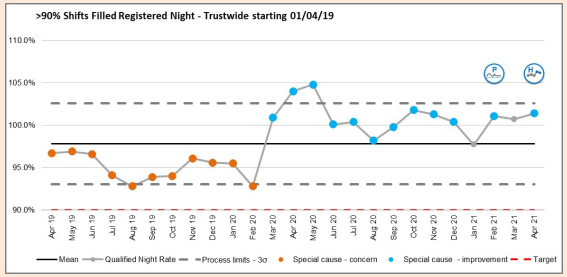
Trusts in lowest third across the sector will represent a concern

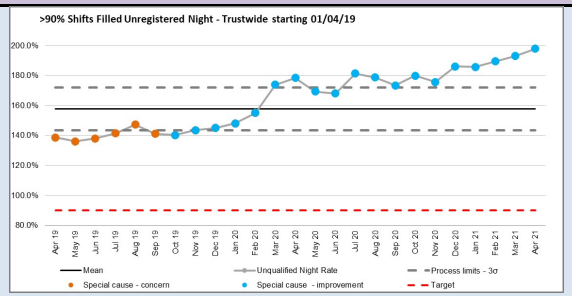
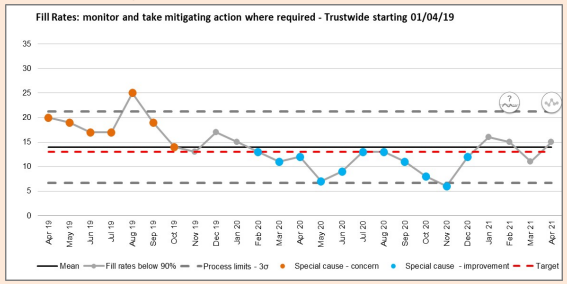
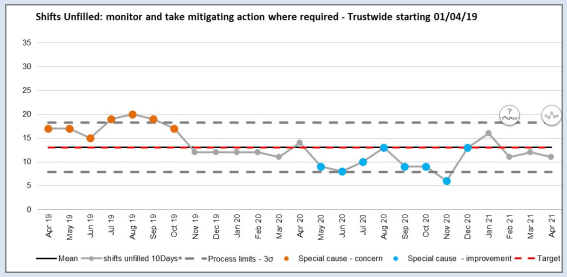
Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leaderor other colleagues in the last 12 months

Staff Survey 2020	EPUT	Average	Comments	
Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	84.7%	86.6%	Below Average (Better than last year)	●
Q15b Discrimination at work from manager / team leader or other colleagues in last 12 months	8.6%	7.1%	Above average	●

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff	We will achieve >90% of expected day time shifts filled.	103%	●	Trend above target = good 	●	The following wards were below target in April: CAMHS: Longview Nursing Home: Clifton Lodge Specialist: Edward House & Fuji Adult: Ardleigh, Gosfield & Peter Bruff Older: Ruby & Topaz LD: Heath Close	N/A
Day Un-Qualified Staff	We will achieve >90% of expected day time shifts filled.	157%	●	Trend above target = good 	●	There were no wards below target in April	N/A
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	101%	●	Trend above target = good 	●	The following wards were below target in April: Older Adult: Beech –Rochford, Gloucester, Kitwood & Henneage Nursing Homes: Rawreth Court	N/A
Night Un-Qualified Staff	We will achieve >90% of expected	198%	●	Trend above target = good	●	There were no wards below target in April	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M1**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	night time shifts						
Fill Rate	We will monitor fill rates and take mitigating action where required	15	●	Below Target = Good 	●	The following wards had fill rates of <90% in April: Adult: Ardleigh, Gosfield & Peter Bruff Older Adult: Beech – Rochford, Gloucester, Henneage, Kitwood, Ruby & Topaz Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Edward House & Fuji CAMHS: Longview LD: Heath Close	N/A
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	11	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in April: Adult: Gosfield & Peter Bruff Older Adult: Beech – Rochford, Gloucester, Henneage, Kitwood, Ruby & Topaz Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Edward House & Fuji CAMHS: Longview	N/A

SECTION 5 – CQC

Click here to return to summary page

Following the unannounced inspection of Finchingfield Ward the CQC issued EPUT with a Warning Notice served under Section 29A of the Health and Social Care Act 2008 (issued on 27th November 2020). An action plan was developed to meet the Warning Notice areas of concern and all areas have been compliance checked to ensure all actions have been addressed and implemented prior to reporting back to the CQC. The Warning Notice Action Plan has now been closed and submitted to the CQC as required.

In addition to the Warning Notice, the CQC identified 6 “Must Do” Requirement Notice actions that the Trust must take; however following discussions with the CQC they have confirmed that the completion of the Warning Notice Action Plan was all the evidence they needed. The Trust is now taking forward an internal action plan using the CQC information, and developing it across the wider service, therefore there is no longer a CQC Action Plan to report against.

The CQC are currently undertaking inspections of the Trust and a new action plan will be developed following these.

SECTION 6 - Finance

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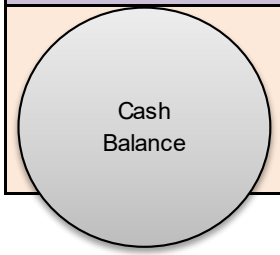
RAG	Ambition / Indicator	Position
Capital Expenditure (CDEL)	Maximising Capital Resources	CDEL as at M1 is £0.3m. Planned CDEL for the year is £14.4m.
Trust I&E 2020/21	Operating Income and Expenditure	The Trust continues to work under the adapted financial regime for H1 (M1-M6) 2021/22. No external reporting to NHSE/I for M1. COVID spend for M1 is £1.5m, Mass Vaccination spend in M1 is £2.4m, both with full recovery expected.
Efficiency Programmes	Planned improvement in productivity and efficiency	The Trust's Efficiency plan for 21/22 is subject to Trust Board approval (May 21) of the H1 21/22 budget plan.
Temporary Staffing	Level of Temporary Staffing Costs	Total spend in M1 was £5.1m ➢ Bank spend £3.6m ➢ Actual Agency spend £1.5m M1 Total COVID spend was £1.0m with COVID Agency at £0.2m. M1 Total Mass Vaccination was £0.7m (mainly bank spend).

RAG	Ambition / Indicator	Position
	Positive Cash Balance	The cash balance at the end of April was £86.2m.

END

		Agenda Item No: 7(b)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**NHS England / Improvement Self-Certification Requirements 2020-21**					
Executive/Non-Executive Lead:	Paul Scott Chief Executive Officer					
Report Author(s):	Chris Jennings Assistant Trust Secretary					
Report discussed previously at:	Finance and Performance Committee 20 May 2021					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	N/A
Are you recommending a new risk for the EPUT BAF?	N/A
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors with details of NHSE/I self certification requirements and makes a recommendation in respect of the declaration that should be made as a result of detailed consideration of compliance with Licence Condition G6.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the recommendation from the Finance & Performance Committee to make a declaration to NHSE/I as detailed in this report.

Summary of Key Issues

NHS Foundation Trusts are required, under normal circumstances, to make annual self-certifications to NHS Improvement under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual plan submission. Four self-certifications are required (one is not applicable to EPUT in relation to Joint Ventures and Academic Health Science Centres (AHSCs)).

Self-certification is required against G6 by 31 May 2021. Self-certification is required against FT4 and Governor Training by 30 June 2021 and these be will included in a report to the Board of Directors in June.

A self-assessment was undertaken by the Trust Secretary's Office and Finance Department against the licence conditions for G6. The self-assessment documentation was circulated to the Council of Governors for comment and no comments have been received. The document will be presented to the Council of Governors on the 28 May 2021.

The Finance & Performance Committee considered compliance with the provider licence requirements at its meeting on the 20 May 2021 and agreed to recommend to the Board of Directors that the following declaration is made:

"Following a review for the purposes of paragraph 2b of Licence Condition G6, the Directors of the Licensee are satisfied, that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the Licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution"

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	
Service impact/health improvement gains	
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**	Nil
Governance implications	✓
Impact on patient safety/quality	
Impact on equality and diversity	

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

Acronyms/Terms Used in the Report			
NHSE/I	NHS England / Improvement		

Supporting Documents and/or Further Reading
Accompanying Report Appendix 1 – Licence Self-Assessment

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 7(b)
Board of Directors Part 1
26 May 2021

EPUT

NHS England / Improvement Self-Certification Requirements 2020-21

1.0 Purpose of Report

This report provides the Board of Directors with details of NHSE/I self-certification requirements and makes a recommendation in respect of the declaration that should be made as a result of detailed consideration of compliance with Licence Condition G6.

2.0 Background

NHS Foundation Trusts are required, under normal circumstances, to make annual self-certifications to NHS Improvement under the NHS Provider Licence, Risk Assessment Framework and the Health and Social Care Act 2012, in addition to those made as part of the annual plan submission. Four self-certifications are required (one is not applicable to EPUT in relation to Joint Ventures and Academic Health Science Centres (AHSCs)).

The NHS Provider Licence requires three declarations, as follows:

- Condition G6(3) Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution. This is covered by this report.
- Condition FT4(8) Providers must certify compliance with required governance standards and objectives. This will be covered by a report to the Finance & Performance Committee and the Extra-Ordinary Board of Directors in June 2021.
- Condition CoS7(3) Providers providing commissioner requested services (CRS) must certify that they have a reasonable expectation that the required resources will be available to deliver the designated service. This is not applicable to the Trust.

In addition there is a requirement for self-certification in respect of:

- Training of governors. This will be presented to the Finance and Performance Committee in June 2021. This is not a licence condition, but Section 151(2) of the Health and Social Care Act requires that [Providers] must take steps to secure that the governors are equipped with the skills and knowledge they require.

The Board must sign off the self-certification, taking into account the views of governors. The Council of Governors is not required to approve the self-certification declarations.

Boards must sign off on self-certification no later than:

- **G6:** 31 May 2021
- **FT4 and Governor Training:** 30 June 2021

3.0 Licence condition G6: Detailed requirement

The requirements for licence condition G6 is as follows:

The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) The Conditions of this Licence
(b) Any requirements imposed on it under the NHS Acts, and
(c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Without prejudice to the generality of the paragraph above, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence, and
(b) Regular review of whether those processes and systems have been implemented and of their effectiveness.

4.0 Condition G6: action and/or evidence of compliance with requirements

The Trust Secretary's Office and Finance have undertaken a comprehensive review of compliance against the provider licence and this is attached as Appendix 1. The recommended declaration to the Board is as follows:

"Following a review for the purposes of paragraph 2b of Licence Condition G6, the Directors of the Licensee are satisfied, that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the Licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution"

5.0 Comments from the Council of Governors

Governors have been invited to express their views on this declaration and send comments to the Trust Secretary. No responses have been received, however, any received prior to the Board meeting will be provided verbally.

In addition, the timing of the Council of Governors meeting on the 28 May 2021 means a draft version of the FT4 will be presented, with a final version circulated electronically once reviewed by the Finance & Performance Committee.

6.0 Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Approve the recommendation from the Finance & Performance Committee to make a declaration to NHSE/I as detailed in this report.

Chris Jennings
Assistant Trust Secretary

On behalf of

Paul Scott
Chief Executive Officer

APPENDIX 1

EPUT REVIEW OF COMPLIANCE AGAINST THE PROVIDER LICENCE 2020/21 AS AT MAY 2021

Objective: As EPUT is required to comply with the terms of the provider licence, it is essential that it ensures there is ongoing compliance with the licence conditions and areas identified to strengthen maintenance of compliance.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
SECTION 1: GENERAL CONDITIONS				
G1	**Provision of Information** Obligation to provide NHSE/I with any information it requires for its licensing functions within required timeframe and format ensuring that such reports and information are accurate, complete and not misleading, and is a true copy of the document requested	The Licensee shall furnish to NHSE/I such information and documents, and shall prepare or procure and furnish to NHSE/I such reports, as NHSE/I may require for any of the purposes set out in section 96(2) of the 2012 Act	Compliant	• Systems and processes in place to identify and respond to routine and ad hoc requests • Board sign off as required • EPUT submits all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time • Any submissions required are made by the Finance Directorate and retained • Copies of all documents to NHSE/I are retained • Submissions to Council of Governors as required for additional assurance (i.e. training and development of Governors requirement; EPUT compliance with the *Code of Governance)*
G2	**Publication of Information** Obligation to publish such information as NHSE/I may require including making available to the public	The Licensee shall comply with any direction from NHSE/I for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services	Compliant	• Compliance with Annual Report/Quality reporting guidance (ARM) and EPUT constitution • Annual Report and Accounts, Quality account/Report, etc. on EPUT website • Included in EPUT's publication scheme • Register of interests • Code of Governance
G3	**Payment of fees to NHSE/I** Gives NHSE/I the ability to charge fees and obligation for licensees to pay them	The Licensee shall pay fees to NHSE/I in each financial year of such amount as NHSE/I may determine	Compliant	• There have been no plans publicised to charge a fee to licensees
G4	**Fit and proper persons as Governors and Directors**	G4.1 The Licensee shall ensure that no person who is an unfit person may	Compliant	• Robust Board Directors policy and procedure in place • Disqualification criteria set out in constitution

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	Prevents licensees from allowing unfit persons to become or continue as a Governor or Director except with NHSE/I approval	become or continue as a Governor, except with the approval in writing of NHSE/I. G4.2 The Licensee shall not appoint as a Director any 'person who is an unfit person, except with the approval in writing of NHSE/I G4.3 The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHSE/I		• Requirement of both Directors and Governors mirrored in Code of Conducts • Directors and Governors sign declarations as part of recruitment and nominations processes • Condition of appointment: relevant checks undertaken by Trust Secretary's Office and HR • Responsibility of Board Directors and Governors to notify in-year changes • Board Directors required to have annual enhanced DBS checks (including children's and vulnerable adults' barred list) and Companies House disqualification checks • Annual declaration received by the Board • Board Director contracts include provision permitting summary termination in the event of the Director becoming/being 'unfit' • There has been no requirement for NHSE/I to allow a Director or Governor to remain in post • Conflict of interests policy and procedural guidelines in place with implementation plan
G5	**NHSE/I Guidance** Obligation to have regard to guidance issued by NHSE/I. A licence holder is required to advise NHSE/I if it decides not to follow such guidance giving reasons	The Licensee shall at all times have regard to guidance issued by NHS Improvement for any of the purposes set out in section 96(2) of the Health and Social Care Act 2012	Compliant	• Systems and processes in place to ensure EPUT responds to/meets guidance issued by NHSE/I • Submissions and information provided to NHSE/I are approved through relevant and appropriate authorisation processes • Monthly Legal Update Report presented to EOSC • Bi-Monthly Chair's Report to Board including Governance • Regular Board Governance Report produced by Trust Secretary presented at Board of Directors meetings containing latest legal and regulatory developments • Full reviews of NHSE/I guidance is undertaken by relevant teams including Compliance Team, Trust Secretary, Legal Team, Finance Team, etc.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
				• Annual review of EPUT's compliance with *Code of Governance* • Self-assessments undertaken and presented to EOSC, Finance and Performance and Quality Committees, e.g. Corporate Governance Statement, Well Led Framework, etc. • Responses to consultations as required
G6	**Systems for compliance with licence conditions and related obligations** Obligation to take reasonable precautions against risk of failure to comply with the licence including the establishment and implementation of processes and systems to identify and manage risks, and the regular review of these processes and systems to ensure implementation and effectiveness	G6.1 The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS G6.2 The Licensee must take the following steps pursuant to G6.1: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence (b) regular review of whether those processes and systems have been implemented and of their effectiveness G6.3 Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHSE/I (by end May) a certificate to the effect that, following a review for the purpose of G6.1.2(b) The Directors of the Licensee	Compliant	• Risk management of compliance failure through Board Assurance Framework, Corporate Risk Register, and review of action plans; and regular Board development sessions • Quarterly update and action plan scrutiny/overview reports to Finance and Performance Committee in respect of EPUT performance and quality • Annual review of compliance with the terms of the provider licence undertaken • Annual internal audit assessment of Risk Maturity (currently being undertaken as part of overall review of the Board Assurance Framework). • Internal audit programme • Clinical audit programme • QIA process • Systems of internal control • EPUT's constitution, policies and vision take account of the NHS Constitution • Compliance declarations made by the Board of Directors within required timeframe (note NHSE/I no longer require these to be submitted) • Annual self-certification information included in Board papers and published on EPUT's website

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition G6.4 The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHSE/I (by end June) in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it		
G7	**Registration with the Care Quality Commission** Obligation to be registered with the CQC and to notify NHSE/I if their registration is cancelled	The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.	Compliant	• EPUT services are registered with CQC without conditions as required and within required timescales; there are two conditions associated with two nursing homes (to have nursing home manager on each site and to limit maximum beds to 35 per unit) • Board received assurance of registration on EPUT's establishment • Processes in place to review and update registration of services as these change • Internal assurance process in place to minimise the risk of non-compliance with essential standards of quality and safety • Regular monitoring of compliance by Quality Committee, Executive Operational Sub Committee, and Board of Directors • CQC compliance checking programme and action plans developed including monitoring process (and lessons learnt) for areas requiring improvement • No requirement to notify NHSE/I of any cancellation • CQC 'good' rating maintained in with CQC inspections regime suspended during the Covid-19

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				pandemic.
G8	**Patient eligibility and selection criteria** Obligation to set transparent eligibility and selection criteria for patients and apply these in a transparent manner	The Licensee shall: (a) set transparent eligibility and selection criteria (b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee (c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them	Compliant	• Patients' eligibility criteria agreed with commissioners in line with relevant guidance and documented in commissioning contracts within individual service specifications: currently available on request • Commissioning contracts are subject to regular reviews and service specifications are generally reviewed annually • EPUT website includes its service provision by geography and service type, and contact details. There is limited eligibility criteria included
G9	**Application of Section 5 (Continuity of Services)** Sets out the conditions under which a service will be designated as a CRS (Commissioner Requested Service)	See section 5 below	N/A	• Covers all services which EPUT has contracted with a Commissioner to provide as a CRS (see CoS1 below) • See section 5 below
SECTION 2: PRICING				
P1	**Recording of Information** Obligation to record information and be transparent particularly about costs/pricing	If required in writing by NHSE/I, and only in relation to the period from the date of that requirement, the Licensee shall: (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information, as are	Compliant	• EPUT maintains a costing system that utilises information from the general ledger to calculate planned and fully absorbed costs of providing services. These costs are published on an annual basis • Information can be provided to NHSE/I as required

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		necessary to enable it to comply with this Condition.		
P2	**Provision of Information** Obligation to submit the above to NHSE/I	The Licensee shall furnish to NHSE/I such information and documents, and shall prepare or procure and furnish to NHSE/I such reports, as NHSE/I may require for the purpose of Chapter 4 in Part 3 of the Health and Social Care Act 2012 (Pricing)	Compliant	• EPUT submits to NHSE/I all documents, reports and declarations in accordance with all relevant statutory and regulatory requirements in force from time to time in respect of pricing • Information provided is approved through the relevant and appropriate authorisation processes • Copies of all documents are submitted to NHSE/I and retained by the Finance Directorate and/or Trust Secretary
P3	**Assurance report on submissions to NHSE/I** Obligation to submit an assurance report confirming that the information provided above is accurate	If required in writing by NHSE/I, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHSE/I an assurance report in relation to pricing/costing	Compliant	• Internal audit could review the costing and pricing processes within EPUT as part of the internal audit programme, and this assurance could be provided to NHSE/I as required
P4	**Compliance with the National Tariff** Obligation to charge for NHS health care services in line with national tariff	Except as approved in writing by NHSE/I, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by NHSE/I, in accordance with section 116 of the Health and Social Care Act 2012 and shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHSE/I in accordance with, section 116 of the Health and Social Care Act 2012, wherever applicable	Compliant	• All NHS Foundation Trusts continue to be paid on the basis of block contract payments 'on account' for 1st April 2021 to 30th September 2021. The usual national tariff payment architecture and associated administrative/transactional processes have been suspended since 1st April 2020.

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P5	**Constructive engagement concerning local tariff modifications**
	Obligation to engage constructively with Commissioners and to reach agreement locally before applying to NHSE/I for a modification
		The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the Health and Social Care Act 2012, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications	Compliant	• On 26 March 2020 revised arrangements for NHS contracting and payment during the Covid19 pandemic were issued by NHSE/I the principles of which
				  • Provide certainty for all organisations providing NHS funded services under the NHS standard contract that they will continue to be paid and
				  • Minimise the burden of formal contract documentation and contract management processes, so that staff can focus fully on the Covid19 response
				• NHSEI have confirmed that the above arrangement will continue for the first half of 2021/22

SECTION 3: CHOICE OF COMPETITION				
C1	**The right of patients to make choices** Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. Restricts providers on giving benefits in kind/pecuniary or other advantages as inducements to refer patients or commission services	Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found	Compliant	• EPUT has in place a service directory on the website setting out the services available • Commissioners monitor EPUT's compliance with the legal right of choice as part of contract Monitoring in line with NHS Standard Contract requirements • Risk Management Framework in place • Conflicts of Interest policy and procedure in place
C2	**Competition oversight** Prevents licensees from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of	The Licensee shall not: (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the	Compliant	• EPUT is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should the Board decide to consider any significant changes such as mergers or joint ventures or when entering into agreements • The Finance and Performance Committee terms of reference includes responsibility for ensuring adoption and best practice in terms of decision-making in line

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	health care users	NHS (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS to the extent that it is against the interests of people who use health care services.		with guidance issued by NHSE/I and CMA in relation to investments (including potential acquisitions and mergers) and the Health and Social Care Act 2012 in respect of mergers, acquisitions and significant transactions • There are no anti-competitive proceedings against EPUT • Current work on new models of care is a Commissioner initiative for collaborative procurement meaning suppliers including all public and private suppliers will be able to supply but with a changed commissioning route. It is in the interest of health care users and not restricting or distorting competition to the extent that it is against the interests of health care users.
INTEGRATED CARE				
IC1	**Provision of integrated care** Obligation to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services	The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS: • to be integrated with the provision of such services by others • to be integrated with the provision of health-related services or social care services by others • to co-operate with other providers of health care services	Compliant	• EPUT utilises integrated care models to provide a range of healthcare services. • EPUT actively works with its partners through both formal and informal mechanisms to foster and enable integrated care • Various collaboration agreements with commissioners and other providers, e.g. section 75 agreements, joint service provision agreements, etc. • EPUT worked through a stakeholder engagement plan for the development of its service transformation work (new models of working) • EPUT is actively involved in three STPs • Some services are provided through partnership working with other local stakeholders (e.g. Essex Learning Disabilities services, work with Samaritans, etc.) • EPUT has representation on local partnership boards feeding into system wide working and planning • Partnership working and mutual, particularly between

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				physical and mental health services has increased to exceptional levels in the C19 crisis • Transformation projects were moving forward in 2020/21 despite the Covid-19 pandemic. • Stakeholders are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership • System wide partnerships, working arrangements and mutual aid principles have proved invaluable during the C19 crisis • Board Seminar held with partner STPs to promote system working • EPUT actively working with other providers regarding new models of care (joint venture, joint collaborative etc.)
CONTINUITY OF SERVICES				
CoS1	**Continuing provision of Commissioner Requested Services (CRS)** Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners	The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with this Condition	Compliant	• All decisions around services are agreed with commissioners as part of the contract negotiations • All changes to services provided by EPUT implemented through the relevant Contract Variations agreed jointly with the commissioners in the standard format issued by NHS England • See P4 and P5 above
CoS2	**Restriction on the disposal of assets** Obligation to keep an up-to-date register of relevant assets used in CRS and to seek NHSE/I's consent before disposing of these assets if NHSE/I has	The Licensee shall establish, maintain and keep up to date, an asset register which complies with this Condition and guidance as may be issued from time to time by NHSE/I regarding: (a) the manner in which asset registers should be established, maintained and updated, and	Compliant	• The Finance Directorate maintain an asset register of all capitalised assets in line with accounting and NHSE/I guidance. This is subject to external audit on an annual basis and would include both relevant and non-relevant assets that are owned (or have had tenant improvements where leasehold) • EPUT is only required to seek NHSE/I's consent for disposal of assets if NHSE/I had a concern about its

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	concerns about the licensee continuing as a going concern	(b) property including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced. The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHSE/I, and in accordance with this Condition if NHSE/I has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern		ability to continue as a going concern (currently does not apply). EPUT has a procedure on asset disposals which includes NHSE/I's requirement for relevant and non-relevant assets • Estates retains an asset register for leasehold assets in line with the Asset Register and Disposal of Assets Guidance for Providers of Commissioner Requested Services guidance
CoS3	**Standards of corporate governance and financial management** Obligation to adopt and apply systems and standards of corporate governance and management that would be seen as appropriate for a provider of NHS services and enable EPUT to continue as a going concern	The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as: (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern	Compliant	• EPUT has robust and comprehensive corporate and financial governance arrangements, systems and processes in place; these are updated according to changes in guidance/requirements • Compliance with the *Code of Governance* reviewed annually • Annual review of EPUT's constitution, SFIs, SoRD and DSoD against regulation and NHSE/I guidance • Annual review of Board standing committees' terms of reference against regulation, NHSE/I guidance and good practice • Well led self-assessment carried out annually, although this has been delayed in 2020/21 due to the Covid-19 pandemic. • Annual committee effectiveness review completed as part of establishment of command structure during the Covid-19 pandemic. A more comprehensive review is underway to support the development of an accountability framework.

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				• Annual financial plan • Monthly monitoring of performance, quality and finance by Finance and Performance Committee with quarterly review of governance arrangements (Board Governance Framework) and considered at each Board meeting • Executive Operational Sub-Committee weekly meetings. New Executive Risk Management Group established. • Risk management programme in place monitored through Finance and Performance Committee and considered at each Board meeting • Independent Well led Review completed in 2019/20
CoS4	**Undertaking from the ultimate controller** Obligation to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause EPUT to breach its licensing conditions	The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHSE/I	N/A	• Not applicable
CoS5	**Risk pool levy** Obligation to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails)	The Licensee shall pay to NHSE/I any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the Health and Social Care Act 2012, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid	N/A	• No payment requests received from NHSE/I; any payment required would be made in accordance with licence conditions
CoS6	**Co-operation in the event of financial stress** Applies when a licensee fails a test of sound finances and	When NHSE/I has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall:	N/A	• EPUT would co-operate should the situation arise

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	obliges the licensee to cooperate with NHSE/I	(a) provide such information as NHSE/I may direct to Commissioners and to such other persons as NHSE/I may direct (b) allow such persons as NHSE/I may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them (c) co-operate with such persons as NHSE/I may appoint to assist in the management of the Licensee's affairs, business and property		
CoS7	**Availability of resources** Obligation to act in a way that secures or has access to the required resources to operate Commissioner Requested Services (CRS)	The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHSE/I a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate in the form set out in this Condition and a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.	Compliant	• EPUT submits certificates/statements as required by NHSE/I • Operational plan superseded by Covid-19 pandemic planning including resources provided. Operational Plan developed for 2021/22 currently being crystallised for presentation to NHSE/I • Annual financial plan sets out details of resource requirements and efficiencies • Board receives at least annually report on establishment requirements. • EPUT has robust processes and systems in place to ensure it has the resources necessary to deliver its services • Predicted segmentation rating of 2 at end of March 2021 • EPUT's reported financial performance was a £31k deficit as at end March 2021, with an adjusted financial performance of £1k deficit

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		This statement shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution. The Licensee shall publish each certificate in such a manner as will enable any person having an interest in it to have ready access to it		
NHS FOUNDATION TRUST CONDITIONS				
FT1	**Information to update the register of NHS FTs** Obligations to provide information to NHSE/I	The Licensee shall ensure that NHSE/I has available to it written and electronic copies of the following documents: (a) the current version of Licensee's constitution (b) the Licensee's most recently published annual accounts and any report of the auditor on them (c) the Licensee's most recently published annual report and for that purpose shall provide to NHSE/I written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted or being published. The Licensee shall comply with any direction issued by NHSE/I concerning the format in which electronic copies of documents are to be made available or provided	Compliant	• EPUT provides NHSE/I with all information it requires taking account of the requirements under this provision
FT2	**Payment to NHSE/I in respect of registration and related costs** Obligation to pay any fees	Whenever NHSE/I determines in accordance with section 50 of the NHS Act 2006 that the Licensee must pay to NHSE/I a fee in respect of NHSE/I's	Compliant	• NHSE/I has undertaken not to levy any registration fees on FTs without further consultation • All payments made are documented in the ledger with details of the date of invoice and date payment made.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
	set by NHSE/I/ NHSE/I	exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to NHSE/I within 28 days of the fee being notified to the Licensee by NHSE/I in writing		To date no payments in respect of licence fees have been requested
FT3	**Provision of information to advisory panel** Obligation to provide information requested by the advisory panel set up to consider questions brought by Governors	The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the NHS Act 2006	N/A	• NHSE/I disbanded the panel in 2016/17 • EPUT has not received any such requests in relation to questions being referred to the advisory panel
FT4	**NHS foundation trust governance arrangements** Provides NHSE/I continued oversight of FTs' governance. Obligation to ensure: • Effective Board and committee structures • Clear responsibilities for Board and committees • Clear reporting lines and accountabilities in EPUT • Establish and implement effective processes/systems	The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS in line with NHSE/I's guidance and this Condition	Compliant	• EPUT has sound corporate governance systems and processes in place • Deloitte carried out an independent well-led assessment in March 2019 • CQC carried out a well-led assessment in July/August 2019 and an overall 'Good' rating was achieved with 'Good' for the well-led domain • The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of EPUT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically • EPUT has carried out a comprehensive self-assessment against Corporate Governance related to this licence condition
		FT4.4 The Licensee shall establish and implement: (a) effective board and committee structures (b) clear responsibilities for its Board, for committees reporting to the Board	Compliant	• Established an effective Board and committee structure with appropriate terms of reference • Annual effectiveness reviews of Board and its committees with recommendations implemented. This was completed in 2020/21 as a result of the Covid-19 pandemic in relation to establishing a command

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		and for staff reporting to the Board and those committees (c) clear reporting lines and accountabilities throughout its organisation		structure. A full review is now underway. • Board committee governance structure chart maintained by Trust Secretary • Scheme of Reservation and Delegation sets out the powers reserved to the Board and those that the Board has delegated, i.e. the schedule of matters reserved to the Board. This is reviewed annually and reflects delegation derived from the constitution, accounting officer memorandum, standing orders, SFIs, NHSE/I *Code of Governance* and Board *Code of Conduct* • Reviews of the corporate governance systems included in internal audit annual work programme • Review of Tier 2 Standing Committees took place in 2018. This is now being undertaken for 2021/22
		FT4.5 The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions (d) for effective financial decision-making, management and control (including but not restricted to	Compliant	• Minutes of Board meetings • Minutes of standing committees, sub-committees and sub-groups • Board assurance reports covering quality, performance, finance, corporate governance, clinical governance, information governance and compliance (see also CoS3 above) • Board Assurance Framework • Corporate Risk Register • Compliance with *Code of Governance* annual review • Annual review of compliance with provider licence • Annual Governance Statement • Annual / operational plan developed each year in line with NHSE/I requirements (see note above relating to Covid-19) • Regular monitoring of progress with objectives set out in the operational plan. Objectives have been reviewed and carried forward to reflect the situation with the Covid-19 pandemic, with a view these will be refreshed for 2020/21.

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) to generate and NHSE/I delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery (h) to ensure compliance with all applicable legal requirements		• Resources allocated to provision of internal legal services team and to secure appropriate legal advice when necessary
		FT4.6 The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations (c) the collection of accurate, comprehensive, timely and up to date information on quality of care	Compliant	• Board's annual internal self-assessment • Board's external well-led assessment by Deloitte • Board and Council Nominations Committees' minutes • Board and Council Remuneration Committees' minutes • Annual performance/appraisals for Executive and Non-Executive Directors including the CEO and Chair • Quality Committee's terms of reference • Minutes of Quality Committee • Quality assurance reports to Board • Quality Strategy and underpinning frameworks • Quality Academy • Patient Safety Strategy developed establishment the Board's focus on safety. • Engagement Strategy and underpinning frameworks

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care (e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources (f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate		including Carers, Membership, etc.
		FT4.7 The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence	Compliant	• Safe staffing reports to Finance and Performance Committee, Quality Committee and Board included in performance, quality and finance reports • Robust HR recruitment processes and selection criteria • Fit and Proper Persons Requirements incorporated in employment contracts, contracts and appointing letters • Fit and Proper Persons policy and procedure • Regular appraisals • Training and development initiatives (EPUT-wide)
		FT4.8 The Licensee shall submit to NHSE/I within three months of the end of each financial year: (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at	Compliant	• All certification requirements signed on behalf of the Board by the Chair and CEO were met (note that NHSE/I no longer require submission of the self-certification) • Submissions reviewed by EOSC and Finance and Performance Committee before final approval by

Ref	Sections/ Condition Summary	Condition on EPUT	EPUT Position	Evidence/Assurance
		the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks (b) if required in writing by NHSE/I, a statement from its auditors either: (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year		Board • NHSE/I have not required such statements

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Freedom to speak up Report 2021**					
Executive/Non-Executive Lead:	Sean Leahy and Alison Rose-Quirie					
Report Author(s):	Yogeeta Mohur EPUT principal Guardian for Freedom to Speak up.					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	**X**	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	
State which BAF risk(s) this report relates to	
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
This report provides the Board of Directors/ Council of Governors: An overview of Freedom to Speak up Guardian Service in EPUT.	**Approval**	
	Discussion	x
	Information	x

Recommendations/Action Required

The Board of Directors/council of Governors is asked to:

1 Note the contents of the report

2 Request any further information or action.

Summary of Key Issues

EPUT's Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust's Raising Concerns (Whistleblowing) Policy and Procedure.

It is said that the Principal Freedom to Speak Up Guardian is a trusted pillar of support for NHS workers. They provide a route through which they speak up about any matter that could get in the way of delivering high-quality patient care, or that presents the workplace being the supportive caring environment that hard-working and caring staff should expect.

The guardian role is not an easy role but a rewarding one. The expectation of the National Guardian Office (NGO) is high and broad, as patient safety and staff well-being is at its heart.

The overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety and anything that gets in the way of

delivering care as part of everyday practice.

- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise the patient safety concern themselves.
- Escalate raised concerns that are not acted upon by managers with the Chief Executive.
- Where concerns about patient safety raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.
- Activity and progress.
- Concerns raised and themes noted.
- Challenges.
- Successes.
- Activities planned in 2021

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	x
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	x
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	x
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	x
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	x
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	x

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

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

Acronyms/Terms Used in the Report			
MDP	Management and Development Programme.	TASI	Therapeutic and safe intervention.
MST	Microsoft Teams	LD	Leadership Development
OLM	Online Learning Mandatory	ARU	Anglia Ruskin University
UOE	University of Essex	UOS	University of Suffolk
HR	Human Resources		

Supporting Documents and/or Further Reading

Lead

Sean Leahy
Executive Director for People and Culture

Meeting cover front sheet May 2021

Agenda Item 7c
Board of Directors
26 May 2021

EPUT

FREEDOM TO SPEAK UP GUARDIAN SERVICE

1.0 PURPOSE OF REPORT

This paper outlines the activity from the Freedom to Speak Up Guardian service in 2021.

2.0 EXECUTIVE SUMMARY

2.1 EPUT's Freedom to Speak Up Guardian Service

The Trust Board of Directors will recall I was elected and commenced in the role of EPUT's Principal Guardian in November 2019, dedicating 2 days per week to role while my substantive role of community psychiatric nurse working for the Trust's Access and Assessment Team is backfilled. Since the pandemic and with the increased amount of activities and concerns raised, the role is now a full time role.

Since becoming the Trust's Principal Freedom to Speak Up Guardian, the role has become more relevant for staff who through fear for their health and safety approached the platform. As reported in November 2020's report initially during the pandemic, staff were approaching regarding concerns for shielding, as they felt they were not being allowed to do so, and also regarding redeployment issues, as well as not having enough personal protective equipment (PPE). As the pandemic took a sharp rise, the issues re PPE and social distancing continued to be reported to Freedom to Speak Up. It soon became apparent that there were a number of concerns regarding bullying and harassment.

EPUT's vision for Freedom to Speak Up is 'Supporting compassion, openness and empowerment'. We aim to continue to grow the number of Local Guardians in the Trust. Due to the pandemic it has been difficult to do so however this remains firmly on the agenda. Unfortunately due to staff turnover as well as job changes and staff not feeling able to continue to commit to be a Local Guardian we have had staff who are no longer able to be a guardian. At the time of writing this report the total number of Local Guardians is 12. We continue to promote the agenda and in doing so we encourage people to consider becoming a Local Guardian.

The Freedom to Speak Up Principal and Local Guardians complement other arrangements already in place in the Trust for staff to raise concerns such as the Trust Raising Concerns (Whistleblowing) Policy and Procedure. As previously noted the 'I'm Worried About' process changed in August 2019 and consequently concerns have been received by the Guardian Service which may be better addressed elsewhere. This remains the case and the Guardian Service are continuing to support, reassure and signpost to other departments as required.

Through other training programmes in the Trust, for example TASI/ personal safety, Clinical Risk and the Management Development Programme, we continue to raise awareness of Freedom to Speak up.

As the Board is aware the overall purpose of the Guardian Service is to:

- Support the organisation in further developing a culture of openness and freedom for staff to raise concerns about patient safety as part of everyday practice.
- Support staff to raise concerns about patient safety directly with their line manager/supervisor.
- Work in partnership with managers where staff are unable to raise concerns themselves.
- Escalate raised patient safety concerns that are not acted upon by managers with the Chief Executive.
- Where concerns raised by staff are not acted upon internally, the Principal Guardian is expected to take the matter externally to the National Guardian for investigation.
- Provide training across the organisation on the raising concerns agenda.

2.2 Overview of activity/progress in 2021 continuing from last year.

- Training of new Local Guardians has continued.
- Continuation of meetings with Board representatives including the Non-Executive Director and Executive Director for the Freedom to Speak Up agenda, the Chief Executive.
- Continuation of the Communications strategy to raise awareness of the agenda in 2021 and beyond.
- Continuation of visits to services and teams in the Trust to develop/increase awareness of the Freedom to Speak up process and Guardian service, particularly those highlighted as 'hotspot' areas. In the recent times these meetings have been done remotely however we are looking to have that physical visibility soon as the rules of the lockdown eases.
- Working closely with Organisational Development (OD) and Staff Engagement Teams.
- Leadership engagement representation.
- Working closely with education and training to identify gaps → closer engagement with TASI training. Due to the pandemic and with social distancing in place, it has not been possible to attend but this remains on the agenda.
- Principal Guardian attending EPUT's Learning oversight Sub Committee.
- Working with Estates and Facilities to ensure colleagues working in this area of the Trust are aware of the agenda.
- As part of Covid-19 attending silver command to discuss with senior leaders how the Guardians can support colleagues to continue to work and improve services and work experience for staff.
- Supporting the anti-bullying ambassadors in creating a better working experience for our workers.
- We continue to reflect with colleagues from learning from serious incidents meeting.

2.3 Concerns Raised

From April 2020 until end of March 2021, 235 concerns were raised with the Guardian Service (this does not include details of concerns raised through the Trust Whistleblowing process, but does include all concerns diverted from the previous 'I'm Worried About' system).

2.4 Number of staff who have received training is below:

The following table details training activities that have taken place in respect of the agenda from April 2020 until October this year:

Training Type	Approximate Number of attendees
MDP Raising Concerns Training for Managers	36
Leadership Training	61
Cohort ARU September 20, delivered 8.1.2021 Cohort ARU January 21, delivered 30.4.2021 Cohort UOE October 2020, delivered 1.2.2021 Cohort UOS September 20, delivered 25.2.2021 Cohort London South Bank September 20, delivered 9.4.2021	94 28 98 5 5
Junior Doctors	47
Staff Induction (From 15/7/20 till 31st of March 21)	523

2.5 Emerging Themes

The following themes have been noted from the concerns raised from 1 April 2019 to 31 March 2021. Please note that individuals may have raised more than one issue as part of their 'raised concern':

Concern Theme	No of concerns since April/May/June 2020
Patient Safety/Quality	1
Staff Safety	9
Bullying/Harassment/Discrimination	15
Infrastructure/Environmental	3
Other	2
Total	**30**
	No of concerns July/Aug/Sept 2020
Patient safety	4
Staff safety	8
Bullying and harassment	24
Infrastructure/Environmental	4
other	10
Total	**50**
	No of concerns Oct/Nov/Dec 20
Patient Safety	5
Staff Safety	14
Bullying and Harassment	26
Infrastructure/Environmental	14
Other	15
Total	**74**

	Jan/Feb/March 21
Patient safety	8
Staff safety	12
Bullying and Harassment	43
Infrastructure/Environmental	6
Other	12
Total	**81**

Bullying and harassment remains the top theme reported since the last report presented to the Board. The law makes clear that all employees have the right to work in a safe environment. In conjunction with Human Resources, the Guardian Service supports staff members who feel they are being bullied and harassed. Sometimes people who use the Guardian Service do not wish to take things further; however the service has provided a platform where they feel they are being listened to. I will continue to encourage people to come forward to hear their stories so that issues get addressed and we can support each other in creating and maintaining a safe workplace, free from bullying, intimidation and harassment.

The main professional background where concerns are raised from are nurses and support workers, followed by administration staff colleagues.

Freedom to speak up training has also been delivered to our doctor colleagues. As yet no concerns have been raised from Doctors. We continue to work with the training department to promote the Freedom to speak up agenda and encourage staff from different backgrounds/professions to join us and promote this agenda further. On our intranet page staff can see at a glance the list of local guardians and their professional background as well as geographical base therefore giving staff the choice of which local guardian to approach.

With regards to the recording of those raising concerns who have protected characteristics, currently the only data collected is in respect of race and it is optional for people to do so or not. Again this is not an area showing any trends to report. Concerns reported by staff from a white background are fairly equal to that reported by the BAME staff members and we have been working with our colleagues from HR as well as the BAME network to support individuals.

We have 4 concerns which are connected to cases of capabilities open with HR, 15 Grievances of which 5 is in regards to bullying and harassment.

2.6 Challenges

As previously reported some of the challenges that exist in the Trust will not change, like the physical size of it and the task of getting around the Trust to continually increase visibility and awareness is ongoing. The pandemic certainly made face to face visibility difficult however I must state that using other means of delivering meetings (MST) actually helps by captivating a bigger audience.

A continuing challenge in the process of raising concerns has been related to timings. Some managers/leaders remain very quick in responding and taking action when a concern has been raised, whilst for others it can be weeks or months before a response is received which can extend the process. As previously noted this was highlighted at a leadership event in October 2019, and is a discussion point during the MDP sessions. It is an area which will continue to be monitored. If progress is slow the sense for staff raising concerns is that nothing has or will happen, and is a major deterrent for others to speak up. The expected timeframes for managers to respond by have been added to the Raising Concerns policy and procedure. As Guardians, we are working closely with the area directors and Associate Directors in continuing to monitor matters and address them especially in the hotspot areas

for example Basildon and Colchester. We meet on a monthly basis to look at these challenges.

Culture change remains the biggest task which will be ongoing. It is noted that the majority of the concerns raised are done so anonymously which is an indication of how safe the staff feel in raising concerns. As noted reducing the time to respond to concerns will be an important aspect of tackling this. Where feedback is not being received in a timely manner, all efforts continue to be invested in following this up and escalating matters as required. The Executive Director for People and Culture is really passionate about our people listening to their stories and making changes to our culture such whereby speaking up becomes more and more business as usual.

The Freedom to Speak up Guardian's access to both the Executive Teams as well as the CEO gives colleagues faith that matters will continue to be raised if not acknowledged and not resolved around the normal route. Furthermore, having access to our Non- Executive Directors also supports the openness and fairness.

This evidences that we have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.

Staff have had the opportunity to use the open door policy and access the Executive Director for People and Culture as well as our CEO and spoke directly about their work experience in EPUT. Having access to our senior leaders really gives staff that feeling of worth and being valued. This also upholds our values of being open, compassionate and empowers colleagues. We also have live sessions open where staff can attend and ask the Executive Team questions directly. I have had a lot of colleagues who have praised this platform as this shows our senior leaders robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.

In my regular meetings with the Executive Director for People and Culture and our CEO, we discuss a lot about the staff who raise concerns and how we can continue to build support around them after speaking up but also how we can continue to look for staff who feel unable to speak up and how to empower this group of individual.

Inductions for student nurses remains firmly on our agenda as they are our future workforce. As guardians, we work with the Practice assessors and placement areas to promote this agenda from the very first port of entry.

As noted in the previous report presented to Trust Board, patient safety concerns are raised regularly during training sessions. As part of my clinical work, I have attended TASI training previously and also attended personal safety training. This is a great opportunity to meet people from different areas and have discussions around patients' safety. The aim is to continue to work with colleagues from other departments to ensure that we have this valuable opportunity to reflect on practice and learn from other people's experiences and continue to improve on the quality of service we deliver and allow our staff to express themselves and continue to promote the speaking up culture. The current pandemic does mean that we now deliver most sessions via MST and in some ways it has actually made these easier for people to attend and have a larger number of people at a time.

2.7 Successes

As noted in the report presented in November last year, the profile of the Freedom to Speak Up service has been raised significantly through the support of the Communications Team and the concerted effort during the National Speak up month in October 2020.

We will continue to publish 'you said we did' for concerns raised. These provide high level information on concerns raised and the action taken by the Trust to resolve them and detail

the improvements put in place as a result. They can be located on the Freedom to Speak Up intranet page.

I continue to have strong links with the Human Resources Team, subsequently if required I am able to signpost to further support systems in the Trust, these included the relevant HR process such the Grievance and Bullying and Harassment procedures.

We have plans to further develop awareness of freedom to speak up and developing OLM training for staff as well as making a more in depth induction on Freedom to speak up for our new starters including temporary workers. I believe that by taking part in staff group supervision, it gives great opportunity to hear about staff's experience as well as any potential challenges that they face and how we can address those.

2.8 Feedback

Feedback from people who have used the Guardian Service is critical to the Freedom to Speak Up agenda and we will have to continue to create this culture of openness. Feedback is requested at the end of each quarter from people who have raised a concern. A survey link is sent asking the individual to answer two questions; 'Given your experience, would you speak up again?' and 'Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?' Out of 55 individuals, we have had 30 responses back giving us 56.6% response. Please also note that some concerns raised are anonymously raised and therefore we cannot send the person the survey to complete.

	Given your experience, would you speak up again?	**Would you recommend to someone else to use the Freedom to Speak Up Guardian Service?**
Period Oct/Nov/Dec 20-Jan/Feb/March 21	Yes – 25 Maybe – 3 Don't' know – 2 No – None	Yes – 30 Maybe – None Don't' know – None No – None

The majority of comments reflected a positive experience of the service, however there were some responses from people who felt that nothing had changed for them. As noted in section 2.6 timeliness of response continues to play a huge part in staff feeling that something has changed for them as well as detailed responses from managers on how they looked into the matter and any actions taken. We will continue to survey people to continue to use feedback as a reflection and how to continuously make improvements to our services.

I have had a lot of people who said that they would be happy to share their story of raising concerns and will welcome the colleagues to share their experience at the board meeting to hear directly from them their experience of using the Freedom to speak up platform and what would they like to see differently and what can we learn from their experience and improve.

2.9 Conclusion

As previously noted EPUT has good processes in place to manage concerns raised by staff and this service is an addition to the Raising Concerns (Whistleblowing) Policy and Procedure. The challenge is to continue to raise awareness and understanding of the Freedom to Speak Up process and to help staff overcome barriers to speaking up. As noted previously the key issue is culture, both of people feeling able to raise concerns and then managers to act on them in a timely manner. The crucial part is to thank the person for raising issues as unless we know of concerns, one cannot address them and have lessons learnt as a result.

The Trust continues to see areas of good practice with staff coming forward to raise issues and managers are listening and responding swiftly. We want to take the opportunity to share good practice and this learning across the organisation.

As noted the pandemic has unfortunately slowed some of our promotional work down, however as noted we continue to provide support to staff during this time.

2.10 Actions planned 2021 and beyond:

In 2020/21 the following have been identified as key items to be taken forward as part of the work plan:

1. Continue to take forward the Communications Plan to ensure awareness of the agenda at all levels with all staff Groups including greater use of social media.
2. Consider how specific training packages for all staff and managers can be rolled out.
3. Share learning from high functioning team cultures where raising a concern is everyday business.
4. Analyse the impact on patient safety by looking at other data, including employee relations.
5. Continue to learn from the F2SU Guardian network, and therefore improve and learn from best practice and case reviews.
6. Continue to work with other departments such as Training and Development, Staff Engagement and OD to increase messaging regarding the agenda.
7. Continue to build a virtual network for the Local Guardians to allow idea generation and sharing, learning, support and celebrating successes.
8. Continue to work with Teams, mainly leaders to encourage them to allow staff to thrive and continue to work not solely for their teams but for the wider organisation. This includes allowing staff to attend non mandatory training where it is identified that in doing so the staff member will benefit from this and improve quality of service we deliver.
9. Continue to work with managers to also recognise the wider organisation and the need to release staff for their involvement in networks to promote equality and fairness.
10. Continue to identify any hot spots areas so we are more aware of those and invest more time in supporting the staff from those areas.
11. Develop stronger links and relationships with the managers to promote the agenda of fairness and speaking up, encouraging a speaking up culture to be part of everyday practice.
12. Continue to be part of the exit interview process, not only to learn from constructive feedback but also positive experiences that staff have had and learn how we can continue to improve on those and reflect on areas we have not done so well and build action plans.

3.0 ACTION REQUIRED:

The Board of Directors is asked to:

1. Note the content of the report and consider recommendations for future actions.

Report prepared by:

Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian

On behalf of:
Sean Leahy, Executive Director of People and Culture

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Complaints Annual Report 2020/21**					
Executive/Non-Executive Lead:	Sean Leahy, Executive Director of People and Culture					
Report Author(s):	Claire Lawrence, Head of Complaints					
Report discussed previously at:	Quality Committee					
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	BAF 50 (Skills, resource and capacity)
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report

This report provides the Board of Directors with a review of the performance of Complaints handling in EPUT for 2020-21, as follows:

- Number of complaints received during the year across the Trust.
- Number of complaints closed during the year, and the outcomes.
- Timescales to Respond.
- Number of complaints referred to the Ombudsman.
- Complaint themes.
- Re-opened complaints.
- PALS enquiries
- Local Resolutions
- Compliments

Approval	√
Discussion	√
Information	√

Recommendations/Action Required

The Board of Directors is asked to:

1 Note and discuss the contents of the report.
2 Approve the Annual Complaints Report for EPUT for 2020-21..

Summary of Key Issues

Total of 275 complaints received this year.
Total of 265 complaints closed this year.
59 complaints remain active at year end.
92.5% complaints answered within agreed timescales
9 complaints were referred to the Ombudsman.
35 complaints were re-opened.

29 independent reviews of complaints handling were undertaken by Non-Executive Directors.
2820 PALS Enquiries received (including 613 relating to Covid Vaccinations)
1,000 compliments received.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	√
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	√
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	√

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	√
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			√
Data quality issues			
Involvement of Service Users/Healthwatch			√
Communication and consultation with stakeholders required			√
Service impact/health improvement gains			√
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			√
Impact on patient safety/quality			√
Impact on equality and diversity			0
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PHSO	Parliamentary and Health Service Ombudsman		
PALS	Patient Advice and Liaison Service		

Supporting Documents and/or Further Reading

Lead

Sean Leahy
Executive Director of People and Culture

Meeting cover front sheet Feb 2021

Essex Partnership University
NHS Foundation Trust

Complaints Annual Report

2020-2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST'S (EPUT) COMPLAINTS ANNUAL REPORT 2018/2019

1.0 INTRODUCTION

EPUT provides community health, mental health and learning disability services for a population of approximately 1.3 million people throughout Bedfordshire, Essex, Suffolk and Luton. We employ over 5,000 members of staff across 200 sites.

The complaints function is overseen and monitored by the People and Culture Directorate; however, complaints and their prompt and effective management are everyone's responsibility. All final response letters are subject to a rigorous approval process and are seen and signed by the Chief Executive or, in his absence, a designated signatory.

We endeavour to always reflect the Trust values of 'Open, Empowering and Compassionate' in our response letters to complainants. This year we have focussed in particular on improving how we detail any lessons learned and actions taken within our response letter, to provide assurance to the complainant that we have listened to and acted on their concerns.

The year has seen unprecedented challenges to the health service due to the Covid-19 pandemic. In EPUT we have worked under extreme pressure, prioritising the need to keep our patients and staff safe whilst continuing to deliver essential services within our community and inpatient settings.

We had to adapt our complaints process, balancing the need to reduce the pressure on our clinical teams with continuing to provide a process to address and respond to concerns raised by our service users. During quarter 1, at the beginning of the first National lockdown, we introduced a temporary pause in the formal investigation process and resolved complaints informally wherever possible.

We were able to resume formal investigations by the beginning of quarter 2, but we have retained the focus of locally resolving complaints where we feel this would provide a more efficient resolution for the complainant.

As in previous years, the number of compliments the Trust received far outweighed the number of complaints about the service. Overall the number of compliments received was lower than previous years due to the pause of the Friends & Family Test feedback, because of Covid-19. But despite this we still received almost 4 times more compliments than complaints.

The Trust achieved 92.5% for complaints closed within agreed timescales with the complainant. This is below the Trust's target figure of 95%, and we have plans underway to improve our response times for this year.

If a complainant is dissatisfied with our response to their complaint, they have the right to refer to the Parliamentary and Health Service Ombudsman (PHSO) as the second and final stage of the complaints process. This year, the Trust had 9 complaints referred to the PHSO, which is 3.3% of the total number of complaints received (275).

It should be noted that the figures stated in this report from point 3, (and those reported in the Trust's Quality Account) 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 this same period.

2.0 NUMBER OF FORMAL COMPLAINTS RECEIVED

A total of 275 formal complaints were received by the Trust during 2019/2020. The total figure represents 18 fewer complaints than the previous year (293). A total of 6 complaints were subsequently withdrawn, 1 complaint was not investigated as consent was withheld, and another was not investigated as it related to a Patient Safety Incident (PSI), for which the PSI Team investigated and provided a full report addressing the concerns raised.

In quarter 1 (Apr-Jun 2020), as a result of the Covid-19 pandemic and the pressures that were facing our service, the Trust introduced a temporary complaints process. Where appropriate, concerns raised during this time were dealt with by PALS or responded to directly by the service, rather than being formally investigated. There were 39 complaints dealt with under this process, and these were logged as "not investigated".

At the end of the financial year, 59 complaints remained under investigation and were carried forward to 2021/22.

Table1: Total Number of Complaints Received and Closed

Total Complaints carried forward from 2019/20	Total Complaints Received 2020/21	Total Complaints Closed 2020/21	Total Complaints carried forward to 2021/22
49	275	265	59

The table below shows the distribution of the 275 complaints received by Trust Area:

Table 2: Number of Complaints Received by Trust area

Area	Formal Complaints Received
Mid and South Essex STP	116
North East Essex STP	42
West Essex STP	22
Medical – Trust-wide	50
Specialist – Trust-wide	20
Total Mental Health	**250**
Community - South East Essex	16
Community - West Essex	9
Total Community	**25**
Grand Total	**275**

The number of Mental Health Services complaints has decreased by 11 (- 4%) from last year's total of 261 complaints.

The number of Community Health Services complaints has decreased, by 7 (- 22%) from last year's total of 32 complaints.

The following charts illustrate the number of complaints received by Area during 2020/21.

Figure 1: Numbers of Complaints received by Area

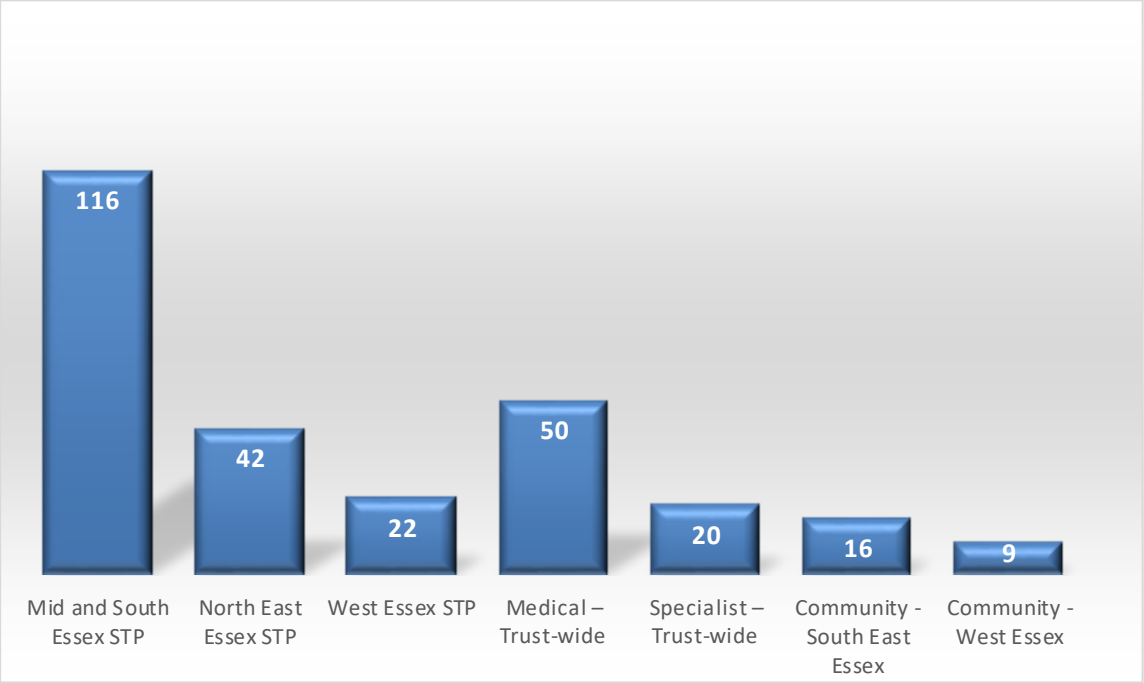
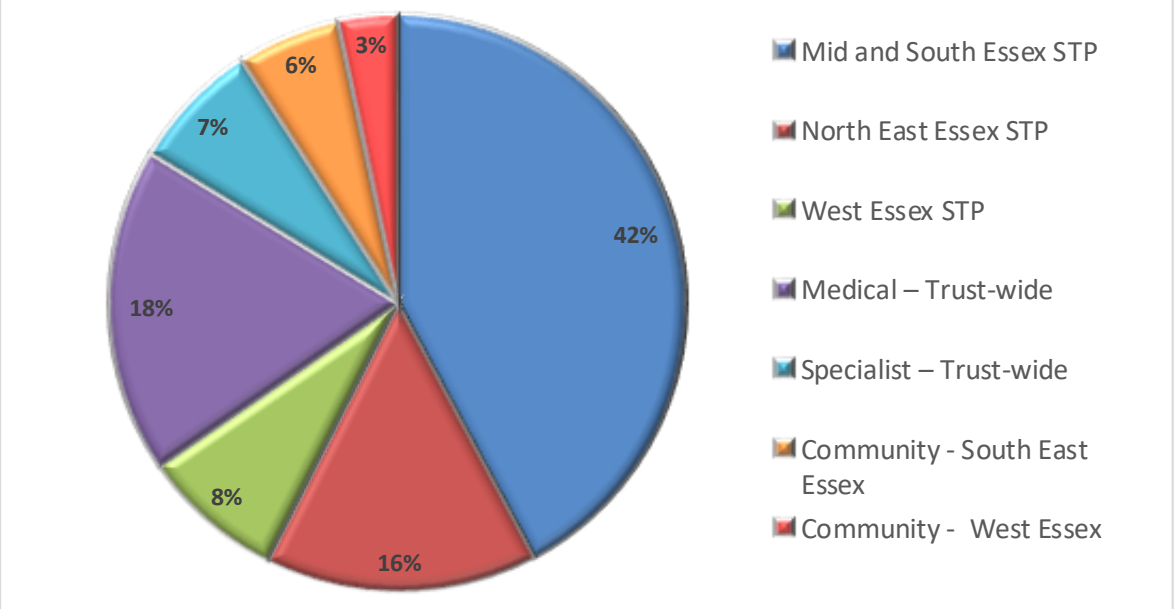


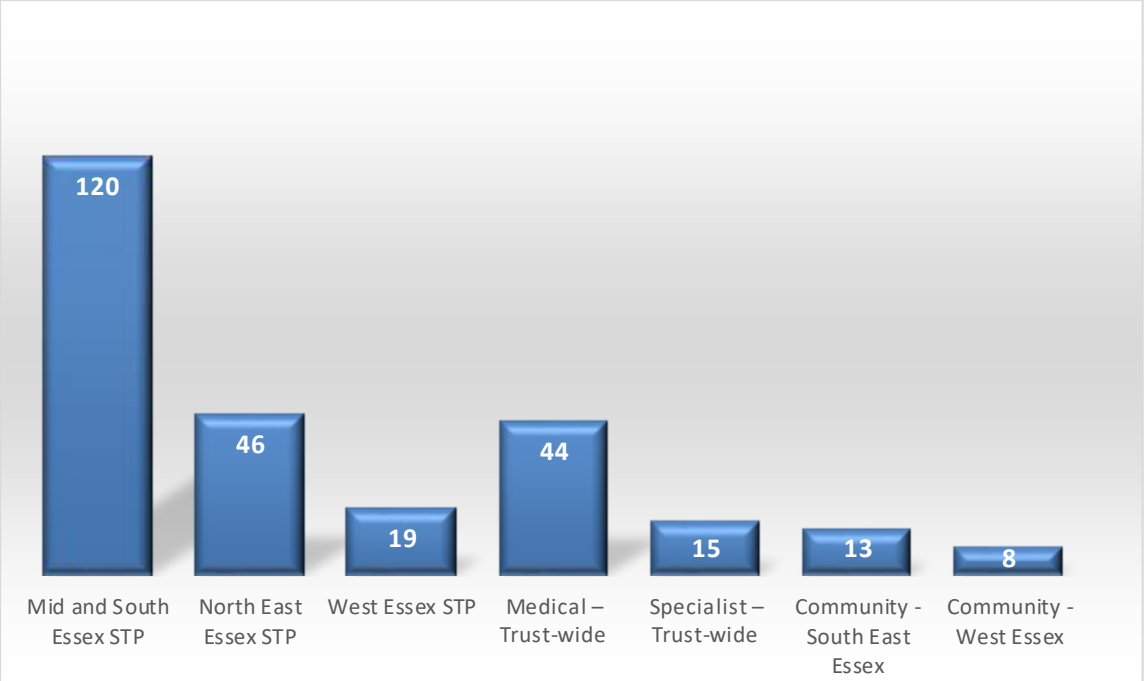
Figure 2: Percentage of Complaints received by Area



3.0 NUMBER OF COMPLAINTS CLOSED AND OUTCOMES

A total of 265 complaints were closed during the year.

Figure 3: Numbers of Complaints closed by Area



Complaints Outcomes

Each separate complaint point is recorded by the Investigator as either 'upheld' or 'not upheld'. Where there are a combination of upheld and not upheld points within the same complaint investigation, the overall outcome of the complaint is recorded as 'partially upheld'.

Table 3: Complaints Outcome by Area

Area	Upheld	Partially Upheld	Not Upheld	Not Investigated	Withdrawn	Total
Mid and South Essex STP	12	66	21	19	2	**120**
North East Essex STP	2	26	7	8	3	**46**
West Essex STP	1	14	1	2	1	**19**
Medical – Trust-wide	3	17	19	5		**44**
Specialist – Trust-wide		10	3	2		**15**
Community - South East Essex	2	6	1	4		**13**
Community - West Essex	1	6		1		**8**
Total	**21**	**145**	**52**	**41**	**6**	**265**
% of Total	**8%**	**55%**	**20%**	**15%**	**2%**	**100%**

4.0 COMPAINTS RESOLVED WITHIN AGREED TIMESCALE

The Trust responded to 92.5% of complaints within agreed timescales with the complainant. The average time taken to respond to complaints was 42.4 working days for Mental Health Services and 26.1 working days for Community Health Services.

5.0 COMPLAINTS REFERRED TO THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN (PHSO)

If the complainant is dissatisfied with the response they receive and feels that all avenues to resolve it with the Trust have been exhausted, they can ask the Ombudsman to conduct an independent review of their complaint.

It should be noted that the PHSO paused work on NHS complaints on 26 March 2020 to help the NHS focus on tackling the Covid-19 pandemic, and restarted accepting new NHS complaints and progressing existing ones on 1 July.

During 2020/21 a total of 9 complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO) which is a decrease of 10 from the number received in the previous year (19). Of these 9 referrals:

- 1 case the PHSO decided not to investigate
- 1 case the PHSO have confirmed they are investigating (still under investigation)
- 7 cases are still awaiting assessment

The table below illustrates the areas of the Trust from which the 9 complaints were referred to the PHSO this financial year, and their current status.

Table 4: Complaints referred to the Ombudsman – by Area

Area	Number of Complaints Referred	Status
Mental Health Mid and South Essex	7	1 assessed and now under investigation 1 closed - not investigated 5 awaiting assessment
Mental Health North East Essex	1	1 awaiting assessment
Community Health West Essex	1	1 awaiting assessment

PHSO Complaints Closed

A total of 2 PHSO investigations were closed during 2020/21, and both were partially upheld by the PHSO. A brief summary of these is provided in the table below.

Table 5: PHSO final reports and findings

Area	Date of PHSO Final Report	Findings and Recommendations
Mental Health Mid and South Essex	01/07/2020	**Partially Upheld** This was a joint case with Essex County Council relating to a delay in carrying out a Care Act assessment. The Trust had a significant role in these events, however the Council retained statutory responsibility, and were instructed to pay the financial redress (£750)
Mental Health North East Essex	15/10/2020	**Partially Upheld** The Trust was required to pay £500 in recognition of failings in care: including not completing a care plan on the patient's departure from the ward.

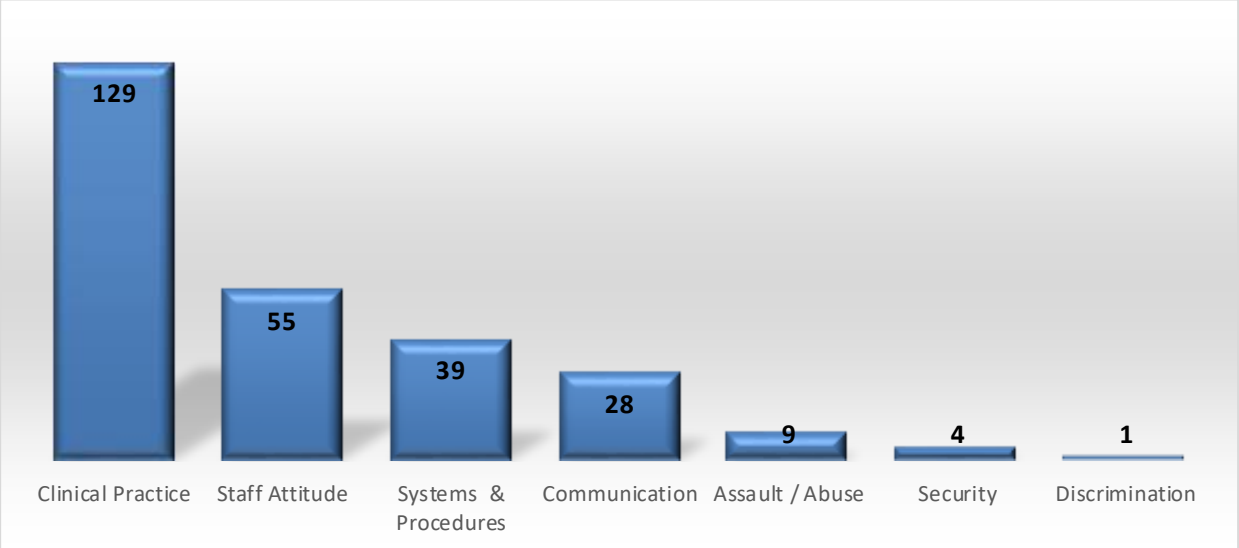
As at year-end 2020-21, there are 12 active cases with the PHSO: 4 cases being investigated by the PHSO, and 8 still awaiting assessment. This figure includes 4 cases that were carried forward from the previous year.

6.0 COMPLAINTS THEMES

Nature of complaints:

The top three complaint categories for complaints closed in 2020/2021 were Clinical Practice, Staff Attitude, and Systems and Procedures.

Figure 4: Complaints Closed by Category



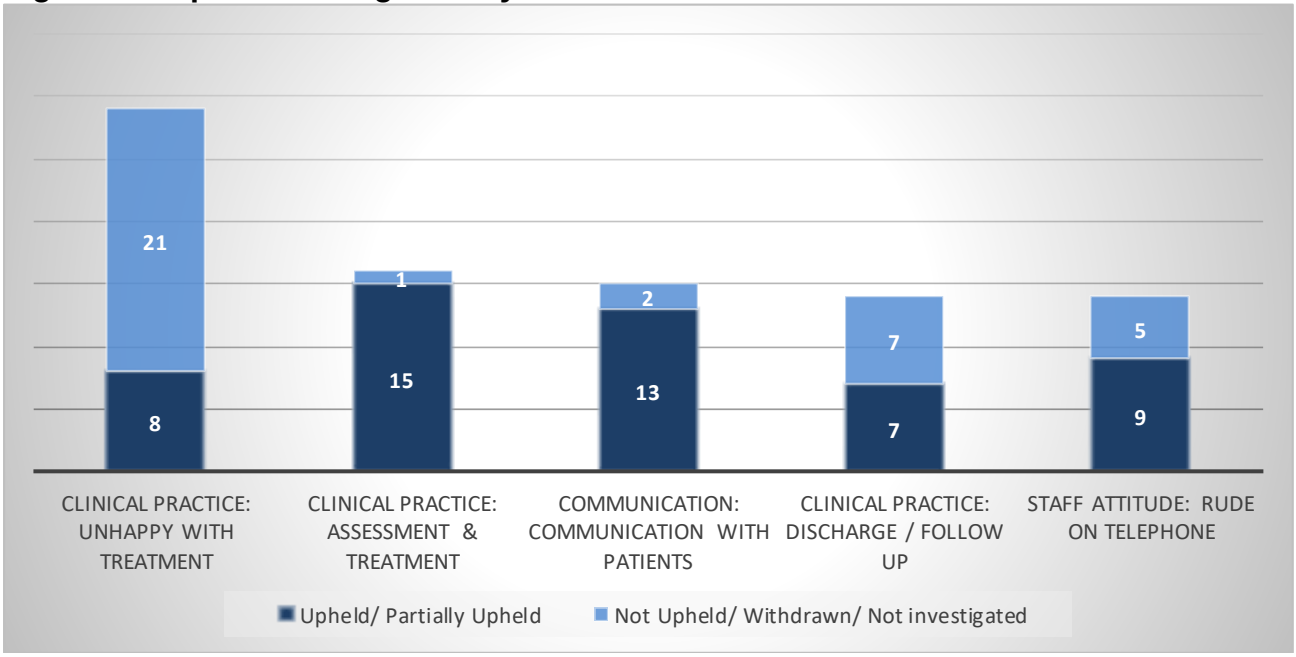
Under each main complaint category, there are a number of "sub-categories". The top five sub-categories made up a third of the total closed complaints in 2020-21 (265), and were as follows:

Table 6: Top 5 Sub-Categories

Complaint Sub-Category	Number of Complaints	% of Total Closed Complaints
Clinical Practice: Unhappy with Treatment	29	11%
Clinical Practice: Assessment & Treatment	16	6%
Communication: Communication with Patients	15	6%
Clinical Practice: Discharge / Follow Up	14	5%
Staff Attitude: Rude on telephone	14	5%
TOTAL	**88**	**33%**

The number of the top 5 sub-category complaints that were upheld or partially upheld is shown on the chart below.

Figure 5: Top 5 sub-categories by outcome

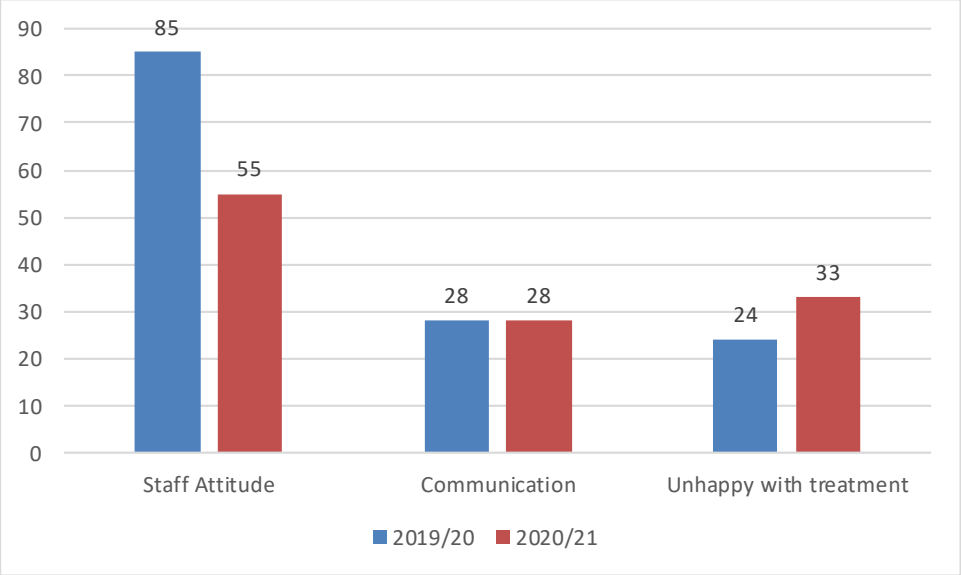


Nationally, the three main complaint themes for health services are:

- Dissatisfaction with treatment
- Communication
- Staff Attitude

These themes are reflected in our top 5 sub-categories. Compared to the previous year, complaints about Staff Attitude have decreased by 35%, whereas the number of complaints raising dissatisfaction with treatment increased by 37%. Complaints about Communication stayed the same, at 28 for both years.

Figure 6: Three main complaint topics



The Trust's complaints data is analysed to identify emerging complaint trends or themes, and areas of concern are highlighted to the Executive Team as well as the Compliance, Serious Incident and Safeguarding Teams as appropriate. In addition, a quarterly thematic report is presented at the Patient and Carer Experience Sub Committee, chaired by the Chief Executive.

Of the 265 complaints closed in 2020/21, 116 (44%) were recorded within these three main themes. Of these, 67 (58%) were either upheld or partially upheld.

7.0 RE-OPENED COMPLAINTS

During 2020/21, of the 265 complaints closed, a total of 35 complaints were reopened as the complainant was dissatisfied with the Trust's response to their complaint. This equates to 13% of complainants being unhappy with the response received to their complaint.

The reasons given for requesting the complaint to be re-opened are detailed below.

Table 7: Reasons for Re-opened Complaint

Reason for Re-opened Complaint	Number of complaints
Disagrees with response	12
Dissatisfied with investigation	7
New questions raised/ information provided	6
Inaccurate response	5
Unhappy with Covid process	3
Unhappy with outcome	2
Total	**35**

8.0 COMPLAINTS REVIEWED BY NON-EXECUTIVE DIRECTORS

The Non-Executive Directors, (NEDs) provide an important and valuable part of the complaints process by undertaking independent reviews of randomly selected completed complaints. They provide an extra level of assurance in monitoring the Trust's complaints performance.

During 2020/21, 23 reviews were completed in Q1-Q3, and a further 6 reviews are underway for Q4 at the time of writing this report. The total of 29 reviews represents 11% of the number of closed complaints in the year (265).

Due to the Covid-19 pandemic, the process for the NED reviews was adapted, and these are now carried out remotely by a paperless process.

Of the 23 complaint responses that were reviewed: 7 were deemed 'Very Good'; 10 'good' and 6 were 'Satisfactory'. None were deemed 'Fair' or 'Poor'.

In answer to the question "Do you feel the Trust has done all it could have to resolve the complaint satisfactorily?" the response was "Yes" in over 95% of the cases reviewed.

Figure 7: NED Reviews by Trust Area and Quality rating:

9.0 PATIENT ADVICE AND LIASION SERVICE (PALS)

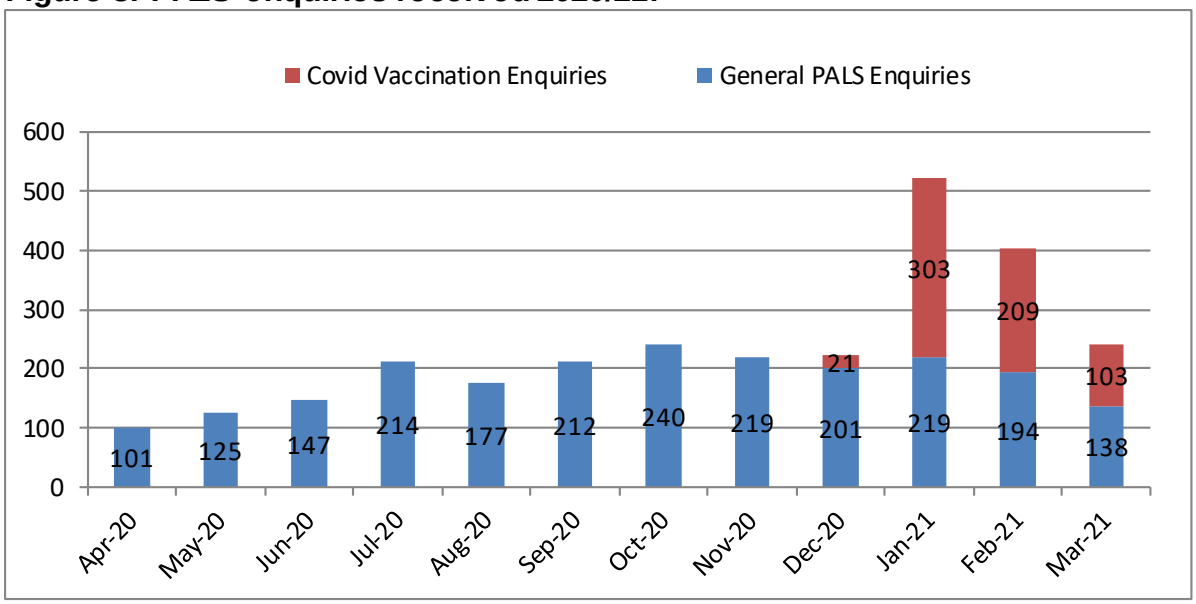
The PALS service sits within the Complaints Team, and serves as a first point of contact for enquiries and concerns, which are received and responded to by telephone and email. PALS provide confidential advice, support and information regarding all aspects of EPUT services, primarily to patients, their families and their carers.

In November 2020 EPUT was appointed one of three lead providers in the East of England region for the COVID-19 vaccination programme, and PALS supported this programme by responding to enquiries from the general public relating to vaccinations.

PALS received 2820 enquiries during the year 2020-21, which was an increase of 182% from the previous year's total of 998.

613 (22%) of these enquiries related to Covid-19 vaccinations. The number of other 'general' enquiries (2,207) was more than double the previous year's figure, and can be attributed to the additional pressure placed on the service by the pandemic.

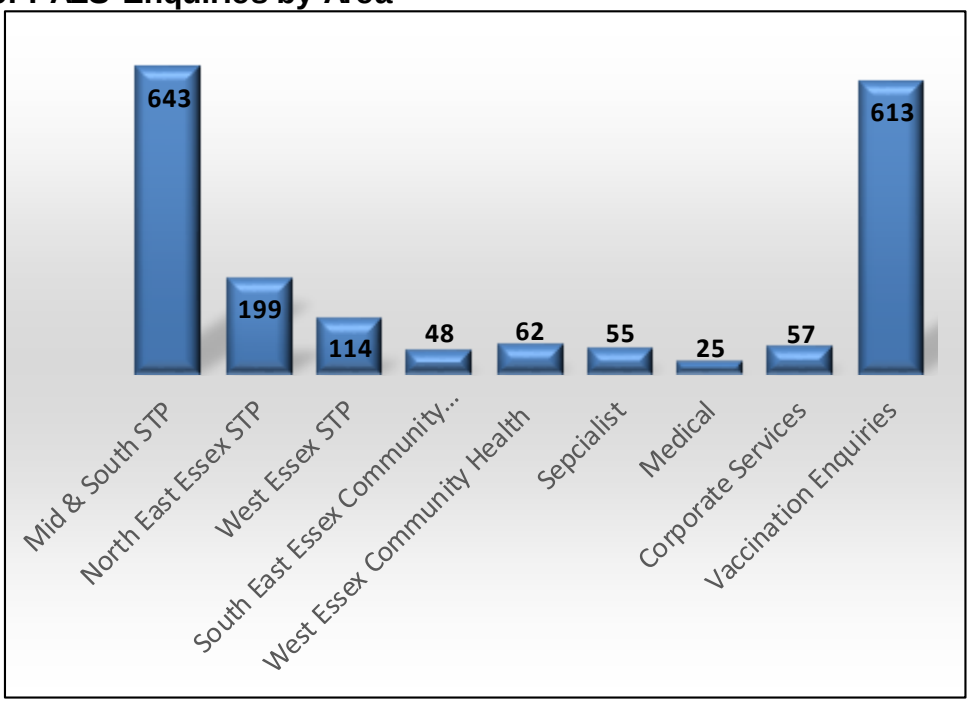
Figure 8: PALS enquiries received 2020/21:



The majority of contacts to PALS are either resolved by the team or passed to the relevant services. If the issue requires a formal complaints investigation it is passed to the Complaints Team to action through the Trust's complaints process. A total of 47 (1.6%) were passed to the Complaints Team to resolve and 1205 (43%) were signposted to other organisations.

The chart below shows which areas the enquiries were received for.

Figure 9: PALS Enquiries by Area



The top 5 themes for PALS enquiries in 2020/21 made up almost exactly 50% of the total enquiries for the whole year (2820). These are shown in the table below as a percentage of the total number of enquiries received.

Table 8: Top 5 PALS Sub-Categories

Sub-Category	Number of Enquiries	% of Total Enquiries
Clinical Practice: Covid Vaccination	613	22%
Communication breakdown with patient	342	12%
Request for Information	207	7%
Communication breakdown with relatives	139	5%
Access to treatment	112	4%
TOTAL	**1413**	**50%**

10.0 LOCAL RESOLUTIONS

The Trust encourages front line staff to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time. A timely intervention can provide the opportunity to listen and discuss the concern and can prevent an escalation to a formal complaint. Local resolutions are recorded on a "Local Resolution Monitoring form" by staff and recorded electronically by the Complaints Team. There was a total of 98 locally resolved concerns recorded for the year.

MP Enquiries

The Trust received 83 enquiries from MPs on behalf of their constituents, which was 37 more than the previous year. This increase can be mainly attributed to enquiries regarding Covid-19 vaccinations, of which there were 31.

The chart below illustrates the areas for which the Local Resolutions and MP enquiries were received.

Figure 10: Local resolutions and MP queries – by area

11.0 TRIANGULATION OF COMPLAINTS, PATIENT SAFETY INCIDENTS AND CLAIMS

All complaints are logged onto the Datix reporting system and are cross-referenced with the incident module; to highlight any incidents that are connected to the complaint. Where there are complaints that are also being investigated as a Patient Safety Incident (PSI), the Complaint Investigator works collaboratively with the Patient Safety Team, ensuring that all elements of the complaint are investigated without conflict or duplication. The complainant is kept informed throughout this process.

During 2020/21, 27 complaints cases were recorded. Of these, 6 complaints were linked to a PSI.

A detailed root-cause analysis is undertaken for a PSI, and the final report is used to inform the complaint response. The joint learning from the serious incident and the complaint is discussed at the Learning Oversight Steering Committee.

Legal Claims related to complaints

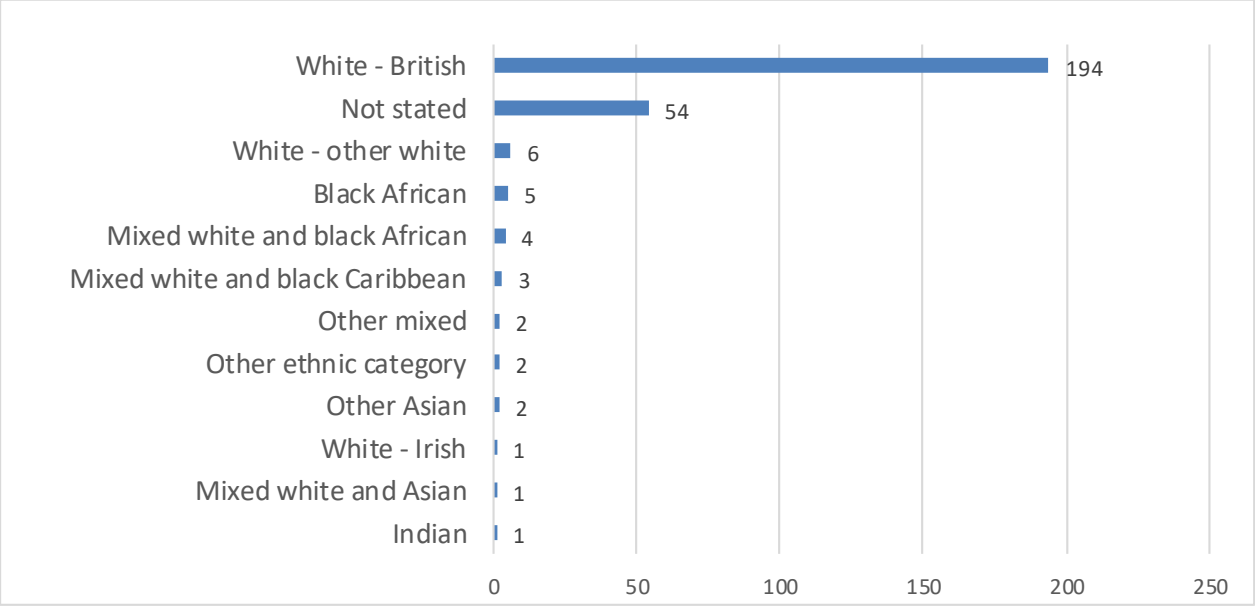
There were 4 claims received by the Trust that related to complaints this year, which is 2 fewer than the previous year. A total of 3 claims were closed, with combined damages of £29,500.

Complaints are also linked to any recorded safeguarding concerns; the Safeguarding Team take these forward through their own processes.

12.0 ETHNICITY OF PATIENTS

The Trust retains an electronic record of a patient's ethnicity, and this is recorded within the complaint record for statistical purposes. In 54 cases the patient has not stated their ethnicity.

Figure 11: Complaints received 2020/21: Ethnicity of patient



13.0 FEEDBACK ON COMPLAINTS PROCESS

In previous years The Trust has sent a questionnaire to complainants approximately 6 weeks after the closure of their complaint, asking for feedback on how the complaint was handled.

In April 2020, following changes made to the complaints process due to the pressure of the Covid-19 pandemic, we stopped sending this survey.

We have taken the opportunity to consider how we can increase the survey response rate to maximise the feedback we receive. We have reviewed the survey contents, reducing the number of questions from 11 to 6. We have made it easier for people to respond by creating an electronic survey that complainants can complete online (via a link we email to them), as well as paper surveys that we post to complainants who correspond by letter.

The revised Complaints Survey was implemented for complaints closed from April 2021, and the new questions are as follows:

1) Did the investigator make contact with you at the start of the process?
☐ Yes ☐ No

How satisfied were you with the following: (Very Satisfied/ Fairly Satisfied/ Neither satisfied nor dissatisfied/ Fairly dissatisfied/ Very dissatisfied)

2) Were all aspects of your complaint addressed?
3) Were the reasons for the outcome of your complaint fully explained?
4) Was your complaint dealt with in a reasonable timescale?
5) Do you believe the complaints process is fair and would you have confidence to use it again if necessary?
6) How satisfied are you overall with the handling of your complaint?

14.0 ONLINE FEEDBACK

The Complaints Department monitors and responds to feedback posted on the NHS Website, (formally NHS Choices). The majority of the comments are left anonymously; it is, therefore, not always possible to identify which particular service the person is referring to. We endeavour to respond to comments individually, and where appropriate we provide the contact details of our PALS and Complaints Departments and encourage the writer to contact us directly to enable us to respond more fully to their specific concerns.

As the base is usually identifiable, the relevant Director is contacted to make them aware of the comments. In 2020/21, a total of 15 comments were received: 11 negative, 3 positive and 1 not related to EPUT services.

15.0 ACTIONS TAKEN TO IMPROVE SERVICES AS A RESULT OF THE COMPLAINTS RECEIVED

The Trust recognises the importance of learning from Complaints to continuously improve our service. This year we adapted our Complaints Investigation Report template, to include a prompt for the Complaint Investigator to consider if it would be beneficial to share any lessons learned from the complaint Trust-wide.

As mentioned in section 12, the Trust has a Learning Oversight Committee which ensures that any learning from complaints and the PHSO's investigations is taken forward and implemented within service delivery. Additionally, some learning which has significant impact across the Trust is published in EPUT's internal Learning Portfolio Newsletter.

Where learning has been identified as part of a complaint investigation, the Complaints Team follow up with the relevant service on a quarterly basis to provide assurance that improvements have been taken forward and embedded in everyday practice. In addition, the lessons are analysed regularly to ensure that there are no recurring themes either within the same service or another service. This is also discussed at the Learning Oversight Committee to ensure Trust-wide learning.

The Commissioners of EPUT's services also receive a report on the lessons learned from complaints for their specific geographical areas.

The following table highlights a selection of some of the lessons learned from complaints over the past year.

Table 9: Lesson Learned

What our patients said	What we did
When I was discharged from the service I didn't receive a discharge letter, and neither did my GP. The contact numbers I was provided for the Crisis Line were incorrect and there was a delay in accessing the service.	The Contact Centre systems were undergoing migration of networks and this caused some issues with the service - these issues are fixed, and all letters following assessments are completed the next working day. The Contact Centre is actively working on improving the experience of callers, and will be reviewing calls from start to finish to ensure that the best and most appropriate support is being given.
I live abroad, and had problems contacting my mother who was a patient. I feel that the communication equipment and infrastructure are inadequate for a modern ward, and this is compounded by the lack of communication between staff.	A walkabout telephone is now available for patient use, and this has been communicated to all staff. Communication equipment and infrastructure on the ward is being addressed with the IT Department; additional booster boxes have been installed to give everyone wi-fi access. The Trust is also providing access to Skype (or similar) which can be accessed via a computer allowing patients to chat with loved ones.

I received a letter advising that my son was being discharged from your service due to lack of engagement and non-attendance of appointments. Due to my son's ADHD, he cannot retain information as his racing thoughts move onto the next thing so quickly. This is why I had requested to be made aware of and involved in his appointments, to ensure attendance. This agreement was not adhered to which is why he did not attend.	We apologised because the patient's mother had previously made it clear that she needed to be informed of appointments, and we had failed to do this. An anonymised summary of this complaint was included in the August 2020 Learning From Complaints report; and the importance of establishing clear communication systems with patient/carers in line with their preferred method of communication was highlighted to all staff.
I received a telephone call from the First Contact Practitioner (FCP) in which I was given MRI results and a diagnosis for a life changing condition. This caused me great distress, during an already difficult time. I feel a phone call was inappropriate and I should have been given a face to face appointment, or at the very least a video call appointment.	As a result of this complaint, additional supervisions will be held with staff regarding patients who receive a diagnosis of Cauda Equina and the life changing impact of this syndrome. Patients will be offered the option of telephone/video consultation in the first instance, followed by face to face appointments where clinically indicated.
My son was sectioned and taken to Rochford Hospital for assessment, then moved to a ward in Colchester near where we live. I have found out that that he has now been moved to a ward in Harlow, but nobody had told me. The Ward Manager was unable to explain why he had been moved.	The Complaint Investigator found that, following a Sitrep meeting, the patient was admitted to the most local hospital to his home address. However, the address we held for the patient was incorrect. We have communicated to staff to check before making transfers back to the home area that the address we hold is correct.

16.0 NUMBER OF COMPLIMENTS RECEIVED

A total of 1,000 compliments were received by the Trust in 2019/20. Services directly received 811 compliments and 189 compliments were taken from the Friends and Family Test (FFT).

This equates to 712 for Mental Health Services and 262 for Community Health Services. In addition, 26 compliments were received for Corporate Services.

Compared to last year's figure of 4,269, the Trust has seen a significant decrease in compliments received. This is a direct result of the FFT (which is typically our greatest source of compliments) being paused during the pandemic.

A selection of compliments are published regularly in our internal newsletters, and uploaded onto the website on the individual services pages. Compliments are also shared with services to discuss at their team meetings and display in their work areas.

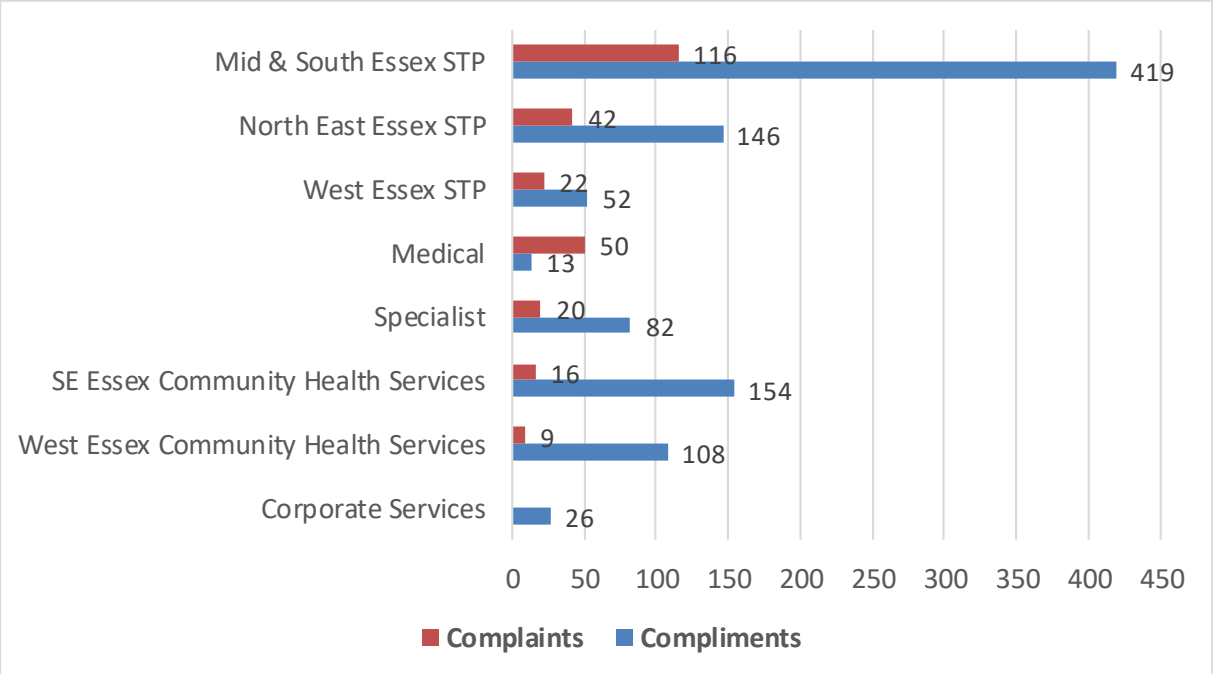
The table and figures below show the compliments received by the Trust and the ratio of compliments to complaints. Overall, there are almost 15 compliments to each complaint. A selection of the compliments received is shown in appendix 1 of this report.

Table 10: Compliments received by area

Area	Compliments Received
Mid & South Essex STP	419
North East Essex STP	146
West Essex STP	52
Medical	13
Specialist	82
Total Mental Health	**712**
South East Essex Community Health Services	154
West Essex Community Health Services	108
Total Community Health	**262**
Corporate Services	26
Total	**1000**

There were almost 4 times as many compliments received than complaints during the year, and the comparison is illustrated on the chart below by Area.

Figure 12: Complaints v. Compliments by Area



N.B. It is not always to ascertain when a compliment relates to the Medical Directorate, therefore these may be captured under other areas.

17.0 COMPLAINANTS' STORIES

Story 1

The service user was diagnosed with Emotionally Unstable Personality Disorder and was under the care of CAMHS for seven weeks before being transferred to an adult inpatient psychiatric unit when she turned 18 in 2020. The service user wrote to her MP expressing concerns around her transition from a children's unit to an adult unit, which she felt was extremely terrifying and challenging.

The service user made a number of suggestions on how to make this transition easier for patients. This included being given the opportunity to visit the adult ward before being transferred and being given the opportunity to speak to other patients and/or staff on the wards. The service user also suggested being given leaflets or a website with more information on the adult ward; this could include pictures, videos and key information about the ward layout and key staff members. Overall, the service user felt that the transition process would have been much easier had she been given more information beforehand. The lack of information before the transition had a negative impact on the service user's mental health.

The issues raised by the service user via her MP were dealt with via the complaints procedure. As a result of the complaint, the Associate Director for CAMHS met with clinical leaders from both CAMHS and the Adult Services to address the concerns raised. The services will be conducting a joint review of the transition process and operational policies which they would like to co-produce with the service user and other young people who may be going through a similar situation. The Associate Director has assured the Patient Experience Team that they will include and update the team as part of the co-production work going forward.

Story 2

The service user was a 22 year old man who throughout his childhood had been in contact with children's mental health services. He was referred to the West Specialist Mental Health Team in June 2020 by his GP due to deteriorating mood, anxiety, generalised stress, insomnia, anger outbursts and paranoid ideation. This was on the background of him using both Cocaine and Ketamine as a form of self-medication.

In July 2020, the service user was assessed via telephone by a Community Psychiatric Nurse. His mother was present at the time. On 20 August 2020, the team received a telephone call from the service user's mother at which time she expressed her concern that the outcome letter they had received following the assessment was not only grammatically poorly written but also did not reflect on any level what concerns/issues had been discussed at the time of the assessment. Essentially, she expressed that they had neither been listened to nor heard. His mother expressed further concerns as some details within the outcome letter were so factually incorrect that she felt it was a defamation of the service user's father's character. At the time of this initial conversation, the team apologised and advised the service user's mother that they would arrange a face to face assessment for the service user.

The team received further telephone calls from the service user's mother during which she made the team aware of further deterioration in his mental state: including physical aggression towards his partner and also high use of illicit substances. In response to these concerns, the team arranged an urgent face to face assessment for that week. This appointment was attended by the service user, his partner and also his mother. The appointment lasted for well over an hour and it was agreed that medication would be commenced. The team also arranged on the same day for a physical health check and blood

investigations as his mother had serious concerns about his physical health. The service user's mother texted the team the following day thanking them for their help and support and expressed gratitude for the urgent meeting:

"I'm texting to just say it again, because I am beyond grateful for all your help and kindness over the past few days. The meeting yesterday was more than I could have wished for - pls thank … for me again as well - what an incredible team you make - I can honestly say in all the years we have been in and out of counselling, GP visits, social services etc etc, never before have we experienced such a thorough, professional and caring consultation. You listened, you heard, you understood and you truly cared. …. wants to feel different. He cried yesterday, that really doesn't happen very often...almost like he took a huge sigh of relief that finally he felt understood. Thank you thank you"

18.0 AIMS FOR 2021/2022

During the next year we will:

- Update our Complaints training to align with the PHSO Complaint Standards, which is a model Complaints Handling Procedure and guidance, due to be published this year.

- Build on the work already in place to learn lessons from Complaints, ensuring that our new complaints process is robust in supporting the identification, appropriate sharing and embedding of lessons across the Trust.

- Provide support to the operational areas and improve adherence to agreed timescales by centralising the process of monitoring impending due dates and keeping complainants updated within the Complaints Team.

- Develop a process to provide information regarding complaints and compliments made about specific staff members for inclusion in reviews and annual appraisal.

- Explore ways to promote and publicise compliments received to the Trust.

19.0 CONCLUSION

EPUT is always looking for ways in which to improve the complaints process for people who are dissatisfied with any of the services we provide. Complaints and compliments provide valuable insight into what is going well and what needs improvement.

Each Service Director receives a weekly situation report for their complaints, displaying timescales and extensions. In addition, a complaints update is discussed at the Executive Team meeting every month, so that any areas of concern can be highlighted, and appropriate and immediate action taken.

During this year, despite the unprecedented challenges presented by Covid-19, a great deal of work has taken place to improve the quality and timeliness of complaint responses.

Highlights of work that has been done in 2020/21 are:

- The complaints process has been improved, and now delivers greater consistency in the quality of complaint responses, and faster responses to less complex complaints.

- The Complaints process is now entirely paperless, with all files stored electronically. Additionally, the independent complaint reviews carried out by the Non-Executive Directors are also now completed electronically. This is a more efficient way of working, and better for the environment too.

- The Complaints Satisfaction Survey has been revised and can now be completed online.

- The PALS and Complaints team have supported the Mass Vaccination Programme by handling and responding to general enquiries and concerns from the general public, whilst also continuing to deliver a responsive service in all other aspects of their work.

Report produced by:

Claire Lawrence
Head of Complaints and PALS

On behalf of:

Sean Leahy
Executive Director of People and Culture
May 2021

		Agenda Item No: 7e
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Equality and Inclusion Annual Report 2020 - 21**					
Executive/Non-Executive Lead:	Sean Leahy Executive Director of People & Culture					
Report Author(s):	Gary Brisco (Equality Adviser) / Jo Debenham, (Director of Engagement)					
Report discussed previously at:	n/a					
Level of Assurance:	**Level 1**	√	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	None
State which BAF risk(s) this report relates to	BAF 35 – Culture that is morally right.
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors with an update on progress on the Trust's Equality and Inclusion responsibilities, as well as key achievements.	**Approval**	
	Discussion	√
	Information	√

Recommendations/Action Required

The Board of Directors is asked to note progress on the EPUT Equality agenda during the last 12 months.

Summary of Key Issues

The report sets out a short overview of progress in the last financial year across the 3 main areas of equality – Patient Equality, Workforce Equality and then Health Inequalities and there is more detail in each of the appendices if required.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	√
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	√
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

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

Acronyms/Terms Used in the Report			
WRES	Workforce Race Equality Standard	ICS	Integrated Care Systems
BAME	Black, Asian and Minority Ethnicity	CCG	Clinical Commissioning Groups
AIS	Accessible Information Standard	HSJ	Health Service Journal
WDES	Workforce Disability Equality Standard	LGBTQ+	Lesbian Gay Bi, Transgender Questioning + (any other gender identity / sexual orientation)
EDS	Equality Delivery System (2)		

Supporting Documents and/or Further Reading

Full detail is contained within the appendices.

Lead

Sean Leahy
Executive Director of People and Culture

ESSEX PARTNERSHIP UNIVERSITY NHS FT

EQUALITY AND INCLUSION, ANNUAL REPORT 2020 - 21

1. Purpose of the Report

The purpose of this report is to provide Trust Board with an overview of Equality and Inclusion progress in the last 12 months. **The report covers the period 1 April 2020 to 31 March 2021.**

.

2. Executive Summary

This report provides assurance to the Board that the Trust is able to report against the general equality duty as outlined in the Equality Act 2010. To have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not.

The report and appendices evidence key highlights and progress on the equality agenda across the last 12 months. We do this through the Equality Delivery System and our Trust objectives, the WRES / WDES. We also publish externally here. https://eput.nhs.uk/about-us/equality-and-diversity

3. Context

Throughout this period, the NHS was responding to the global COVID-19 pandemic. Equality was a key priority, with many discussions in the UK about disparity of treatment and access, disproportionate death and global racism – all of which served to further shine a light on the way we promote equality, inclusivity and equitable treatment of marginalised and minority communities.

EPUT is proud of its work around equality and inclusion (E&I). We aim to promote a *"Be You"* culture that combines equality, inclusion, wellbeing and psychological safety for our staff and encourages them to act as allies within our services. We also work alongside our patients, carers, and local organisations to make improvements to our systems and processes with inclusivity in mind.

We want the Trust to address health inequalities in our localities to ensure that we are providing parity of care and accessibility for those from marginalized and minority communities, as well as ensuring our staff are allies to these communities and have the appropriate resources and training to provide person centered care.

4. Governance

Equality is governed by the E&I Sub-Committee, led by the Executive Director of People and Culture and supported by senior representatives. The group monitors progress on delivering E&I whilst identifying risks which are then escalated as appropriate. It also serves to share good practice and celebrate progress:

The key aims of the E&I Sub-Committee are:-

- Ensure that the Trust remains compliant with Public Sector Equality duties
- Provide assurance and support in respect of compliance and delivery of the Equality Delivery System (EDS2) Framework and Work plan
- To provide assurance and evidence that the Trust is meeting the equality and diversity elements of the Care Quality Commission Fundamental Standards as well as CQC suggested actions
- To promote Equality, Human Rights and Inclusion throughout the Trust, and to evidence this in line with Trust Equality Objectives

The E&I Sub-Committee Governance Structure is set out in **APPENDIX A**

5. Equality Objectives and the Equality Delivery System (EDS2)

As part of the Trust's public sector duties, EPUT must publish its equality objectives every four years. Following a process of consultation with key stakeholders during December 2017 and March 2018, we developed three Equality Objectives (2018 - 2022) as follows:-

Equality Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe, and innovative services

Equality Objective 2: We will ensure all staff feel safe, included and have fair access to employment.

Equality Objective 3: We will empower our staff to build strong and healthy communities by being open and compassionate when involving people from all communities and groups.

Implementation of the EDS2 is a mandatory requirement for both NHS commissioners and NHS providers. The Trust is required to demonstrate four key objectives; two for service users and two for staff. The main purpose of the EDS2 is to guide NHS organisations, in discussion with local partners and local people, in reviewing and improving the services and functions they provide for people from marginalized and minority communities.

The EDS2 (2020-21) was graded by Stakeholders on March 25 2021, with stakeholders (including patients, staff, public governors and CCG representatives) giving their feedback on the work we as an organization have done during this period as well as suggestions for actions for the upcoming year (2021-22).

Our EDS2 2020-21 Action Plan, Full Summary and Grading Report is published on the Trust website and is available on the E&I Hub on the Trust intranet.

Key highlights and achievements are as follows:-

- Renewing the E&I Sub-Committee and Improving the data we collect on our service users and workforce to help us better identify marginalized and minority communities in our locality and reduce health inequalities.
- Working closely with our Patient Experience / Complaints Team to ensure that this feedback is part of the E&I Sub-Committee. Implementing an E&I question into our FFT.
- Promoting awareness events, including LGBT+ Pride Month, Black History Month, Disability History Month, Asian Heritage Month and International Days.
- Working collaboratively with our Staff Equality Networks to provide feedback on Policy and Procedure as well as COVID-19 Equality Impact Assessments (for both general impacts and the development of our vaccination services).
- Achieving good improvements in our Staff Survey Results around E&I, engagement score, and being named as one of the HSJ Top 10 Improved Trusts this year.
- A strong network of engagement champions with a direct line to the Board with a stronger level of comfort in the organisation around raising difficult and challenging issues with senior leaders.
- Targeted work aimed at supporting groups disproportionately affected by COVID-19 and the Racial Justice movement following the death of George Floyd (support events, messaging and resources aimed at those from ethnic minority communities and those with disabilities and long-term conditions)
- Developing toolkits, resources and training to educate our staff on key concepts in E&I. Including our LGBTQ+ Awareness Training sessions available for all staff and our "Identifying and Supporting Protected Characteristics" toolkit. All of these have the goal of providing 'more aware' patient care in our services.

6. Service Access and Provision

Equality and inclusion is embedded into everything the Trust does, and the aim is for the Trust to be a leader in championing this in our care. The aim of embedding equality and inclusivity into our services is to ensure they are valued, treated with respect and dignity, are treated equitably and have the best possible patient journey. Further detail is available in **APPENDIX B**

7. Workforce

We want our workforce to bring their whole self to work as part of our *"Be You"* culture, combining Equality and Inclusion with both Staff Wellbeing and Psychological Safety. We are passionate about our staff understanding the key concepts of equality and inclusion, as well as their benefits.

We work closely with members of our workforce who have lived experience from many different perspectives, and work in collaboration with them to raise awareness of national awareness events to help us promote this positive workplace culture. We also work in collaboration with these staff, our Staff Equality Networks and over 350 Staff Engagement Champions across the Trust to develop and improve resources, create and present training programs and help us make improvements to our existing systems and policies / procedures to ensure that they are inclusive. Further detail is available in **APPENDIX B**

8. Staff Equality Networks

Our Staff Equality Networks have been a vital function within the Trust throughout the COVID-19 period. They have provided support for staff members, as well as supporting us in our Equality Impact Assessments for COVID-19 throughout 2020-21. Throughout this period they have shared their lived experience and continued to develop actions aimed at promoting and improving inclusivity in our services for our workforce. **Further detail is available in** APPENDIX C

9. General Areas for Action and Improvement in Equality & Inclusion for 2021-2022

Following the grading of our progress on the EDS2, and after identifying barriers and trends from the previous year, the following are key priorities for 2021 – 22.

- Inclusion of patients and carers in our reverse mentoring program.
- A full audit of restrooms and changing areas across the Trust to ensure there are gender neutral options for patients carers and staff, as well as referring to "disabled" facilities as "accessible".
- Development of Race Equality training covering key concepts (such as privilege and representation)
- Equality and Inclusion training courses provided in the Trust should be mandatory and also targeted at senior leaders, middle managers and frontline service staff across the Trust.
- Improving the ways we engage with marginalised and minority groups in our local communities.
- Strengthening our impetus around the Population Health and Health inequalities agenda.

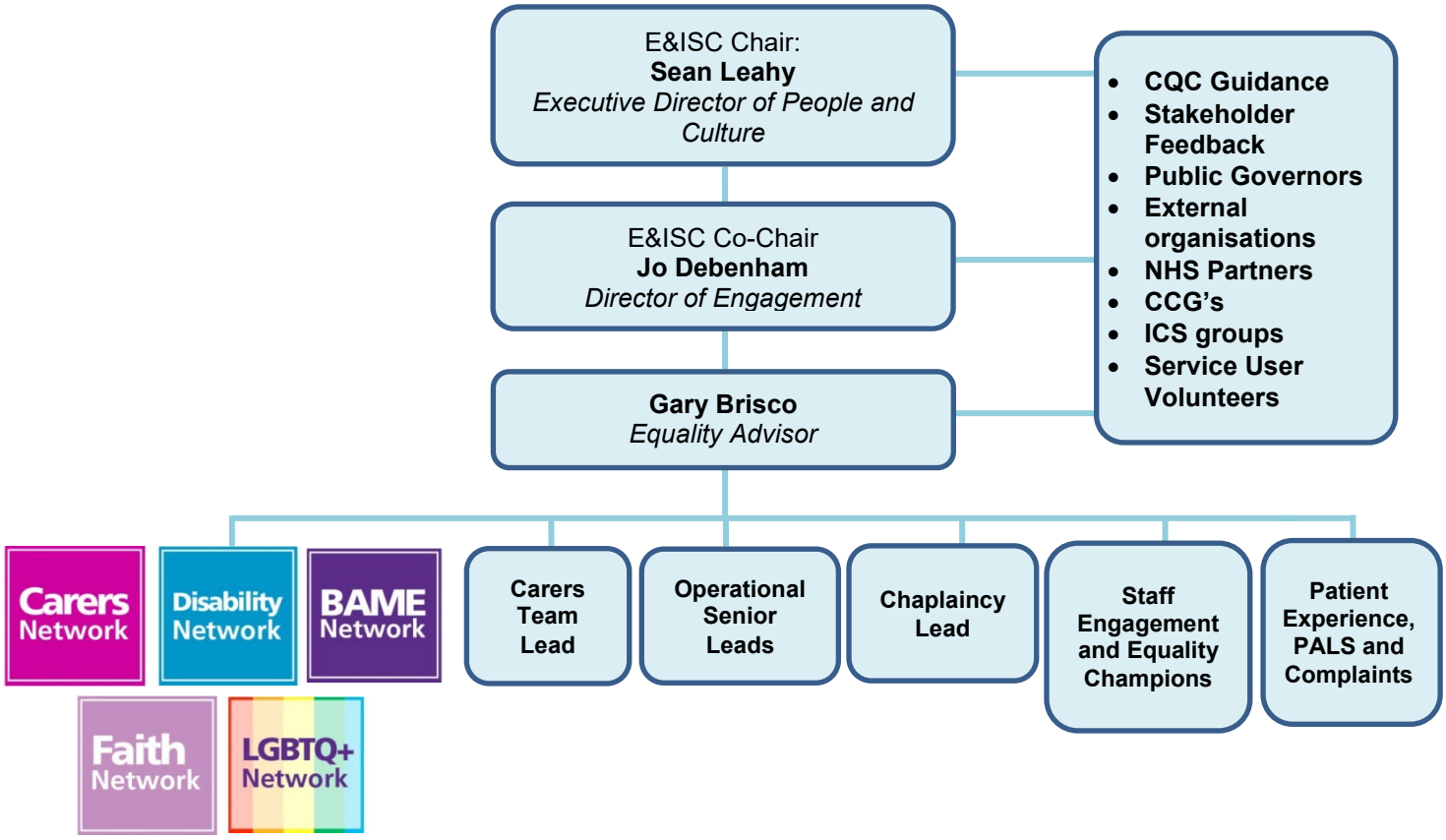
Report prepared by

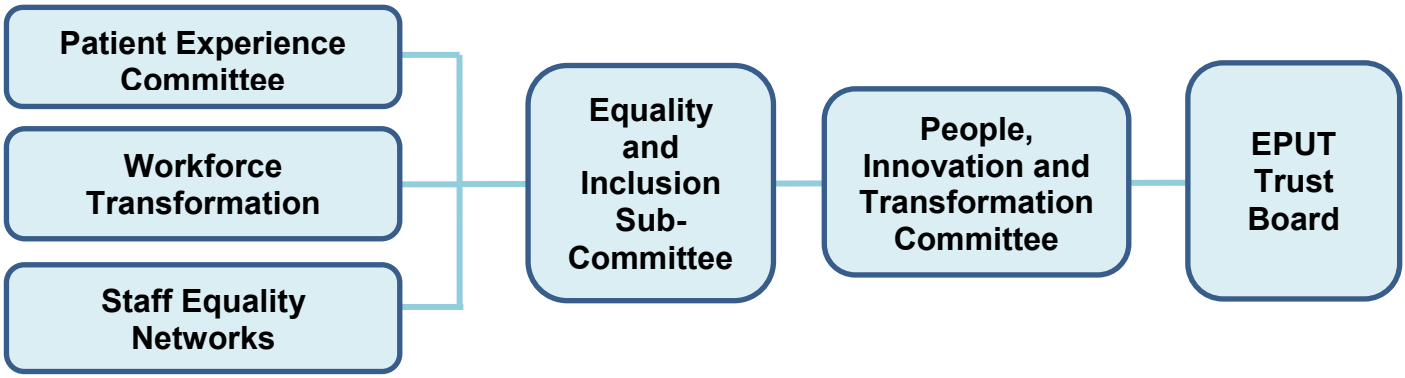
Name **Gary Brisco and Jo Debenham**
Job Title **Equality Advisor and Director of Engagement**
Date **May 2021**

On Behalf of:

Name **Sean Leahy**
Job Title **Executive Director - People and Culture**

APPENDIX A: Equality and Inclusion Governance Structure 2020 - 21





APPENDIX B - EQUALITY AND INCLUSION; SERVICE ACCESS, PROVISION AND WORKFORCE

SERVICE ACCESS AND PROVISION

Accessible Information Standards (AIS)

The Accessible Information Standards require all NHS and Adult social care systems to have a consistent approach to identifying, recording, flagging, sharing and meeting the needs of anyone accessing our services

Accessible Information Standards have been implemented at EPUT for some time. It is part of our Equality Induction for all new staff, and information is available for all staff on the Trust intranet. During this period we also reviewed our Trust website and our mental health appointments service to ensure it complied with the AIS.

Faith and Chaplaincy Services

We have worked closely with our Chaplaincy services throughout this period, in particular providing guidance on how staff members can observe their faith and spirituality. Our Chaplaincy service have supported us in providing guidance in how we as a Trust can best support the spiritual and faith needs of those accessing our services, as well as helping us create guidance for observing faith and spirituality during a period where services are adhering to COVID-19 guidelines.

Interpreting and Translation Services

The Trust has a contract in place with Language Empire to provide interpreting and translation services for our patients and service users. Supplying our service users with translation / interpreting helps bridge any language or cultural gaps between our patients and their healthcare providers. It also allows service users to communicate accurate information to clinicians and practitioners.

We have worked closely with our contract managers to request regular breakdowns of the interpreting and translation support commissioned as part of our Equality and Inclusion Sub-Committee to identify trends and needs of our local communities, as well as facilitating the use of interpreting to better support those accessing our COVID-19 vaccination services. Languages and formats supported by Language Empire are available on the Trust Intranet.

Equality Impact Assessments

The Trust has processes in place to ensure that equality impact assessments are completed for all policies and key decisions, to good quality standards. This includes all decision making processes and Proposals presented to official committees. An update of the process as part of the new Equality, Inclusion and Human Rights Policy has included strengthening the link to Quality Improvements process to ensure they are impact assessed, encouraging a more thorough process and making sure that equality related quality initiatives are encouraged.

Complaints Process and our Patient Advice and Liaison Service (PALS)

The Trust complaints policy sets out a framework for listening, responding and improving when patients and service users or service users, their families or carers raise concerns. In addition to this, a process has been set up with the complaints department to ensure that AIS are embedded in the complaints process. As part of the complaints and PALS (Patient Advice & Liaison Service) process we consider if issues raised are related to equality or diversity. Trained Complaint Investigators thoroughly and independently review all issues raised, and where injustice or wrongdoing is identified we take immediate steps to resolve the problem. We record and track lessons learned and actions taken, and ensure that

learning is shared across the Trust. E&I related incidents or concern data is also reported to our Equality and Inclusion Sub-Committee to help us identify trends and develop improvements.

The Equality Advisor throughout this period has met with service user complainants and teams that have been subject to complaint to share this lived experience for future developments.

Friend and Family Patient Survey

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. A specific question asking service users if they felt they were treated equally and if not, how we could improve on this is included on every FFT form. An online dashboard is available for operational managers to access their service's FFT results, including the specific equality and inclusion question. They are then able to discuss the feedback with their team or individuals, 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. Any concerns identified in the FFT comments are fed back by the Patient Experience Team to the relevant team/service to action appropriately.

Quarterly reports on the Equality and Inclusion FFT feedback are presented to the Equality and Inclusion Committee. FFT data is presented at the Patient and Carer Experience Sub-committee as well as service 'deep dive' reports being presented too which identify any areas for learning and improvement.

The Trust also participates in the annual National Community Mental Health Survey which is sent to patients who received treatment from the Trust from September to November each year to complete and return. The survey asks a number of questions around care and treatment and these results are presented the following year, with a comparison against other Trusts. The survey asks respondents to answer a number of questions on their demographics which then allows the Trust to report on this from an equality and inclusion perspective. Any areas within the Trust which require improvement are raised with Operations and any actions to be taken are monitored and evidenced throughout the year.

Equality Monitoring Policies

At present, we as an organisation are currently due to review our Ethnic Monitoring Policy (CP27), which has been frozen due to COVID-19 pressures. This shows the Trust's commitment to support the implementation of the national requirements on ethnicity monitoring (DSCN 02/2001, DSCN 03/2001 and DSCN 21/2000), in which the ethnicity of our service users and staff are recorded based on key ethnicity groups.

Whilst we adhere to the Sexual Orientation Monitoring standard (a non-mandated standard that requests we record sexual orientation in a similar standard), we are due to add this to our updated Ethnic Monitoring Policy to broaden the scope into an "Equality Monitoring" policy and procedure."

WORKFORCE

Workforce Profile by Equality
Each year we produce a detailed analysis of our workforce by each of the protected characteristic groups and then a range of HR interventions. It also includes a full summary of what progress we have made in the area of workforce equality and inclusion. The most recent report is available on the Staff Intranet.

Gender Pay Gap
We produce an annual report on Gender Pay Gap. This year, as COVID pressures pushed these deadlines forward

Workforce Race Equality Standards (WRES)
The Workforce Race Equality Standards are a mandatory requirement for NHS Employers looking at the experience of Black Asian and Minority Ethnic (BAME) staff compared to their white counterparts. Our most recent published report is available on both the Trust website, with internal updates available quarterly on our Trust intranet.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standards are a mandatory requirement for NHS Employers looking at the experience of staff who are disabled or who have long term health conditions compared to non-disabled staff. Our most recent published report is available on both the Trust website, with internal updates available quarterly on our Trust intranet.

Disability Confident Scheme
We have has successfully completed accreditation as a Disability Confident Employer. This means as an organisation we are making sure that people who work for us who have a disability have a fair chance within the Trust as the Disability Confident scheme supports employers in making the most of the talents of disabled people and what they can bring to a workplace.

We gave gained accreditation for both Level 1 (*Disability Confident Committed*) and Level 2 (*Disability Confident Employer*). To achieve these levels, we have had to self-assess the organisation and agree core actions around recruitment of disabled people and retention of our disabled employees. We are now working towards achieving Level 3 (*Disability Confident Leader*) accreditation, which we hope to complete in 2022. For more information, please visit: *disabilityconfident.campaign.gov.uk*

Mindful Employer
EPUT are proud to be a signatory to the Charter for Employers who are Positive about Mental Health. Mindful Employer is about supporting employers to support mental wellbeing at work, it is UK-wide and run by Workways which is part of the Devon Partnership NHS Trust. It is led by employers and is for employers. It's about increasing awareness of mental health, demonstrating commitment to the mental wellbeing of all staff and showing that organisations are working towards putting their principles into practice. For more information please visit: *www.mindfulemployer.net*

APPENDIX C – STAFF EQUALITY NETWORK UPDATE 2020 - 21

The following are examples of some of each Network's key achievements, based on actions developed independently by their membership groups and facilitated by the EPUT Equality Advisor.

General Actions: All Networks

- Network Chairs acted as equality representatives as part of COVID-19 Silver command and were consulted as part of both Equality Impact Assessments for COVID-19 impacts and the COVID-19 Vaccination program across the Trust.
- Regularly held Bi-Monthly sessions virtually throughout 2020-21.
- Provided guidance and input for the "Identifying and Supporting Protected Characteristics" Toolkit and other online resources developed throughout 2020-21.

Black, Asian and Minority Ethnicity (BAME) Staff Equality Network

- Working in collaboration with the Staff Engagement Team to develop and support the Workforce Race Equality Standard report and action plan from 2021 – 2022.
- Organizing a suite of online events, articles and engagement across Black History Month (October 2020) as well as Asian Heritage Month (May 2020). Highlights included an event in collaboration with Princess Alexandra Hospital and a preliminary training session provided by the Equality Advisor teaching Race Equality, White Allyship and Challenging Discrimination as part of our "Big Conversations" sessions.
- Working alongside the Workforce, Development and Training team to support the development of reverse mentoring sessions. Although this has now been opened out to include those from other marginalised or minority communities.
- Worked alongside the Trust to help promote the COVID-19 Vaccination program to staff members from ethnic minority groups and to raise awareness and provide accurate information and reassurance about the vaccines
- Supported the development of messaging to reassure staff members from ethnic minority groups during the Racial Justice events of 2020-21 and how they could get support *(Black Lives Matter movement, the Death of George Floyd and Government Disparity Reports).*

Lesbian, Gay, Bi, Trans and other sexual or gender minority groups (LGBTQ+) Staff Network

- Implementation of LGBTQ+ Awareness Training, teaching key concepts in gender identity, sexuality and supporting people from these communities in our workforce and accessing our services. The Network bid for funding via NHS Charities to provide Rainbow EPUT Lanyards for attendees to show their Allyship.
- Organizing a suite of online events, articles and engagement across LGBTQ+ Pride Month (June 2020), including a "Virtual Pride" event with guest speakers including Senior Trust Leaders and Paul Deemer (NHS Employers) showing their support. As well as "What Pride means to me" competition.
- The addition of a Transgender Procedure to our Specialist Services, and Transgender Guidance to our Sexual Safety Group. With a view to implementing a Trans Policy and Procedure for Staff in 2021-22.
- Meeting with LGBTQ+ organisations including Transpire, Basildon Pride and Stonewall to review existing resources and to develop new resources for staff.

Faith and Spirituality Staff Network

- Took part in Faith and Spirituality Week and Faith and Spirituality Appreciation day in collaboration with Spiritual Care (November 2020).
- New guidance was developed to support faith and spirituality in our services during the period of COVID-19 Lockdown for events including Ramadan, Easter and other spiritual and religious observances. The Network consulted with our staff Chaplains to provide guidance and advice to those seeking prayer spaces during religious events.
- Worked alongside the Trust to help promote the COVID-19 Vaccination program to staff members from ethnic minority groups and to raise awareness and provide accurate information and reassurance about the vaccines

Disability and Mental Health Staff Network

- Promoted Disability History Month, Deaf Awareness Week, Dyslexia and Dyspraxia Awareness Week and other Disability and Mental Health related events throughout the year, providing staff stories, articles and videos through the Trust Intranet. Including a Disability History Month event where staff were given support on how they can support colleagues with disabilities and long term conditions, with staff members sharing their lived experiences.
- Shared their lived experience to help update our resources for supporting Autistic patients, carers and staff.
- Reviewed the Sickness, Wellbeing and Ill Health policy, and due to their feedback the Bradford score is no longer used within the Trust
- Supported the implementation of the Reasonable Adjustments Passport for use in the new Sickness, Wellbeing and Ill Health Policy and Procedure.
- Took part in “Tea at Three” and Big Conversations sessions aimed at groups disproportionately affected by COVID-19.

Staff Carers Network

- Reviewed the Sickness, Wellbeing and Ill Health policy, and due to their feedback the Bradford score is no longer used within the Trust
- Supported the implementation of the Reasonable Adjustments Passport for use in the new Sickness, Wellbeing and Ill Health Policy and Procedure.
- Took part in “Tea at Three” and Big Conversations sessions aimed at groups disproportionately affected by COVID-19.

We would like it noted that the contribution of each of our networks is a significant reason for the progress we have made this year and we would like to thank them for their commitment and time.

		Agenda Item No: 7(f)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	Learning from Deaths – Mortality Review Summary of Quarter 3 2020/21 information					
Executive/Non-Executive Lead:	Prof Natalie Hammond, Executive Nurse					
Report Author(s):	Michelle Bourner, Mortality Project Co-ordinator					
Report discussed previously at:	Mortality Data Group (virtually via email 24/03/21) Mortality Review Sub-Committee (25/03/21) Quality Committee (15/04/21)					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	N/A
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors: • Information relating to deaths in scope for mortality review for Q3 2020/21 (1st October – 31st December 2020) together with updated information for Q1-Q2 and for 2019/20, 2018/19 and 2017/18; and • Learning that has been identified within the Trust as a result of mortality review undertaken since the last report to the Board of Directors.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required
The Board of Directors is asked to: 1 Note the contents of the report; and 2 Request any further information or action.

Summary of Key Issues
This report presents information that the Trust is nationally mandated to report to public Board meetings on a quarterly basis – ie the number of deaths in scope, the number reviewed and the assessment of problems in care scores; as well as the learning realised from mortality review. The Annexes to the report present the data outlined in the report in the nationally prescribed dashboard format. The report also contains additional information over and above national requirements in order to provide the Board of Directors with information relating to actions being taken in response to trends identified from the data and assurances in terms of the timeliness of review processes. There were **60** deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in Q3. This is broadly consistent with the same quarter in 2019/20 and with other quarterly figures for periods not impacted by COVID-19. Of the 60 deaths, 15 were inpatient deaths and 6 were nursing home deaths. 11 of the 15 inpatient deaths and all of the 6 nursing homes deaths have been confirmed as due to natural causes. Three causes of death are currently under determination and one has been determined as unknown. The attached report includes details of the grade of review to which deaths are being subjected and the timeliness of completion of those reviews. It indicates that the improvement in the timeliness of consideration via the Deceased Patient Review Group has continued. It also indicates that the significant majority of deaths continue to either be closed at Grade 1 desktop review by the Deceased Patient Review Group or investigated at Grade 4 serious incident investigation, with limited use of the Grade 2 case note review option. This will be addressed via implementation of the national Patient Safety Incident Response Framework (PSIRF). The attached report also includes details of the profile of problems in care scores assigned to deaths in scope. This indicates that the significant majority of deaths have been assessed as having no problems in care (score 6). The Mortality Review Sub-Committee also reviews data on deaths of substance misuse service users who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. There are no issues of note / concern to report. Details of learning from mortality review in Q3 are included in the attached report, together with examples of actions taken in response to learning from mortality review.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

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

Acronyms/Terms Used in the Report			
DPRG	Deceased Patient Review Group	MRSC	Mortality Review Sub-Committee
EPUT	Essex Partnership University NHS Foundation Trust	SI	Serious Incident
LeDeR	National Mortality Review Programme for Learning Disability Deaths	SMI	Severe Mental Illness

Supporting Documents and/or Further Reading

Attached - Report on Mortality Information and Learning from Deaths for Q3 2020/21
Annex A – 2020/21 Dashboard (national reporting format)
Annex B – 2019/20 Dashboard (national reporting format)
Annex C – 2018/19 Dashboard (national reporting format)
Annex D – 2017/18 Dashboard (national reporting format)

"National Guidance on Learning from Deaths" *Quality Board March 2017*

https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

"Implementing the Learning from Deaths framework: Key requirements for Trust Boards" *NHS Improvement July 2017*

https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

Lead

Natalie Hammond
Executive Nurse

EPUT

LEARNING FROM DEATHS – MORTALITY REVIEW PUBLICATION OF MORTALITY DATA AND LEARNING QUARTER 3 2020/21

1.0 PURPOSE OF REPORT

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

- Information relating to deaths in scope for mortality review for Q3 2020/21 (1st October – 31st December 2020);
- Updated information relating to deaths in scope for mortality review in Q1-Q2 and in 2019/20, 2018/19 and 2017/18; and
- Learning that has been identified within the Trust as a result of mortality review since the last report to the Board of Directors.

The Annexes attached to this report present the data outlined throughout this report in the nationally mandated format.

2.0 BACKGROUND AND CONTEXT

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

2.2 In line with national guidance, quarterly reports of the nationally mandated information are presented to the Trust Board of Directors outlining mortality data and learning from deaths. This report presents data for Q3 2020/21 (and updated data for previous quarters / years) as at the day the report was prepared (ie 20th March 2021).

3.0 SCOPE OF DEATHS INCLUDED IN THIS REPORT

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

3.2 The Mortality Review Sub-Committee also monitors the deaths of patients who had had contact with the EPUT element of the substance misuse service in the 6 months preceding their death. The data for Q3 has been considered by the Mortality Review Sub-Committee and there are no issues of note or concern to report.

4.0 TOTAL NUMBER OF DEATHS IN SCOPE FOR REVIEW

4.1 There were **60 deaths** which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy in **Q3 2020/21**. This total number of deaths is broadly consistent with the same quarter in 2019/20 and with previous quarters not impacted by COVID-19.

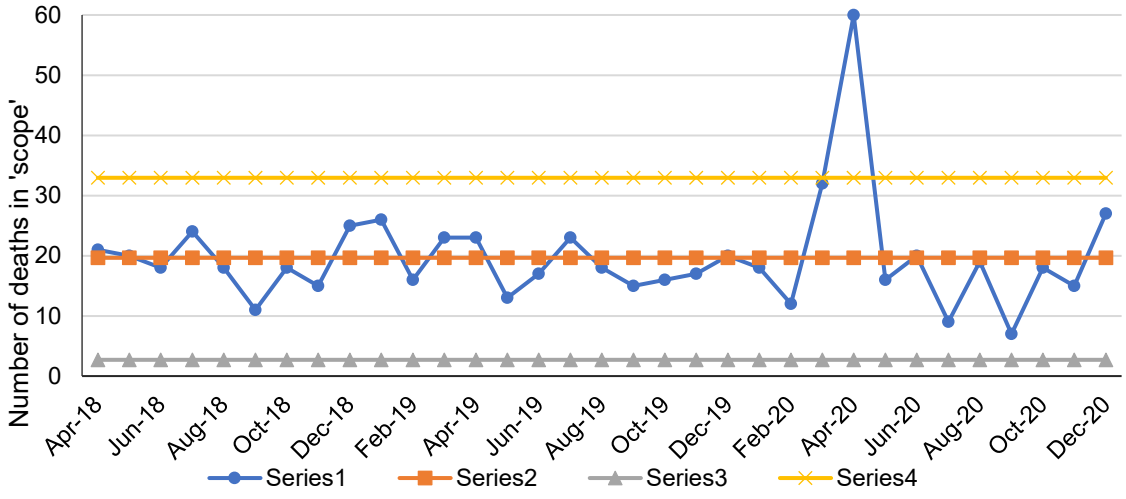
Table 1: Breakdown of total deaths in scope for review

Period	Total 2017/18	Total 2018/19	2019/20 Q1 Total	2019/20 Q2 Total	2019/20 Q3 Total	2019/20 Q4 Total	Total 2019/20	Apr 2020	May 2020	June 2020	2020/21 Q1 Total	July 2020	Aug 2020	Sept 2020	2020/21 Q2 Total	Oct 2020	Nov 2020	Dec 2020	2020/21 Q3 Total	2020/21 YTD
Deaths in scope	248	235	53	56	57	62	228	60	16	20	96	9	19	7	35	18	15	27	60	191

Please note, the total number of deaths in Q1 2020/21 was impacted by COVID-19. Reviews of deaths potentially related to COVID-19 were undertaken in order to identify learning and proactive actions taken to enhance clinical practice based on the findings of those reviews.

4.2 Figure 1 below shows the total number of deaths that fell within the scope of the policy each month in a Statistical Process Control diagram. The "control limits" (depicted by the horizontal dotted lines) are calculated via a defined statistical methodology and have been set based on 20 months historical mortality data (April 2017 – November 2018). This statistical tool is designed to help managers and clinicians decide when trends in the number of deaths should be investigated further. If the number of deaths in the month falls outside of the control limits this is unlikely to be due to chance and the cause of this variation should be identified and, if necessary, eliminated. Figure 1 below indicates that the number of deaths in scope Q3 falls within the control limits.

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



4.3 Of the 60 deaths in Q3, 15 were inpatient and 6 were nursing home deaths. Given the nature of the services provided by the Trust, there will be a number of deaths that occur on in-patient wards and in nursing homes which will be expected and which will be due to natural causes. Of the 15 inpatient deaths, 11 have been confirmed as due to natural causes and all of the 6 nursing homes deaths have been confirmed as due to natural causes. Three causes of death are currently under determination and one has been determined as Unknown.

5.0 GRADE AND PROGRESS OF REVIEWS / INVESTIGATIONS

5.1 The Trust has assurance that all deaths within scope have been or are in the process of being reviewed. The table below outlines the grade of review / investigation to which deaths in scope have been / are being subjected to. Please see paragraphs 5.5 - 5.7 below for information in terms of timeliness of review progress.

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

Grade 1 = Desk Top Review (by Deceased Patient Review Group)
Grade 2 = Clinical Case Notes Review (by Clinician)
Grade 3 = Critical Incident Review
Grade 4 = Serious Incident Investigation

Grade of review / investigation	2017/18 total	2018/19 total	2019/20 Total	2020/21 Q1 total	2020/21 Q2 total	2020/21 Q3 total	YTD 2020/21
Grade 1 Deceased Patient Review Group	148	147	144	72	17	28	117
	60%	63%	63%	75%	47%	46%	60%
Grade 2 Case Note Review	11	19	16	3	0	0	3
	4%	8%	7%	3%	0%	0%	2%
Grade 3 Critical Incident Review	1	0	1	0	0	0	0
	0.5%	0%	1%	0%	0%	0%	0
Grade 4 Serious Incident Investigation	88	69	65	17	16	18	51
	35%	29%	28%	18%	46%	30%	26%
Final grade under determination	0	0	2	4	2	14	20
	0%	0%	1%	4%	8%	23%	11%
TOTAL	248	235	228	96	35	60	191

5.2 The above table indicates that the significant majority of deaths are either being:

- closed at Grade 1 desktop review by the Deceased Patient Review Group (60% 2017/18, 63% 2018/19, 63% thus far 2019/20 and 60% thus far 2020/21); or
- being investigated as Grade 4 serious incident investigations (35% 2017/18, 29% 2018/19, 28% thus far 2019/20 and 26% thus far 2020/21).

5.3 There has been limited use of the Grade 2 clinical case note review option (only 4% in 2017/18, 8% in 2018/19, 7% thus far in 2019/20 and 2% thus far in 2020/21). This has been kept under review and has been taken into account in development of the arrangements to be put in place in the Trust to implement the national Patient Safety Incident Response Framework (PSIRF).

5.4 Positive progress has continued since the last report to the Board of Directors in terms of the timely consideration of deaths via mortality governance processes, with only 11% of deaths in 2020/21 (reduced from 22% in the last quarterly report) and 1% of deaths in 2019/20 requiring the grade of review to be determined. The Deceased Patient Review Group is awaiting further requested information on the 2 deaths in 2019/20 requiring a grade of review to be finalised.

5.5 Progress in terms of completion of reviews / investigations is as follows:

Level of review	Progress	2017/18		2018/19		2019/20		YTD 2020/21	
Grade 1 (DPRG)	Complete	148	100%	147	100%	144	100%	117	100%
	In progress	0	0%	0	0%	0	0%	0	0%
Grade 2 (CNR)	Complete	11	100%	16	84%	10	63%	0	0%
	In progress	0	0%	3	16%	6	37%	3	100%
Grade 3 (CIR)	Complete	1	100%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	1	100%	0	0%
Grade 4 (SI)	Complete	88	100%	69	100%	64	98%	30	59%
	In progress	0	0%	0	0%	1	2%	21	41%
Under determin-ation	Complete	0	0%	0	0%	0	0%	0	0%
	In progress	0	0%	0	0%	2	100%	20	100%
TOTAL	Complete	248	100%	232	98%	218	96%	147	63%
	In progress	0	0%	3	2%	10	4%	44	37%

5.6 Case Note Reviews constitute all reviews still in progress for 2017/18 and 2018/19 deaths. There has been positive progress with completing Case Note Reviews this quarter as and when capacity has allowed. 7 Case Note Reviews have been completed and signed off this quarter. The 3 outstanding Case Note Reviews for 2018/19 have been completed and are due for consideration by the Deceased Patient Review Group on 26th May. 2 of the 6 outstanding Case Note Reviews for 2019/20 have been completed and are due for consideration by the Deceased Patient Review Group on 26th May, 1 is to be completed later in May and the remaining 3 are scheduled for completion in June.

5.7 Reviews / investigations have already been completed for 63% of deaths in 2020/21. The continuation of improvement of timeliness of consideration via the Deceased Patient Review Group has continued with virtual Group meetings being held on a monthly (sometimes fortnightly) basis to ensure timely review of deaths within scope of the Mortality Review Policy.

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

6.1 The following table details the profile of scores assigned for the extent to which problems in care may have contributed to the deaths reviewed:

Score	*2017/18 (Number)	*2017/18 (as a %)	2018/19 (Number)	2018/19 (as a %)	2019/20 (Number)	2019/20 (as a %)	2020/21 (Number)	2020/21 (as a %)
6 - definitely less likely than not	115	86%	192	82%	169	74%	127	66%
5 - slight evidence	14	10%	22	9%	28	12%	12	6%
4 - not very likely	3	2%	11	5%	13	6%	5	3%
3 - probably likely	2	2%	6	3%	4	2%	0	0%
2 - strong evidence	0	0%	1	1%	0	0%	0	0%
1 - definitely more likely than not	0	0%	0	0%	0	0%	0	0%
Under determination	0	0%	3	1%	14	6%	47	25%

* Note: Problems in care scores only assigned for deaths from 1st October 2017

6.2 The above table indicates that the significant majority of deaths have been assessed as definitely less likely than not to have had problems in care which may have contributed to the death (score 6).

6.3 Those deaths assessed with a score lower than a 6 have action plans associated with the findings of the review / investigation and their implementation is monitored. The families / carers of these deceased patients have been fully involved in the outcomes of the review / investigation and the actions resulting.

7.0 REFERRAL TO THE NATIONAL MORTALITY REVIEW PROGRAMME FOR LEARNING DISABILITY DEATHS (LeDeR)

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

8.0 LEARNING FROM MORTALITY REVIEW OF DEATHS

8.1 LEARNING FROM INDIVIDUAL MORTALITY REVIEW

8.1.1 Detailed information on learning from serious incident investigations and other individual mortality reviews is presented and considered at the Learning Oversight Sub-Committee and Quality Committee to ensure actions are being taken to address the learning.

8.1.2 Example of learning themes from Q3 have related to patient follow up by community psychiatrist following discharge; considering improvements to sharing clinical information via electronic methods; consistency in the way in which discharge from inpatient service follow up is conducted; accurate recording of patient information on discharge.

8.1.3 The Trust actively ensures that learning identified from the reviews leads to improvements in practice. Examples of actions taken in response to learning identified from individual mortality review include:

- Ensuring that learning is shared with clinicians across the Trust to enhance clinical practice – for example regular “lunchtime learning sessions” are held via MS Teams which focus on specific learning from SI deaths and are attended by high numbers of clinicians.

- Influencing policy and procedure development – for example in 2020, the Patient Safety Team identified a recurring theme in a number of Serious Incident investigations relating to community mental health patients disengaging from contact with EPUT services. As a result of these it was recommended that the Trusts Disengagement Guidance be reviewed to ensure it provided appropriate and achievable guidance for all staff. A small Task & Finish Group was therefore convened to review the policy; a comprehensive review of the guidance undertaken and significant changes made to reflect the learning identified through the Serious Incident investigations. This guidance is now in use.
- Clinical Intervention Support Groups have been established across the Trust.
- The themes emerging from individual mortality review were directly used to shape the Trust's focus under the newly implemented Patient Safety Incident Response Framework.

8.2 **LEARNING FROM THEMATIC MORTALITY REVIEW**

8.2.1 The Mortality Thematic Reviews for deaths occurring in 2019/20 are underway. Information in terms of findings and learning will be presented to the Quality Committee following presentation and consideration by the Mortality Review Sub-Committee.

9.0 CONCLUSIONS AND FUTURE ACTIONS

9.1 This report provides assurances that all deaths in Q3 which were within scope for mortality review have been reviewed / investigated or are in the process of being reviewed / investigated. The report also provides assurances that the overarching aim of mortality review – ie learning from deaths - is being achieved with examples of the learning themes being acted upon.

10.0 ACTION REQUIRED

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

Report prepared by:
Michelle Bourner, Project Co-ordinator

On behalf of:
Prof Natalie Hammond, Executive Nurse

ANNEX A – MORTALITY DATA DASHBOARD 2020/21

2020/21 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT
Month	May-21
Year	2020-21

Total Deaths in Scope:

- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria

* Deaths subject to a complaint / claim
* Deaths subject to a serious staff concern
* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	96	8	88	64	0	0	3	0	0	16	1	4	0	0	0	4	8	66	10
YTD		**96**	**8**	**88**	**64**	**0**	**0**	**3**	**0**	**0**	**16**	**1**	**4**	**0**	**0**	**0**	**4**	**8**	**66**	**10**
2020-21	Q2	35	6	29	12	0	0	0	0	0	9	8	0	0	0	0	1	2	18	8
YTD		**131**	**14**	**117**	**76**	**0**	**0**	**3**	**0**	**0**	**25**	**9**	**4**	**0**	**0**	**0**	**5**	**10**	**84**	**18**
2020-21	Q3	60	15	45	18	0	0	0	0	0	5	13	9	0	0	0	0	2	20	23
YTD		**191**	**29**	**162**	**94**	**0**	**0**	**3**	**0**	**0**	**30**	**22**	**13**	**0**	**0**	**0**	**5**	**12**	**104**	**41**
2020-21	Q4																			
Total 2020-21		**191**	**29**	**162**	**94**	**0**	**0**	**3**	**0**	**0**	**30**	**22**	**13**	**0**	**0**	**0**	**5**	**12**	**104**	**41**

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

2020/21 Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Apr-21
Year	2020-21

Learning Disability Deaths

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

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2020-21	Q1	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
YTD		8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
2020-21	Q2	6	6	5	0	0	0	0	0	0	0	1	0	0	0	0	0	5	1
YTD		14	14	13	0	0	0	0	0	0	0	1	0	0	0	0	0	13	1
2020-21	Q3	15	15	10	0	0	0	0	0	0	0	5	0	0	0	0	0	10	5
YTD		29	29	23	0	0	0	0	0	0	0	6	0	0	0	0	0	23	6
2020-21	Q4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total 2020-21		29	29	23	0	0	0	0	0	0	0	6	0	0	0	0	0	23	6

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

ANNEX B – MORTALITY DATA DASHBOARD 2019/20

2019/20 Learning from Deaths Dashboard - Breakdown for deaths in scope (excluding learning disability deaths)

Trust	EPUT	**Total Deaths in Scope:** • All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria * Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)
Month	May-21	
Year	2019-20	

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	53	8	45	24	0	5	1	0	0	15	0	0	0	0	0	2	6	34	3
YTD		53	**8**	45	24	0	5	1	0	0	15	0	0	0	0	0	2	6	34	3
2019-20	Q2	56	3	53	24	0	3	0	0	0	26	0	0	0	0	3	4	12	34	0
YTD		109	11	98	48	0	8	1	0	0	41	0	0	0	0	3	6	18	68	3
2019-20	Q3	57	11	46	25	0	0	4	0	1	13	1	2	0	0	1	4	6	29	6
YTD		166	**22**	144	73	0	8	5	0	1	54	1	2	0	0	4	10	24	97	9
2019-20	Q4	62	8	54	39	0	2	2	0	0	10	0	1	0	0	0	3	4	41	5
Total 2019-20		228	30	198	112	0	10	7	0	1	64	1	3	0	0	4	13	28	138	14

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

2019/20 Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT
Month	Apr-21
Year	2019-20

Learning Disability Deaths

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

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2019-20	Q1	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
YTD		8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
2019-20	Q2	3	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
YTD		11	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0
2019-20	Q3	11	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0
YTD		22	22	22	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0
2019-20	Q4	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0
Total 2019-20		30	30	30	0	0	0	0	0	0	0	0	0	0	0	0	0	30	0

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

ANNEX C – MORTALITY DATA DASHBOARD 2018/19

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

Trust	EPUT
Month	May-21
Year	2018-19

Total Deaths in Scope:

- All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services)
- All community Learning Disability deaths (detailed on sheet 2)
- All community deaths meeting Serious Incident criteria

* Deaths subject to a complaint / claim
* Deaths subject to a serious staff concern
* Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	59	7	52	34	0	5	1	0	0	12	0	0	0	0	2	0	3	46	1
YTD		59	**7**	52	34	0	5	1	0	0	12	0	0	0	0	2	0	3	46	1
2018-19	Q2	53	11	42	19	0	3	1	0	0	19	0	0	0	1	3	3	4	30	1
YTD		112	18	94	53	0	8	2	0	0	31	0	0	0	1	5	3	7	76	2
2018-19	Q3	58	4	54	27	0	5	0	0	0	22	0	0	0	0	0	5	7	42	0
YTD		170	**22**	148	80	0	13	2	0	0	53	0	0	0	1	5	8	14	118	2
2018-19	Q4	65	10	55	35	0	3	1	0	0	16	0	0	0	0	1	3	8	42	1
Total 2018-19		235	32	203	115	0	16	3	0	0	69	0	0	0	1	6	11	22	160	3

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

2018/19 Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT	**Learning Disability Deaths**
Month	Apr-21	
Year	2018-19	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2018-19	Q1	7	7	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0
YTD		7	7	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0
2018-19	Q2	11	11	11	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0
YTD		18	18	18	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0
2018-19	Q3	4	4	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0
YTD		22	22	22	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0
2018-19	Q4	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0
Total 2018-19		32	32	32	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0

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

ANNEX D – MORTALITY DATA DASHBOARD 2017/18

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

Trust	EPUT	**Total Deaths in Scope:**
Month	May-21	• All inpatient deaths (Mental Health Services, Community Health Services, Learning Disability Services and Prison Services) • All community Learning Disability deaths (detailed on sheet 2) • All community deaths meeting Serious Incident criteria
Year	2017-18	Plus from Q3: * Deaths subject to a complaint / claim * Deaths subject to a serious staff concern * Severe Mental Illness as defined in Policy (not already included in above categories)

Financial Year	Quarter	Total number of deaths in scope	Number of Learning Disability deaths (breakdown detailed on separate sheet)	Number of Other Deaths in Scope (exc LD)	Number of deaths in scope (excluding Learning Disbaility deaths) subjected to review by the Trust									Extent that these deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
					Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CIR)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
					Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	59	13	46	19	0	3	0	0	0	24	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		59	**13**	46	19	0	3	0	0	0	24	0	0							
2017-18	Q2	55	9	46	23	0	0	0	0	0	23	0	0							
YTD		114	22	92	42	0	3	0	0	0	47	0	0							
2017-18	Q3	58	9	49	26	0	6	0	1	0	16	0	0	0	0	1	2	5	41	0
YTD		172	31	141	68	0	9	0	1	0	63	0	0	0	0	1	2	5	41	0
2017-18	Q4	76	9	67	41	0	2	0	0	0	24	0	0	0	0	1	1	9	56	0
Total 2017-18		248	40	208	109	0	11	0	1	0	87	0	0	0	0	2	3	14	97	0

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

Learning from Deaths Dashboard - Breakdown for learning disability deaths

Trust	EPUT	**Learning Disability Deaths**
Month	Apr-21	• All Inpatient and Community patients with a Learning Disability recorded on Trust electronic clinical record system
Year	2017-18	

Financial Year	Quarter	Total Number of Learning Disability Deaths (inc inpatient and community)	Total number of these LD Deaths subjected to national LeDeR programme	Number of these LD deaths subjected to review by the Trust									Extent that these LD deaths deemed likely to be due to "problems in care" (categorised according to National Guidance)						
				Grade 1 (DPRG)		Grade 2 (CRP)		Grade 3 (CI)		Grade 4 (SI)		Under determination	1 - Definitely more likely than not	2 - Strong evidence (significantly more than 50:50)	3 - Probably likely (more than 50:50)	4 - Not very likely (less than 50:50)	5 - Slight evidence (significantly less than 50:50)	6 - Definitely less likely than not	Under determination
				Complete	In progress	Complete	In progress	Complete	In progress	Complete	In progress								
2017-18	Q1	13	0	12	0	0	0	0	0	1	0	0	Please note, prior to implementation of the Mortality Review Policy from 1st October 2017 (timeframe in line with the National Guidance on Learning from Deaths), the Trust did not operate a process to assess the extent to which deaths reviewed / investigated were due to problems in care using a scale of 1 - 6. It is therefore not possible to complete this information for quarters 1 and 2. All Grade 4 (Serious Incident) investigations undertaken during this period used established root cause analysis methodology and identified learning arising from the investigation. Further information is included in the narrative report accompanying this dashboard.						
YTD		13	0	12	0	0	0	0	0	1	0	0							
2017-18	Q2	9	3	9	0	0	0	0	0	0	0	0							
YTD		22	3	21	0	0	0	0	0	1	0	0							
2017-18	Q3	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
YTD		31	12	30	0	0	0	0	0	1	0	0	0	0	0	0	0	9	0
2017-18	Q4	9	9	9	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0
Total 2017-18		40	21	39	0	0	0	0	0	1	0	0	0	0	0	0	0	18	0

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

		Agenda Item No: 7g
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Patient Led Assessment of the Care Environment Updated Trust Position following 2019/2020 Assessments**					
Executive/Non-Executive Lead:	Trevor Smith, Chief Finance Officer					
Report Author(s):	Fiona Benson, Head of Estates and Facilities					
Report discussed previously at:	Executive Operational Team Estates & Facilities; Property & Projects Senior Management Team;					
Level of Assurance:	**Level 1**		**Level 2**	√	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	• The PLACE Inspection addresses the provisions of the care environment from the Service Users perspective highlighting areas of address and suitability for client groups. This process ensures that standards are being met and maintained and are adequate for the provision of operational services. • The Trust is required to submit scores to NHS Digital, which enables the Trust to measure standards/functionality of the care environment against other NHS Trusts nationally. • Issues highlighted from the PLACE Assessment are recorded and addressed in a timely manner or scheduled in as part of a programme of works to rectify.
State which BAF risk(s) this report relates to	n/a
Does this report mitigate the BAF risk(s)?	n/a
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	Measures have been implemented following the last PLACE Assessment, this report provides an update.

Purpose of the Report		
This report is to inform the Board of Directors of the reactive estates and Facilities actions undertaken to address any identified areas of improvement in the 2019/2020 Patient Led Assessment of the Care Environment (PLACE)	**Approval**	
	Discussion	√
	Information	√

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

Summary of Key Issues

Due to the impact of the COVID-19 pandemic, NHS Improvement took the decision to cancel PLACE Assessments for 2020/2021; therefore, this report is to provide update on actions identified on published results for 2019/2020 for the Trust.

In the absence of formal PLACE assessments for 2021/22, the Trust has taken the decision to conduct an internal "PLACE Lite" assessment using the same formula. This has been organised for Early August 2021, with the results expected to be presented to the Executive Team (ET) in late September 2021. It is intended that the Assessments will be undertaken by Service Users, Volunteers, and Governors.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	√
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	√
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	√
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	√
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

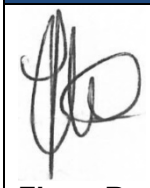
Which of the Trust Values are Being Delivered	
1: Open	√
2: Compassionate	√
3: Empowering	√

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

Acronyms/Terms Used in the Report

Supporting Documents and/or Further Reading

Lead



Fiona Benson
Head of Estates and Facilities

Agenda Item:7g
Board of Directors
Date: 26 May 2021

Patient Led Assessment of the Care Environment Updated Trust Position following 2019/2020 Assessments

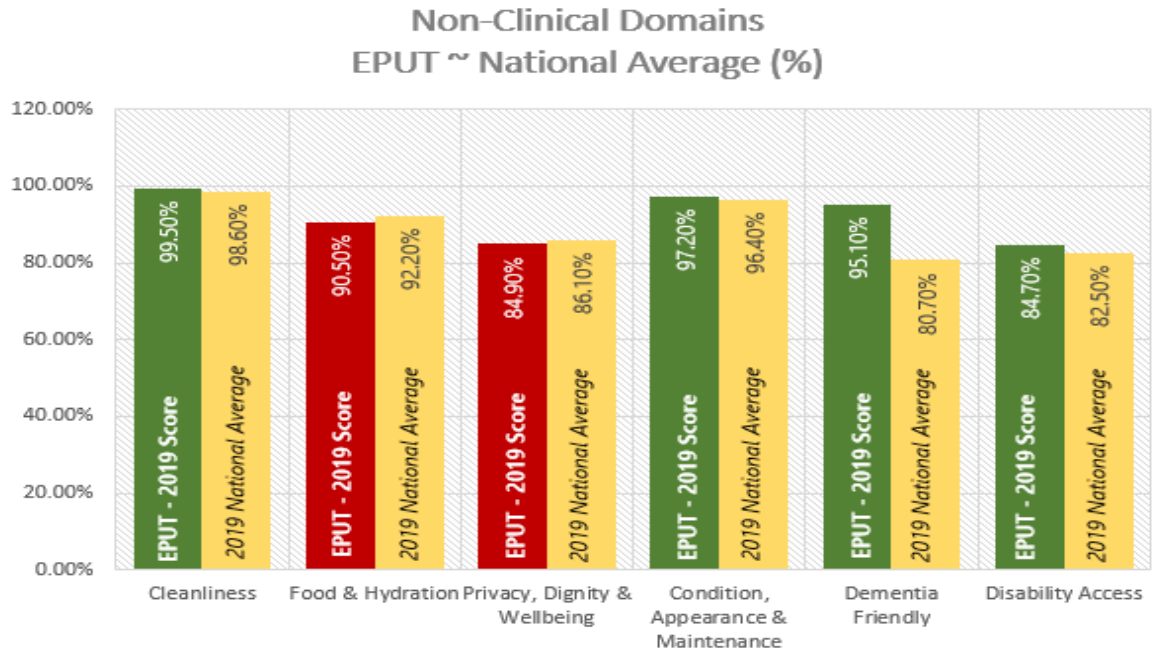
1.0 Purpose of the Report

The purpose of this report is to update the Board of Directors regarding identified PLACE actions following the 2019/2020 assessments.

Due to the impact of the COVID-19 pandemic, NHS Improvement took the decision to cancel PLACE Assessments for 2020/2021; therefore, this report is to provide update on actions identified on published results for 2019/2020 for the Trust.

2.0 Position Update

NHS Improvement published the PLACE scores into the public domain on the 30th January 2020.



2.1 Non-Clinical Domain Update:

2.1.1 Cleanliness

The assessment of Cleanliness covers all items, commonly found in healthcare premises, including patient equipment, baths, toilets and showers, furniture, floors and other fixtures and fittings.

2.1.2 Food & Hydration

It is considered difficult to verify these scores, as food and hydration is down to personal preference rather quantifiable data. Concerns raised

in the 2019 Assessment have been considered and addressed through the review of the current catering provisions which expired on the 30th November 2020. The main action was to ensure that Service Users hydration, nutritional, cultural and dietary needs are met. The Catering Review group was formed of multi-disciplinary members, consisting of Speech and Language Therapists, Nutritionals, Specialist Clinical Representation with Service Users invited to Taste Test products for feedback. There was discussion held at Unit level, between Service Users and Staff to ascertain what concerns or complaints could be identified around food provision. This included meal times (which should be protected), menu choices, portion sizes and availability of food for all dietary needs 24/7.

The Trust is currently preparing to mobilise the new contracts which are anticipated to be in place by July 2021.

2.1.3 Privacy, Dignity & Wellbeing

Reviewing the full 2019/2020 PLACE Assessment reported identified that some of the Privacy, Dignity and Wellbeing responses were incorrectly recorded or not appropriate for Mental Health settings.

The Trust is now in the process of addressing the CQC and PLACE recommendation to remove dormitory accommodation, which should satisfy the PLACE requirements for 2021/2022 around separation of sleeping and bathroom/toilet facilities for single sex use.

There is planned work to ensure that the outdoor facilities are safe and suitable for Service Users to utilise. We now have garden standards that are applicable to some inpatients, areas that do not conform will be addressed on an individual basis.

Estates and Facilities are now in receipt of the recommendations following the Five Facet Survey, which will ensure that we have a rolling five year plan to work to. This will ensure all areas maintained and are working towards improving the Trust's, and especially, Service Users pathway.

2.1.4 Condition, Appearance & Maintenance

Key areas highlighted were:

- Grounds and Gardens
- Tired and weary décor

2.1.5 Dementia Friendly

The Trust continues to strive to improve dementia friendly standards, with collaborative working between Clinical Services, Risk Management and Estates and Facilities have clearly defined the Trust Dementia Friendly Standard, which will be implemented during the this financial year.

2.1.6 Disability Access

The Trust continues to look at improvements, and it is featured in the Trust's works programme in 2021.

3.0 Recommendation

There will be no formal PLACE Assessments undertaken in 2021/2022 as instructed by NHS Improvement. However, the Trust has taken the decision to conduct an internal "PLACE Lite" assessment using the same formula. This has been organised for Early August 2021, with the results expected to be presented to the Executive Team (ET) in late September 2021. It is intended that the Assessments will be undertaken by Service Users, Volunteers and Governors, led by Estates and Facilities.

The Board of Directors are asked to consider the contents of this report and to note that further investment is required to address the above areas.

4.0 Action Required

The Board of Directors are asked to:

1. **Discuss and note the contents of this report.**

Report prepared by:

Fiona Benson
Head of Estates and Facilities
May 2021

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	Board Assurance Framework 2021/22 May 2021					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	ET BAF Sub-Group April and May 2021 (single reports)					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	All BAF and CRR risks
State which BAF risk(s) this report relates to	All – see report
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	Yes
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	Included in report
Describe what measures will you use to monitor mitigation of the risk	Included in report

Purpose of the Report		
This report presents the EPUT Board of Directors with an overview of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) 2021/22 as at 26 May 2021 covering the two month period April 21 and May 21	**Approval**	✓
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2021/22 May summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOC at its April meeting
2 Approve the BAF risk escalations, closures and amendments iterated in key issues below
3 Note the Q4 Key Performance Indicators for April (Appendix 2)
4 Note the CRR May summary table (Appendix 3) including actions taken by EOSC at its April meeting;
5 Approve the CRR risk escalations, closures and amendments iterated in key issues below
6 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Summary of Key Issues

Introduction

- This report covers two months of reporting to EOC BAF Sub-Group and the May summary includes reference to any changes made by Executive BAF Sub-Group April 2021
- The EOSC BAF Sub-Group established in January, is a dedicated forum for detailed review of the BAF and CRR

- In view of the work progressing at Board/Executive level around governance, structure and accountability, the BAF, CRR and Directorate Risk Registers (DRR) continues to roll over until the Board approves Strategic Objectives for 2021/22

Board Assurance Framework (Appendix 1)

- There are **18 risks** on the Board Assurance Framework. Recommendations in the report take this to **17**.
- The **summary sheet (Appendix 1)** iterates the current mitigating actions/ controls in place for risks on the BAF and any further actions that are needed. Work continues on the review of individual risks ahead of a refresh of the BAF.
- **BAF action plans** are under regular review with Executives and their direct reports. All action plans are seen by the Executive Team and by the relevant Board Standing Committees on a quarterly basis. It is proposed that relevant Committees/Groups will approve/ sign off BAF action plans rather than the Executive Team going forward.
- The Risk Management and Assurance Framework Annual Report was well received by Audit Committee in April 2021
- The Trust is continuing to explore implementation of a bespoke electronic risk register system. All risk register demonstrations have taken place and information is being gathered for the procurement process following discussions with the Deputy Director of IM&T.
- Corporate objectives have been removed from the BAF

- **There are no risks recommended for escalation to the BAF**

- **The following risk is recommended for closure:**

ID	Risk	Rationale and discussion points
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community	In discussion with AG it is recommended that this risk closes as it is more about the right capacity for post-Covid surge and reducing out of area placements rather than preparing for the unknown. Reduce score to threshold and close.

- **The following risks (12) are amended as follows:**

ID	Risk	Rationale and discussion points
BAF63	If EPUT does not continuously learn and improve then serious incidents will occur resulting in a failure to achieve our safety strategy ambitions	Wording changed in discussion with AG and NH as requested at previous meeting
BAF4	If EPUT does not implement fire safety systems and processes then serious injury or death may occur resulting in Fire Authority enforcement action and failure to meet our safety ambitions	Wording changed to reflect Cause, Event and Effect. Further drilling down into this risk is underway before we make a decision on this risk going forwards. Improve evidencing of controls in particular driving up numbers of fire marshals and management of patients.

BAF10	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	Wording changed to reflect Cause, Event and Effect and following discussion at ESOG Additional mitigating actions identified.
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Wording changed to reflect Cause, Event and Effect.
BAF36	If EPUT does not set purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	Wording changed in discussion with AG and NH as requested at previous meeting. Additional mitigating actions identified.
BAF45	If EPUT does not learn from focused inspections, patient safety incidents and meeting CQC fundamental standard then further regulatory action may take place resulting in a failure to maintain or improve on our Good rating	Wording changed to reflect Cause, Event and Effect.
BAF55	If EPUT is not open, transparent or demonstrate learning from the Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	Risk score reduced to 5x3=15 following discussion at ESOG and reflection on mitigations and controls in place
BAF58	If EPUT does not record clinical activity in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety First Safety Always Strategy	Risk score reduced to 4x4=16 following discussion at ESOG and reflection on mitigations and controls in place
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT will be required to admit against clinical best practice, potentially resulting in failure to meet our patient safety ambitions and ensure provision of high quality care.	Risk score reduced to 4x4=16 and change in wording to reflect Cause, Event and Effect. Additional mitigations identified and additional mitigation actions identified. Discussions held in detail at ESOG.
BAF61	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	Risk score reduced to 4x4=16 and change in wording to reflect Cause, Event and Effect. Following discussion at ESOG.
BAF62	If EPUT does not use staff and resources effectively then staff recovery and recovery of services is compromised resulting in a failure to meet our People Plan and Safety ambitions	Risk score reduced to 5x3=15 and wording changed in discussion with AG and NH and following ESOG. Additional mitigations identified and additional mitigating actions identified.
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SUNEE	Risk score reduced to 4x3=12 and wording changed to reflect Cause, Event and Effect following ESOG.

- **There are currently two risks sitting at a score of 20 (extreme) following changes made**:

ID	Risk	Comments/Action
BAF50	If EPUT does not have the **skills, resource and capacity** to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	Need to ensure we implement new strategies in an integrated way. A new action plan will be developed for 2021/22
BAF57	If EPUT receives a substantial fine from the **HSE** court case then there may be a significant impact on resources and recovery from past failings, resulting in lower public confidence in our vision of 'safety first, safety always'	RMAF states more than £3m would see this risk materialise. External legal team is non-committal on estimate of fine.

BAF Action Plans

Work is taking place to ensure that there is an appropriate Committee allocated to each risk for approval, sign off and monitoring purposes in addition to the Standing Committee quarterly review and scrutiny.

Key Performance Indicators (Appendix 2)

All KPIs are showing improvement and RAG rated green.

Corporate Risk Register (Appendix 3)

- There are **14 risks** on the Corporate Risk Register
- Strategic objectives have been removed from the CRR
- There are no risks recommended for escalation to the CRR
- There are no risks recommended for closure on the CRR

- **The following risks are amended as follows:**

ID	Risk	Rationale and discussion points
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	Risk score reduced to 5x3=15 following discussion at ESOG and identification of additional mitigations.

Covid19 Risk Register Summary

The Covid19 Risk Register summary is provided to TB as part of the Covid 19 update report. There are no significant changes.

Mass Vaccinations Risk Register

The EPUT Mass Vaccination risk register has been updated. There are no significant changes.

EU Exit Trade Deal Risk Register

An EU Exit Trade Deal Risk Register is up to date and with monitoring through the monthly Task and Finish Group. One risks remains high, settlement scheme, this is detailed to TB as part of the EU Exit update report.

Directorate Risk Registers

Updates on Directorate Risk Registers continue on a regular basis and the accountability framework

will be introduced in due course

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	CRR	Corporate Risk Register
DRR	Directorate Risk Register	CQC	Care Quality Commission
IT	Information Technology	CVG	Covid19 Gold Risk
CVS	Covid19 Silver Risk	EU	European Union
RAG	Red Amber Green	ESOG	Executive Safety Oversight Group
KPI	Key Performance Indicators	IAPT	Access to Psychological Therapies
EOSC	Executive Operational Sub Committee	ECTAS	Electroconvulsive Therapy Accreditation Standards

Supporting Documents and/or Further Reading
Appendix 1 Summary of BAF as at 26 May 2021 Appendix 2 Key Performance Indicators (April 2021) Appendix 3 Summary of CRR as at 26 May 2021

Lead

Paul Scott
Chief Executive Officer

Agenda item 8a
Board of Directors Part 1
26 May 2021

EPUT

BOARD ASSURANCE FRAMEWORK 2021/22 MAY 2021

PURPOSE OF THE REPORT

This report presents the Board of Directors with an overview of the Board Assurance Framework and Corporate Risk Register 2021/22 as at 26 May 2021.

UPDATE AS AT MAY 2021

1. Board Assurance Framework 2021/22

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

There are 18 risks on the BAF. Recommendations in the report take this to 17. **Appendix 1** provides a summary of BAF risks as at May 2021 including a heat map of risks against the 5 x 5 scoring matrix and movement on scoring from June 2019 to May 2021. Corporate objectives have been removed from the BAF summary.

The ET BAF Sub-Group meets monthly to discuss the BAF and CRR and a Task and Finish Group meets in between to undertake further work.

Work on a BAF 'refresh' is underway in parallel with high-level governance, assurance and diagnostic work that will frame EPUT's strategic objectives for 2021/22. A training and development opportunity took place with the Board at its April development session facilitated by Amberwing. The current BAF and risk registers roll over into 2021/22 for the refresh to align with Board approval of new strategic objectives. In addition, procurement of an electronic risk register is underway to streamline systems and processes, facilitate ward to Board reporting and create real-time visual analytics. Introduction of an electronic risk register will align closely to the BAF refresh.

2. Recommendations for BAF escalation, closures and amendments

The key issues above iterate:

- Recommendation for one closure, BAF43 Surge Planning
- Recommendations amendments are outlined below:

ID	Risk	Rationale and discussion points
BAF63	If EPUT does not continuously learn and improve then serious incidents will occur resulting in a failure to achieve our safety strategy ambitions	Wording changed in discussion with AG and NH as requested at previous meeting
BAF4	If EPUT does not implement fire safety systems and processes then serious injury or death may occur resulting in Fire Authority enforcement action and failure to meet our	Wording changed to reflect Cause, Event and Effect. Further drilling down into this risk is

ID	Risk	Rationale and discussion points
	safety ambitions	underway before we make a decision on this risk going forwards. Improve evidencing of controls in particular driving up numbers of fire marshals and management of patients.
BAF10	If EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	Wording changed to reflect Cause, Event and Effect and following discussion at ESOG Additional mitigating actions identified.
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Wording changed to reflect Cause, Event and Effect.
BAF36	If EPUT does not set purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	Wording changed in discussion with AG and NH as requested at previous meeting. Additional mitigating actions identified.
BAF45	If EPUT does not learn from focused inspections, patient safety incidents and meeting CQC fundamental standard then further regulatory action may take place resulting in a failure to maintain or improve on our Good rating	Wording changed to reflect Cause, Event and Effect.
BAF55	If EPUT is not open, transparent or demonstrate learning from the Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	Risk score reduced to 5x3=15 following discussion at ESOG and reflection on mitigations and controls in place
BAF58	If EPUT does not record clinical activity in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety First Safety Always Strategy	Risk score reduced to 4x4=16 following discussion at ESOG and reflection on mitigations and controls in place
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT will be required to admit against clinical best practice, potentially resulting in failure to meet our patient safety ambitions and ensure provision of high quality care.	Risk score reduced to 4x4=16 and change in wording to reflect Cause, Event and Effect. Additional mitigations identified and additional mitigation actions identified. Discussions held in detail at ESOG.
BAF61	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	Risk score reduced to 4x4=16 and change in wording to reflect Cause, Event and Effect. Following discussion at ESOG.
BAF62	If EPUT does not use staff and resources effectively then staff recovery and recovery of	Risk score reduced to 5x3=15 and wording changed in discussion with

ID	Risk	Rationale and discussion points
	services is compromised resulting in a failure to meet our People Plan and Safety ambitions	AG and NH and following ESOG. Additional mitigations identified and additional mitigating actions identified.
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SUNEE	Risk score reduced to 4x3=12 and wording changed to reflect Cause, Event and Effect following ESOG.

3. BAF Action Plans

Potential risks on the BAF should have (in most cases) a detailed action plan to mitigate risks. ET reviewed BAF Action Plans in March 2021. Standing Committees reviewed their allocated risks in March 2021. BAF action plans are available on request. It is proposed that relevant Committees/ Groups will in future approve/ sign off BAF action plans.

4. Key Performance Indicators

Appendix 2 highlights Key Performance Indicators and progress against these for April 2021.

KPI	RAG
KPI 1 % risks with action plans completed by target completion date	↔
KPI 2 % stagnant risks	↓
2a % increased scores	↓
2b % decreased scores	↓
KPI 3 % current risks on BAF over 12 months	↔
3a % current risks on BAF over 24 months	↓
3b % current risks on BAF over 12 months (excluding known ongoing risks)	↔

5. Corporate Risk Register

There are 14 risks on the Corporate Risk Register. **Appendix 3** provides a summary of CRR risks as at May 2021 including a heat map of risks against the 5 x 5 scoring matrix.

There are no escalations or closures and one amendment as outlined below for May 2021.

ID	Risk	Rationale and discussion points
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	Risk score reduced to 5x3=15 following discussion at ESOG and identification of additional mitigations.

6. Covid19 Risk Register

The Covid19 Risk Register summary is an Appendix to the Covid19 Assurance report.

7. Mass Vaccinations Risk Register

The EPUT Mass Vaccination risks are agreed and updated monthly.

8. EU Exit Trade Deal Risk Register

An EU Exit Trade Deal Risk Register is up to date and with monitoring through the monthly Task and Finish Group. A separate Board report is on the agenda.

9. Directorate Risk Registers

Updates on Directorate Risk Registers continue on a regular basis with submission to Service Management Teams.

9. Recommendations

The Board of Directors is asked to:

1 Review the risks identified in the BAF 2021/22 May summary and approve the risk scores including recommended changes (Appendix 1) taking account of actions taken by EOSC at its April meeting
2 Approve the BAF risk escalations, closures and amendments iterated in key issues below
3 Note the April Key Performance Indicators (Appendix 2)
4 Note the CRR May summary table (Appendix 3) including actions taken by EOSC at its April meeting;
5 Approve the CRR risk escalations, closures and amendments iterated in key issues below
6 Identify any further risks for escalation to the BAF, CRR or Directorate risk registers

Report prepared by**:**

Susan Barry
Head of Assurance

On behalf of:

Paul Scott
Chief Executive

Table 1 – BAF 2020/21 Summary of Risks as at May 2021

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe and innovative services - Lead Director: Natalie Hammond - Impact of not achieving the Strategic Objective 5 (Consequence) x 3 (Likelihood) = 15 Risk Score							
BAF23	If EPUT does not monitor EU Exit trade deal areas without agreements or with further discussions pending then there may be unforeseen circumstances resulting in an impact on service delivery	PS and all Executives	Finance and Performance	Monitoring/ Project Action Log – EU Exit Group	• EU Exit (transition) deal in place • Task and Finish Group in place and meeting monthly • Risk Register in place • Action log in place, monitored and updated monthly • EU Admin meeting monthly • Daily sitrep through Silver Command • Assessment of financial risks in supply chain is that there is negligible impact • EU Settlement Scheme – 50 staff have settlement status and 14 are in application process • HR communicating directly with those needing settlement status • New guidance documentation development re settlement status	**Risk score unchanged 4 x 3 = 12** **Target date June 21 4 x 2 = 8**	• Maintain watching brief on gaps during first six months of deal ○ Data adequacy ○ Mutual recognition of professional qualifications ○ EU staff ○ Medicinal products approval process ○ Pharmacovigilance co-operation • Retain on BAF whilst there is a national expectation to do so • EU Settlement Scheme – as at March 21 110 staff are working on EU passports and require settlement status (45 permanent staff, 3 fixed term staff, 57 bank/locum and 5 honorary workers) • Leads to have conversations with above staff and signpost for assistance • Weekly communications are planned from May 21 • Support clinics planned from end April

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF63 (replaces BAF32 and BAF35)	If EPUT does not continuously learn and improve then serious incidents will occur resulting in a failure to achieve our safety strategy ambitions	NH supported by all Executive Leads	Quality	Action Plan to be developed - ESOG	• Approval of Safety First, Safety Always Strategy • Workstream in place for continuous learning as part of the Safety First, Safety Always Strategy Implementation Project • Task and Finish Group in place (NED led) to integrate quality improvement, research and innovation with governance arrangements • Key principles set • Newton Diagnostic work is the first partnership in relation to Quality Improvement • Executive Safety Oversight Group in place – will monitor action plan	**Score agreed by Executive Team April 5 x 3 = 15** **Align target date with Safety First, Safety Always** **Target score 5 x 2 = 10**	• Newton action plan • As part of the Safety First, Safety Always Strategy ensure improvement journey is a continuing process by taking urgent actions to ensure safe care and developing a culture of continuous learning and improvement • Implement PSIRF • Improve record keeping • Take urgent action on estate and security issues • Appoint Senior Safety Specialist • Scope EPUT Trust wide infrastructure to integrate Executive portfolios into learning and forums at all levels – Individual, Team, Profession, Service and Directorate • Ensure Accountability Framework enables a management leadership culture with mechanisms and processes for robust governance, monitoring and assurance • Approval of implementation plan for Safety First, Safety Always Strategy • Develop standardised language for understanding and communicating continuous learning • Develop action plan • Create dedicated learning time and mentorship • Consider masterclasses as part of the MDP • Develop alternative to SI approach to move to continuous learning • Two year organisational transformation

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF4	If EPUT does not implement fire safety systems and processes then serious injury or death may occur resulting in Fire Authority enforcement action and failure to meet our safety ambitions	TS	Finance and Performance	Action Plan monitoring by FSG	• Trust follows all relevant statutory fire safety legislation and adheres to articles of RRO, HTM Fire Code and Government standards/ guidance as best practice • Fire Safety Policy updated and approved at April 21 FSG • Fire Safety Group (Executive led) • Rolling Fire Strategy programme in place • Fire Risk Assessments in place with spot checks undertaken • Remedial action trackers in place and monitored • Directorate Risk Registers have this risk mirrored particularly in relation to fire wardens and fire drills • BAF action plan 2020/21 to FSG for approval April 21 • BAF action plan 2021/22 to FSG for approval April 21	**Risk score unchanged 5 x 3 = 15** **Target date March 2022 4 x 3 = 12**	• Fire drills remain an issue although there is some improvement in form completion for fire evacuation drills. Training to include a reminder that form should be in site folders. • Fire wardens remain a significant issue monitored through FSG • Fire risk assessment remedial works is an ongoing rolling action for the year monitored through FSG • Vaccination hub FRA programme and contractor Covid restrictions continue to impact on FRAs • Category 1 and 2 fire training compliance below target end February • This will link to the accountability framework to ensure clear responsibility for key issues such as fire wardens and fire drills • TS to discuss/ drill down with PM to establish what risks EPUT faces in relation to fire safety • Improve evidencing of controls, in particular driving up number of fire marshals and management of patients

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF10	IF EPUT does not continue to implement a reducing ligature risk programme of works (environmental and therapeutic) that is responsive to ever changing learning, then there is a likelihood that serious incidents may occur, resulting in failure to deliver our safety first, safety always ambitions	TS supported by PS and all Executives	Quality	Action Plan monitoring by LRRG	• Ligature Risk Policy, Procedures and Assessment Process in place • Ligature Risk Training / Awareness Programme in place and monitored • Ligature inspection programme • Floor plan heat maps in place • Ligature Risk Stratification Process including cross referencing with ligature assessments • Ligature Risk Reduction Group • Executive Lead in place • Quarterly reporting to HSSC, Quality Committee and four monthly to Board • Suicide prevention and general ligature e-learning training linked • Human factors training and reflection included in OLM programmes • Retrospective review of serious incident action plans carried out and followed up monthly through LRRG with assurance to LOSC • Recommendations from BDO audit implemented • New corporate risk identified for all inpatient areas from increased ligature incidents involving towels and bedding supplied by new contractor – risk shared by operations, estates/ facilities, and compliance/ assurance	**Risk score unchanged 5 x 3 = 15** **Target date to be aligned with approved action plan** **Threshold 4 x 3 = 12**	• Develop project plan on open actions and non-compliance, looking at actions more than three years old. ESOG to monitor governance process. Still cross-referencing 3i system with Datix to identify gaps • Mitigation statement work added to Ligature Co-ordinator work plan for further action when new post holder in place • Increase awareness and ownership of ligature reduction work at all levels of the organisation • Review Tidal Training for 2021/22 • Develop the process of governance around ligature reduction work including a SOP for use of 3i system and a resource to input and monitor • Review policy by March 22 • Review LRRG TOR by Jan 22 • Review Anti-Ligature shop and the Design in MH Forum work • Re-establish local area ligature forum • Re-instate ligature audit process • Ligature Coordinator Vacancy to be recruited to

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF38	If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	PS	Finance and Performance	Monitoring/ Covid19 Action Log - Command Structure	• Executive lead in place for EPRR • Business Continuity Plans in place and undergoing constant review • Gold, Silver and Bronze Command well established • Sit rep daily monitoring • Covid intranet page and range of staff training in place	**Risk score remains at threshold 5 x 2 = 10** **Target date – ongoing throughout pandemic**	• None identified

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF36	If EPUT does not set purposeful admissions then ward environments may become volatile and difficult to manage resulting in increased length of stay and failure to meet our safety ambitions	AG supported by MK/NH/PS	Quality	Action Plan / Task and Finish Action Log	• BAF action plan completed for 2020/21 • Work has been undertaken on meaningful principles for admission and psychology services to be part of the MDT to link with community services • A task and finish group has been set up with terms of reference and an action log. First meeting discussion purposeful admission, therapeutic offer/model, EUPD Management principles, BAF risk, safety first safety always strategy, implementation and mobilisation plan • Second meeting of Task and Finish Group has moved forward on purposeful admission, therapeutic offer/model • Joint working between operations, psychology services and medical	**Risk score unchanged 5 x 3 = 15** **Target date March 22 Threshold 5 x 2 = 10**	• Agree outcome based accountability template as part of quality improvement forum and purposeful admissions work stream • Agree how we provide care and treatment to individuals diagnosed with Emotionally Unstable Personality Disorder management in acute inpatient settings • Firm up Terms of Reference and Membership of Task and Finish Group • Scope current activity/ therapeutic programme baseline; impact of Covid19 alternatives; therapeutic offer proposals for next three years pending MHIS funding • Develop action plan in conjunction with task and finish group • Get new model up and running for purposeful admission with robust mechanisms for flow and length of stay, and allow 12 months to embed before closing risk • Take immediate action around current long-stay patients by taking to Executive panel

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF45	If EPUT does not learn from focused inspections, patient safety incidents and meeting CQC fundamental standard then further regulatory action may take place resulting in a failure to maintain or improve on our Good rating	PS supported by all Executives	Quality	Action Plan monitored by ESOG	• CQC 'to outstanding' meetings with operational teams • Quality and Safety meetings – CQC on agenda • Operational meetings – CQC on agenda • Clinical Support Groups • Quality leads in place for operations • Compliance Team with Clinical Leads • Monitoring through Executive Safety Oversight Group and Quality Committee • Internal support visits, expanded to include participation from corporate nursing team. All wards visited March-May2021 • Action plan testing ongoing as part of compliance workstream this includes testing against findings from CQC warning notice • Safety First, Safety Always Strategy and implementation plan • Preparation project plan in place and 90% implemented • Dedicated communications team resource • New inspection resources issued and revamped CQC intranet page • Regular reporting to ESOG, QC and TB	**Risk Score Reduced to 4 x 3 = 12 due to preparation project** **Target date July 2021 Threshold 4 x 2 = 8**	• PHSO/HSE action plan testing 21/22 • Develop action plans from all internal support visits to wards • Implement all action plans from internal support visits • Implement conduit between compliance team and Matrons • Ensure communications strategy in place to work at pace up to, during and post inspection

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF54	If EPUT is not open, transparent or demonstrate learning from the Independent Inquiry then it may not deal with the consequences of past failings resulting in undermining our Safety First, Safety Always Strategy	NL/All Executives	Quality	Monitoring	• Executive Lead identified • Establishing governance arrangements • Updated stakeholders including NHSE/I • Principles developed on EPUT approach • Job matching and posts advertised on secondment or permanent basis • Core team with appropriate skills, and resources required to support EPUT internally	**Risk score reduced to 5 x 3 = 15 due to positive steps taken** **Target date April 23 (or length of Inquiry)** **Threshold 5 x 2 = 10**	• Awaiting Terms of Reference
BAF57	If EPUT receives a substantial fine from the HSE court case then there may be a significant impact on resources and recovery from past failings, resulting in lower public confidence in our vision of 'safety first, safety always'	NL/TS	Finance & Performance	Monitoring	• Executive Lead in place • All actions taken in relation to HSE investigation • Guilty plea submitted • 'Safety First Safety Always' Strategy approved at January Board • Meeting with lawyers	**Risk score unchanged 5 x 4 = 20** **Target June 2021 Threshold 5 x 2 = 10**	• Implementation of Safety First Safety Always Strategy • Communications plan • Sentencing date has been re-scheduled for June 2021

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF58	If EPUT does not record clinical activity in real time, accurately and on the patient information system(s) then patient and staff safety is compromised resulting in failure to deliver its Safety First Safety Always Strategy	AG/MK	Quality	Action Plan to be developed by project team	• Recognised that this is a fundamental shift in philosophy with 5% gap being identified as patient safety risk, rather than the tolerated variance • 'Safety First Safety Always' Strategy approved at January Board • Task and finish group set up with Chairs of Quality and Safety Groups, Clinical Governance, Performance and Assurance Teams – met 1 April • Operations project team lead identified	**Risk score reduced 4 x 4 = 16 due to mitigations in place** **Target to be aligned with project action plan** **Threshold 4 x 2 = 8**	• Project Team to be set up with Operations Lead, Terms of Reference and link to appropriate Committee for monitoring • Specialist Services identified a problem with the Medical Secretariat. Whilst records are now contemporaneous there is a backlog going back to October 2020 that needs addressing. This may be more widespread than Specialist Services.
BAF50	If EPUT does not have the skills, resource and capacity to deliver on high quality care and other wide ranging of priorities and pressures then achieving our organisational objectives may be compromised resulting in stagnation of risks and failure to maintain our position within the system	PS and all Executives	PIT	Action Plan to be developed for 2021/22	• Participation in system calls • Command structure in place for Covid19 • Project Board in place for mass vaccination programme • Project Group for EU Exit Trade Deal • Creating resilient teams • Continuous improvement work stream as part of Safety First, Safety Always Strategy • Collective leadership – identifying senior talent, succession planning and Quality Champions • Leadership handbooks • Robust and forward thinking Executive Leadership Team	**Risk score unchanged 5 x 4 = 20** **Ongoing for duration of pandemic** **Threshold 5 x 2 = 10**	• Programme Management Office related to Safety First, Safety Always Strategy • Develop new strategic and corporate objectives for 2021/22 and articulate risks to achieving those • Newton diagnostics to ensure systems and processes are effective • Preparation for Independent Inquiry • Bolstering staffing and project support as required • Redefining Executive portfolios to best manage services and resources • Surge planning for post Covid19 • Develop a new action plan for 2021/22

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF64	If the pressure continues for local, regional and national CAMHS Tier 4 capacity, then there is the risk EPUT will be required to admit against clinical best practice, potentially resulting in failure to meet our patient safety ambitions and ensure provision of high quality care.	AG	Quality	Action Plan in development – ESOG to monitor	• Task and Finish Group led by MSE looking at social care aspects of crisis • A model has been identified for crisis bed management founded on evidence based practice • Negotiations are in place with partners including NELFT, providers of community services for young people • Mitigation currently is inappropriate care in HBOS beds, Emergency Departments and adult inpatient beds • Ongoing system working including collaboration with acute sector, work with ICS's, work with Local Authorities and regional focus.	**New risk Score 4 x 4 = 16** **Target Score 4 x 2 = 8** **July 2021**	• Agree a crisis care pathway and Standard Operating Procedure • Reprofile agreed number of beds at Larkwood and Poplar Wards that are gate kept as crisis beds for a maximum stay of 10 days • Identify and agree any resource implications • Agree a go live date • Work closely with NELFT CYPS community provider • Evaluate service after agreed time period • Action plan to be developed • Engage with the Regional system and escalate capacity shortfall for low secure placements, crash pads and support for 'looked after children' to all quality surveillance groups • Address pressures from the community and top down (regional and national) to fill gaps in the system

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts - Lead Director: Paul Scott supported by all other Executive Directors - Impact of not achieving the Strategic Objective 4 (Consequence) x 3 (Likelihood) = 12 risk score							
BAF61	If EPUT does not address inequalities then it will not embed, recognise and celebrate equality and diversity resulting in a failure to meet our People Plan ambitions	SL supported by all Executives	PIT	Action plan to be developed and monitoring by EIG	• Risk was escalated from Corporate Risk Register to the BAF in March 2021 • Range of Equality and Diversity Networks • Equality and Inclusion Hub on InPut • Staff Network pages and virtual networks • Equality Champions • Equality, Diversity and Inclusion Group • The NHS People Plan • Equality Advisor and Network Chairs • Executive Lead	**Risk score reduced 4 x 4 = 16** **Target March 2022 or aligned with action plan when complete** **3 x 2 = 6**	• People and Culture Team will be undertaking an Equality and Diversity root and branch review • Engagement of a senior Equality, Diversity and Inclusion lead • Develop BAF action plan
BAF62	If EPUT does not use staff and resources effectively then staff recovery and recovery of services is compromised resulting in a failure to meet our People Plan and Safety ambitions	SL supported by all Executives	PIT	Action Plan to be developed and monitoring group to be identified	• Diagnostic work being undertaken by Newton around Health Rosters, reliance on temporary staff and establishment budgets • Proposal presented to EOSC regarding staffing establishment issues and the larger piece of work that needs to take place in reviewing staffing numbers and skills mix to mitigate this risk • Daily management of resources in place • Recovery support in place • Recruitment successes	**Risk score reduced 5 x 3 = 15** **Target Nov 21 5 x 2 = 10**	• Develop action plan from Newton diagnostic work • Transfer Bank staff into permanent roles to fill vacancies to capacity of safer staffing levels • Establishment review as part of project initiation document • Allocate software diagnostic around rostering software • Develop risk into two distinct risks (Staff and Services). Develop action plan that reflects all strands of this risk – review of systems and processes, staff recovery, and recovery of services

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF41	If recurrent CIPs for 2020/21 are not identified then delivery of the programme is compromised resulting in a challenge to the sustainability of EPUT going forward	TS (financial)	F&P	Monitoring through performance meetings	• The Trust's internal Cost Improvement target for 20/21 is now £8.6m from the initial £11.7m because of the suspension of 2020/21 national efficiency requirement • A total of £7.1m remains to be identified recurrently from historic shortfalls	**Risk score unchanged 3 x 4 = 12** **Target April 2021** **Threshold 4 x 2 = 8**	• The focus remains on delivery of the full recurrent efficiency • Executive sign-off meetings need to take place to ensure full approval of agreed schemes • Month 12 update to follow • Bring forward £7m underlying recurrent shortfall CIPS from previous years to 2021/22 plus any new year requirement • Update risk for 2021/22 following completion of M12 updates
BAF42	If the Covid19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	Finance & Performance	Monitoring through finance meetings	• The revised planned deficit is £8.3m • The Trust has received an additional £8.3m income from NHSE/I in recognition of national planning process income error assumptions • In February 2021 M11 as a consequence of the above the Trust recorded a surplus of £6.2m against the planned deficit of £1.3m (year to date surplus £2.2m against the planned deficit £6.8m) • The forecast outturn is £2.7m deficit • M11 year to date Covid19 costs of £13.3m with M7-M12 recovery anticipated from M&SE and H&CP • M11 cash was £112.9m, which remains better than planned • Continuous monitoring through reporting to F&PC, EOSC, and Board	**Risk score unchanged 4 x 3 = 12** **Target April 2021 Threshold 4 x 2 = 8**	• Continue to monitor financial situation and Covid19 costs to ensure recovery • Month 12 update to follow • Financial planning for 2021/22 – draft plan by 6 May and final plan by 3 June (system and internal colleagues)

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
BAF43	If EPUT does not plan for an expected surge in demand for Mental Health services or physical CHS and rehabilitation during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community Consider closing this risk (discussion with AG) – more about the right capacity for post-Covid surge and reducing out of area placements	AG	People Innovation and Transformation	Monitoring of surge plans	• A phased plan remains in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiatives in place • From Nov to Mar 21 winter funding schemes signed off, implemented/ monitored, underpinned by MH Winter KLOE's • Topaz Ward re-opened to provide additional mental health surge capacity • 18 spot purchase beds available at The Priory • Allocation of additional funding confirmed on STP/ICS footprints to support capacity and flow; schemes developed which address both process and capacity • This may be a longer term risk but all current resources are targeted at management of the pandemic incident	**Recommend closure of risk** **Risk score to reduce to 5 x 2 = 10** **Target date June 2021** **Threshold 5 x 2 = 10**	• Contingency plans include exploring use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk • Issues with Topaz Ward refurbishment resolved and ESOG will be asked to sign off by end of March prior to opening – now likely to be early April • Review monitoring / action planning

Risk ID	Potential Risk	Exec Lead	Standing Committee	Action Plan/ Monitoring	Mitigating Actions/ Controls in Place	Risk scoring status (consequence x likelihood) Target Score/ Date/ Assurance	Actions outstanding / further mitigating actions required
Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve - Lead Director: Nigel Leonard supported by all other Executive Directors - Impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score							
BAF51	If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SUNEE	NL	Quality	Monitoring by Project Management Group	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Programme Board in place • Allocation of some sites to be operated by acute partners • Working with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Guidance implemented on Oxford Astra Zeneca Vaccine • Security Audits • All costs passing through NHSE and laptop costs supported by skill mix work • Robust communication in place with vaccination centre • Good coverage in both MSE and SUNEE with robust joint working (rationale for reducing consequence to 4)	**Risk score reduced 4 x 3 = 12** **Target date is ongoing for the duration of the mass vaccination programme** **Target 4 x 2 = 8**	• No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations • Awaiting outcome of extension to existing licences for premises • Alternative models may be implemented including mobile vehicles and drive through centres which will require alternative skill mix • Work to ensure that individuals are not at risk of missing a second vaccine due to booking system • Maintain watching brief on variable vaccine supply and impact on programme

Table 2 – Heat Map against 5 x 5 scoring matrix

		RISK RATING				
		Consequence				
		1	2	3	4	5
Likelihood	1					
	2					41 ↓ 38 ↔
	3				23 ↔ 42 ↔ 45 ↓ 51↓	4 ↔ 10 ↔ 36↔ 54 ↓ 63 ↔ 62↓
	4				58 ↓ 64 ↔ 61 ↓	50↔ 57 ↔
	5					

Table 3: Movement on scoring – period from May 2019 to April 2021 *Notes: Risks closed for over two years removed from table*

Risk ID	Initial Score	Jun 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Risk ID
BAF4	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF4
BAF6	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔																		BAF6
BAF9	16	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	8↓	8↔	8↔	8↔	close			BAF9
BAF10	12	15↔	15↔	15↔	15↔	15↔	15↔	20↑	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF10
BAF13	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	6↓													BAF13
BAF14	12	12↔	12↔	12↔																						BAF14
BAF15	15	15↔	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	Close							BAF15
BAF16	12	12↔	12↔	12↔																						BAF16
BAF18	15	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔													BAF18
BAF20	12	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close						BAF20
BAF21	15	8↔	8↔	8↔	8↔																					BAF21
BAF22	16	9↔	9↔	9↔	9↔																					BAF22
BAF23	15				20↑	20↔										Esc	20	20↔	16↓	16↔	12↓	12↔	12↔	12↔	12↔	BAF23
BAF28	16	12↔	12↔	12↔																						BAF28
BAF30	12	12↔	12↔	12↔	12↔																					BAF30
BAF31	16	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	Close							BAF31
BAF32	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	close		BAF32
BAF33	12			New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	6↓													BAF33
BAF34	16				New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	8↓							BAF34
BAF35	16				New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	close			BAF35
BAF36	15						New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	BAF36
BAF37	15								New	15	15↔															BAF37
BAF38	15									New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	BAF38
BAF39	20									New	16															BAF39
BAF40	12											New	12	16↑	16↔	16↔	12↓	12↔	Close							BAF40
BAF41	16											New	16	16↔	16↔	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	10↓	BAF41
BAF42	12											New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	BAF42
BAF43	20											New	15	20↑	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	20↔	close	BAF43
BAF44	12												New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	close			BAF44
BAF45	12												New	12	12↔	12↔	12↔	12↔	12↔	16↑	20↑	20↔	20↔	20↔	12↓	BAF45
BAF46	16													New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	close			BAF46
BAF47	16														New	16	16↔	16↔	16↔	16↔	16↔	16↔	close			BAF47
BAF48	16														New	16	16↔	16↔	Close							BAF48
BAF49	15														New	15	15↔	15↔	8↓							BAF49
BAF50	20																	New	20	20↔	20↔	20↔	20↔	20↔	20↔	BAF50
BAF51	20																	New	20	20↔	20↔	15↓	15↔	12↓	9↓	BAF51
BAF52	20																	New	20	20↔	20↔	Close				BAF52
BAF53	20																	New	20	20↔	20↔	20↔	close			BAF53
BAF54	20																		New	20	20↔	20↔	20↔	20↔	15↓	BAF54
BAF55	20																		New	20	15↓	15↔	close			BAF55
BAF56	20																		New	20	Merge	Close				BAF56
BAF57	20																		New	20	20↔	20↔	20↔	20↔	20↔	BAF57
BAF58	20																		New	20	20↔	20↔	20↔	20↔	12↓	BAF58
BAF59	20																	Esc	from	CRR	20	Close				BAF59
BAF61	20																						20	20↔	16↓	BAF61
BAF62	20																						20	20↔	15↓	BAF62
BAF63	20																						New	20	20↔	BAF63
BAF64	16																						New	16	16↔	BAF64

Table 4: Milestones

Risk ID	Initial Score	Length of time on BAF	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 22	May 21	Risk ID
BAF4	15	> 2 years																									BAF4
BAF9	16	> 2 years				16↑								12↓						8↓				Closed			BAF9
BAF10	12	> 2 years							20↑					15↓													BAF10
BAF20	12	> 2 years																			Closed						BAF20
BAF23*	15	> 2 years				20↑													20↔	16↓		12↓					*BAF23
BAF32	16	> 2 years																		12					Closed		BAF32
BAF35	16	> 1 year				New	16																	Closed			BAF35
BAF36	15	> 1 year						New	15																		BAF36
BAF38	15	> 1 year									New	15															BAF38
BAF41	16	> 6 months											New	16					20↑	12↓							BAF41
BAF42	12	> 6 months											New	12					16↑	12↓							BAF42
BAF43	20	> 6 months											New	15	20↑											Closed	BAF43
BAF44	12	> 6 months												New	12									Closed			BAF44
BAF45	12	> 6 months												New	12						16	20↑					BAF45
BAF46	16	> 6 months													New	16								Closed			BAF46
BAF47	16	>6 months															16							Closed			BAF47
BAF48	16	<6 months															16			Closed							BAF48
BAF49	15	<6 months															15			Closed							BAF49
BAF50	20	<6 months																	New	20							BAF50
BAF51	20	<6 months																	New	20			15↓		12↓		BAF51
BAF52	20	<6 months																	New	20			Closed				BAF52
BAF53	20	<6 months																	New	20				Closed			BAF53
BAF54	20	<6 months																		New	20						BAF54
BAF55	20	<6 months																		New	20	15↓		Closed			BAF55
BAF56	20	<6 months																		New	20	Merge	Closed				BAF56
BAF57	20	<6 months																		New	20						BAF57
BAF58	20	<6 months																		New	20						BAF58
BAF59	20	<6 months																				20	Closed				BAF59
BAF61	20	<6 months																						20			BAF61
BAF62	20	<6 months																						20			BAF62
BAF63	20	New																							20		BAF63
BAF64	16	New																							16		BAF64

Key Performance Indicators for Board Assurance Framework 20th May 21

KPI Ref	Key performance indicator (KPI)	Target	Oct 20	Nov 20	Dec 20 * recommended risks included	Q3 YTD * recommended risks included	Jan 21	Feb 21	Mar 21 * recommended risks included	Q4 YTD * recommended risks included	Apr 21 * recommended risks included
Total number of risks on BAF			**22**	**20**	**24* (19)**	**24* (19)**	**25**	**22**	**24* (20)**	**24* (20)**	**19* (17)**
KPI 1	% risks with action plans completed by target completion date	90%	100% (1)	0	0	Q3 100% (1)	0	0	100% (2)	100% (2)	100% (5)
KPI 1a	Number of risks open with action plans fully completed	Information only	0	0	0	0	0	0	2* (0)	2* (0)	5* (action plans replaced with new)
KPI 1b	Number of risks with open action plans	Information only	11	10	12*(11)	12*(11)	9	10	10* (8)	10* (8)	4*
KPI 1c	Number of risks with no action plan	Information only	10	10	14*(13)	14*(13)	15	12	14* (12)	14* (12)	14* (13)
KPI 1d	Number of risks closed/de-escalated in month (YTD)	Information only	0	6	1*	Q3 7*(6) YTD 11*(10)	0	3	4* (0)	7* YTD 18*(14)	1* (3)
KPI 1e	Number of new/ escalated risks in month (YTD)	Information only	0	4	5*	Q3 9*(4) YTD 19*(14)	0	0	2* (0)	2* (0) YTD 21*(19)	2* (0)
KPI 2	% stagnant risks (no movement)	Less than 30%	68% (15)	40% (8)	57.8% (11 of 19)	57.8%	56%	45%	55%	55%	↓
KPI 2a	% of increased risks	Less than 10%	18% (4)	20% (4)	26% (5 of 19)	26%	0%	9%	10%	10%	0%↓
KPI 2b	% of decreased risks	60%	13% (3)	25% (5)	26% (5 of 19)	26%	8%	4.5%	10%	10%	↓
KPI 3	% of current risks on BAF over 12 months	Less than 40%	45% (10)	35% (7)	21% (4 of 19)	21%	8%	9%	15%	15%	11.7%↓
KPI 3a	% of current risks on BAF over 24 months	Less than 30%	22.7% (5)	15% (3)	15.7% (3)	15.7%	20%	22.7%	25%	25%	0%↓
KPI 3b	% of current risks on BAF over 12 months (excluding known ongoing risks)#	0%	36.8% (7 of 19)	23.5% (4 of 17)	6% (1 of 16)	6%	0%	0%	0%	0%	0%↔

Notes:

* recommended risks (April) included – figure in parenthesis does not include these risks and % calculations do not include recommended risks

#known ongoing risks – BAF4 Fire Safety BAF10 Ligature Reduction BAF41 CIPs

BAF23 not included in KPI3/3a/3b – intermittent on BAF over two-year period

Any action plans of risks carried forward into a new financial year are reviewed and updated

Table 1 – CRR 20/21 Summary of Risks as at May 21

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Corporate Objective 1: To provide safe and high quality services during Covid19 pandemic – Lead: Paul Scott supported by all Executive Directors – impact on not achieving the strategic objective C5 x L3 = 15 risk score						
CRR11	If EPUT fails to implement and embed its Suicide Prevention Strategy into Trust services then it may not track and monitor progress against the ten key parameters for safer mental health services resulting in not taking the correct action to minimise unexpected deaths and an increase in numbers	NH supports by MK	Quality Committee and Sub-Committees	• Implementation of 2018-20 Suicide Prevention Strategy • Local reflective sessions • Schwartz Rounds (funded project with structure and governance) • Links to ligature reduction	**Risk score unchanged 4 x 3 = 12** **Target March 2022 4 x 2 = 8**	• A plan in place for review of the 2018-20 Suicide Prevention Strategy • Implementation of revised Strategy • Align with Safety First, Safety Always Strategy
CRR64	If EPUT experiences further serious inpatient safety incidents then high quality patient care is compromised resulting in additional regulatory scrutiny and failure to achieve our Safety First, Safety Always ambitions	AG	LRRG	• Risk closely aligned to BAF10 Ligature reduction • Information requests to CQC responded to in a timely manner • Joint meetings across operations to encompass learning from serious incidents • Learning is a key risk for 2021/22 with a Trust wide approach	**Risk score unchanged 4 x 3 = 12** **Target March 2022 4 x 2 = 8**	• Serious incident resulting in death related to an abscond from Finchingfield saw this risk materialise with an unannounced visit from CQC • Serious incident resulting in death related to ligature on Henneage also saw this risk materialise • Serious incident at St Aubyn Centre saw risk materialise • Put into effect Safety First, Safety Always Implementation Plan

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR75	If EPUT does not achieve ECTAS accreditation then there may be adverse media coverage resulting in a lack of public confidence in the services offered to our patients	MK	ESOG	• EPUT is working to ECTAS standards • EPUT is prepared for the accreditation inspection	**Risk unchanged 4 x 3 = 12** **Target date June 21 4 x 2 = 8**	• Awareness of media/social media activism related to ECT • Delay in accreditation is due to Covid19
CRR48	If EPUT is unable to suitably fill consultant vacancies across clinical services on a substantive or locum basis then the Trust may not be able to deliver safe and effective services, resulting in poor patient flow and possible patient harm	MK	Medical Staffing Committee	• Cover maintained by locum and agency staff • GMC approval to allow overseas doctors to work in the UK • National Fellowship Scheme in place • Staffing deployment is a key risk for 2021/22	**Risk score unchanged 4 x 4 = 16** **Target September 2021 4 x 2 = 8**	• Continue to recruit to vacancies - there are 20 Consultant vacancies, of which Locum posts cover 16. Locums remain hard to source.
CRR68	If EPUT does not complete annual General Workplace Risk Assessments or they are of poor quality then its statutory requirement is not met resulting in non-compliance with CQC well led standards	PS supported by all Execs	HSSC	• A Task and Finish Group within the Risk, Compliance and Assurance Directorate reviewed and simplified risk assessment paperwork, looking at other Trusts' paperwork as well as HSE guidance • Legal advice received on proposed documentation • Discussion through HSSC	**Risk score unchanged 4 x 4 = 16** **Target June 2021 4 x 2 = 8**	• Formal launch of new GWPRA documentation
CRR74	If EPUT inpatient areas do have robust airlocks in place for access/egress then patients detained under the MHA may abscond resulting in potential serious harm to patients, staff or the public	TS	Executive Safety Oversight Group	• Recent incident on Finchingfield resulted in the death of a patient, injury to a member of staff and a focused inspection by the CQC – all action taken as required by the CQC inspection report • Linden Centre work completed • Rochford work completed • The Lakes work completed	**Risk score unchanged 5 x 3 = 15** **Target Mar 21 5 x 2 = 10**	• TS to pick up with PM to see if this can close • HSSC action log requested a one page report confirming the scope of the airlock work – phase 1 perimeter phase 2 interior • Peter Bruff and Gloucester to be considered in the paper

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR76	If EPUT continues to receive inferior quality towels and bedding from its contractor then ligature incidents are increased resulting in possible serious patient harm	TS	ESOG/LRRG	• Contractor has visited site to review quality of towels and agreed to add new towels to the system • Manufacturer confirmed towels are for high risk areas • Observation and engagement • Datix analysis undertaken • Safety Alert issued reminding staff to return any sub-standard towels and bedding	**Risk score reduced 5 x 3 = 15** **Target June 21 5 x 2 = 10**	• Ensure patient privacy and dignity is not compromised • Enhanced observation and engagement • Look at alternative options for towels as they continue to be an issue • Deep dive into how towels are being torn • Consult Mental Health Forum
CRR77	If EPUT does not track missing or unregistered medical devices then unsafe, non-serviced, non-calibrated may be in use resulting in a failure to achieve our safety first, safety always strategy	NH	Medical Devices Group	• Robust procurement process in place	**Risk score unchanged 4 x 4 = 16** **Target date Sept 21** **4 x 2 = 8**	• Analysis of medical devices inventory • Medical Devices lead to communicate with teams • Confirm Executive Leadership for Medical Devices • Streamline inventory • Establish financial impact of contracts for missing devices • Review Medical Devices policy including definitions • Identify resource for medical devices
CRR40	If the Trust is not adequately prepared, or there is a lack of funding for the cyber team, it could be subject to a cyber-attack that compromises clinical or corporate IT systems, and the consequent cost pressure may result in a financial risk to EPUT	TS	ESOG PST	• Windows 10 upgrade licences now purchased • Cyber Essentials Accreditation • Cyber Team in place • Robust updates and patching	**Risk score unchanged and at threshold 4 x 2 = 8**	• None

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR53	If the dormitory elimination project plan is not implemented in line with agreed timescales then there could be a delay to providing single bedroom accommodation by 2021 which could potentially impact on CQC ratings and patient experiences.	TS	Capital Group	• Phases 1 and 2 completed • Tender specification document issued to contractors end Jan 21 • Phase 3: Cherrydown and Kelvedon – redundant pipe work complete. Infrastructure on Cherrydown installed – cabling, new heating pipework, potable water and domestic water services. Walls, ceiling constructed, and being plastered. • Phase 4 moving Cherrydown Ward to Langdon Unit and Sankey House and relocate Kelvedon Ward to Willow Ward completed • Phase 8 alterations to the Assessment Unit to reduce bed numbers to 18 and create better male and female segregation	**Risk score unchanged 4 x 3 = 12** **Target date March 2022**	• Phase 3: Cherrydown and Kelvedon Ward – Kelvedon slippage due to additional works to remove old pipes and access issues. Late request for assisted bathrooms and these will be in the Assessment Unit. Some access issues due to Covid. Additional work taking place to BMHU in order to remove ligature points, improving ventilation and heat loss as well as aesthetic appearance. • Phase 4 Grangewater Ward/ Thorpe Ward – affected by delays above; works include refurbishing the ward to 16 single en-suite bedrooms. Work planned 21/22. Thorpe Ward will become a staff rest and change area with some offices, touchdown, meeting, conference and training rooms

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR34	If EPUT does not train and support staff effectively in suicide prevention then staff may not have the necessary skills or confidence to support suicidal patients resulting in self-harm or death and a failure to achieve our safety first, safety always strategy	NH supported by MK	Suicide Prevention Group	• Training is now virtual • Suicide prevention month provided a range of events and opportunities for learning for all staff • Access and assessment services no longer exist in West and North East are moving away from this service to new community assessment model. The new Crisis 24 team are also taking referrals • Community transformation paper signed off in NEE, redesign of CMH pathways and provision of IAPT through EPUT • Transparent monitoring through contracting • MH/LD network members discussion on Suicide Prevention Training	**Risk score unchanged 3 x 3 = 9** **Target March 2022 3 x 2 = 6**	• Exploring Connecting for People training virtual delivery • Improvement trajectory and reporting on suicide prevention training. • Raise frequency of training and adherence to targets with workforce as budget/resource holder – continue dialogue • Cover required for appointed suicide prevention trainer for 12 months commencing late 2021 • Explore whether role can be moved to Nursing Directorate to provide closer support/management and oversight • Workforce undertaking review of suicide prevention training • Business case to be produced for training

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
CRR72	If EPUT does not have a suitable IT/communication systems in place for its STaRS and dual diagnosis services then patients may not receive appropriate care, treatment or medication, partners may not be able to access clinical records in a timely manner, and data integrity may be compromised, resulting in potential serious harm to patients, staff vulnerability and poor system working	AG	SSMG	• Auditing and monthly data cleansing exercises in place • Dual Diagnosis working group restarted and reviewing Policy and Procedure • Pilot in West using Pando for Consultants at Derwent Centre to ping each other drug and alcohol cases to check with STaRS	**Risk score unchanged 4 x 3 = 12** **Target June 2021** **4 x 2 = 8**	• Reinforce importance of Datix recording to map incidents and build evidence of problems • Theseus does not constitute an official medical record as content may be deleted – numerous difficulties experienced with Theseus including non-connection to HIE and no access to prescribing activity -ECC advise Theseus 2.0 in development • Open Road not checking if patient known to MH and vice versa – poor system working and communication • Plan to move to SystmOne for prescribing • EPUT ITT working towards a resolution • Follow up with Specialist Services – no update on DRR
Corporate Objective 3: Deliver our people agenda for 20/21 with adjustments in line with the Covid19 response – Lead Director: Sean Leahy supported by all other Executive Directors – Impact of not achieving the Corporate Objective 4 x 3 = 12						
CRR14	If EPUT does not continue to work on staff morale then it may not be able to deliver high quality services resulting in a challenge to transformational change, patient experience and outcomes	SL	WTG	• Thank you vouchers sent to staff • Staff are saying they are tired and fatigued as opposed to having low morale • EPUT hero badges sent to all staff	**Risk score unchanged 4 x 3 = 12** **Target March 2021** **4 x 2 = 8**	• Reviewing and refreshing communication strategies

Risk ID	Potential Risk	Executive Lead	Monitoring	Mitigating actions/ controls in place	Risk scoring status (consequence x likelihood) / target score/ completion/ assurance	Actions outstanding/ further mitigating actions required
Corporate Objective 2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans - Lead Director: Nigel Leonard supported by all other Executive Directors - impact of not achieving the Corporate Objective 5 (Consequence) x 3 (Likelihood) = 15 risk score						
CRR45	If EPUT does not achieve mandatory training policy requirements then patient and staff safety may be compromised resulting in additional scrutiny by regulators and not meeting the IG Toolkit requirements	SL supported by all Executives	Training and Development Group	• Local trajectory in place for safety focused and IG mandatory training as a priority • Monthly reporting to ET	**Risk score unchanged 4 x 4 = 16** **Target March 2022 4 x 2 = 8**	• Plan to return to recommended update training intervals • All staff to ensure that mandatory training is up-to-date as soon as possible, including Information Governance and fire training for all staff and Grab Bag and TASI training for frontline colleagues • Managers are reminded to check training trackers and prompt staff whose training is overdue • Risk materialised on meeting the Information Governance Toolkit requirements – further work to be done in 2021/22

Table 2 – Heat Map against 5 x 5 scoring matrix

		RISK RATING				
		Consequence				
		1	2	3	4	5
Likelihood	1					
	2				40	74
	3			34 75	11 14 53 64 72	76↓
	4				45 48 68 77	
	5					

		Agenda Item No: 8b(i)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Board of Directors Audit Committee Assurance Report**					
Executive/Non-Executive Lead:	Janet Wood, Chair					
Report Author(s):	Carol Riley, Audit Committee Secretary					
Report discussed previously at:	Assurance Reports provided to the Board following Audit Committee Meetings.					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	
Does this report mitigate the BAF risk(s)?	~~Yes~~/ No
Are you recommending a new risk for the EPUT BAF?	~~Yes~~/ No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
This report provides the Board of Directors: • Assurance to the Board that the duties of the Audit Committee, which include Governance, Risk Management and Internal Control, have been appropriately complied with.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

- Minutes of meeting held on the 16 March 2021
- Internal Audit Progress Report 2020/21
- Final Head of Internal Audit Opinion 2020/21
- LCFS Progress Report
- Counter Fraud Strategy & Annual Workplan 2021/22
- External Audit
- Waiver of Standing Orders
- Annual Risk Management Assurance Report
- Governance Development Plan
- Independent Inquiry
- Directors Expenses
- Use of Legal and Consultancy Expenses

- Statement of Financial Position Write Offs
- Impaired Debts Write Offs

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead

Janet Wood **Chair of Audit Committee**

Agenda Item: 8bi
Board of Directors
Meeting: 26.5.2021

EPUT

ASSURANCE REPORT FROM THE AUDIT COMMITTEE CHAIR

1.0 PURPOSE OF REPORT

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

2.0 EXECUTIVE SUMMARY

Audit Committee Meeting 6 May 2021

The Audit Committee met on the 6 May 2021 and approved the minutes of the meeting held on 16 March 2021. These minutes are available to Board members on request.

At the meeting held on 6 May 2021 the following matters were discussed:

The Audit Committee

1. **Internal Audit**

Internal Audit Progress Report 2020/21
The Inpatient Deaths audit has now been completed with no significant findings. The report is due to be presented to the July 2021 Audit Committee.

The following audits are scheduled for May 2021:

- Data Quality
- Ligature Risks

Follow up of Recommendations
The Committee received an update on 27 recommendations, noting that 4 were overdue.

Final Head of Internal Audit Opinion 20/21
The above report confirmed there are no signs of material weaknesses in the framework of control.

LCFS Progress Report

Referrals
The Committee received an update on the current investigations/referrals.

Counter Fraud Strategy & Annual Workplan 2021/22
The LCFS Annual Report was presented to the Committee. The report was discussed and noted.

2. **External Audit**
The draft 2020/21 Annual Accounts are in the process of being reviewed.

3. **Waiver of Standing Orders**
During the period from 1 March 2021 to 28 April 2021, standing orders for competitive quotations were waived on thirteen occasions to the value of £393,178 (including VAT). Of these, two relate to the mass vaccination to the value of £39,009.

For the same period, standing orders for competitive tenders were waived on two occasions to the value of £2,201,642.

4. **Annual Risk Management Assurance Report**
The Annual Risk Management Assurance report was discussed and noted.

5. **Governance Development Plan 2020/21**
The Governance Development Plan for 2020/21 was approved by the Committee.

6. **Independent Inquiry**
The key issues were highlighted to the Committee with regards to the independent inquiry. It was noted that regular updates would be provided to the Committee under Part 2 of the agenda.

7. **Directors Expenses**
Due to the pandemic and the reduced need for Directors to travel over the last 12 months, expenses for the 2020/21 financial year have reduced to £2,497 from £27,875 incurred during 2019/20. These have been claimed by 13 members of the Board compared to 16 members the previous year.

8. **Use of Legal and Consultancy Expenses**

Legal – The total services procured by the Trust during the period April 2020 – March 2021 totals £527k including a prior year reversal of £30k, which increases underlying legal expenses for the year to £557k. Of the £557k, £533k has been spent with panel firms including £129k with Brown Jacobson who are supporting the Trust with the HSE investigation.

Consultancy – The consultancy services purchased by the Trust from April 2020 – March 2021 totalled £2,753k. Spends with suppliers in excess of £10k totals £2,691k. The residual net amount of £62k relates to spend with a further individual suppliers of less than £10k, and the release of VAT refunds or prior year accruals.

The Trust has incurred a greater level of consultancy spend during 2020/21 as a result of the rollout of the mass vaccination programme (Price Waterhouse Coopers) and the new safety agenda (Newton Europe).

A review of value for money has been carried out on consultants with individual invoices over £10,000.

10. **Statement of Financial Position Write Offs**
The Executive Chief Finance Officer approved the write offs with regards to the above totalling £1,628.58.

11. **Impaired Debt Write Offs**
The Executive Chief Finance Officer approved the write off of debts totalling £2,865.13.

3.0 MANAGEMENT OF RISK

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

4.0 NEW RISKS

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

5.0 ACTION REQUIRED

The Board of Directors are asked to:

1. Note the summary of the meeting held on 6 May 2021
2. Confirm acceptance of assurance given in respect of risk
3. Request further action/information as required.

Janet Wood
Non Executive Director
Chair of Audit Committee

		Agenda Item No:8bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis Chair of the Finance and Performance Committee Paul Scott Chief Executive Officer					
Report Author(s):	Janette Leonard Director of ITT, Business Analysis and Reporting					
Report discussed previously at:						
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Listed in BAF report
State which BAF risk(s) this report relates to	all
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	

Purpose of the Report		
This report provides the Board of Directors with details that: • Performance Committee (FPC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objective and impact on quality are being managed effectively. Assurance to the Board of Directors that the Finance and	**Approval**	
	Discussion	
	Information	✓

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

Summary of Key Issues

Performance Report

This month's report has been aligned to the CQC scoring metrics in order to align the monitoring of key performance indicators, using inadequate, Requires improvement and Good as the principles for the prioritisation of focus. This report covers the position for month 12 and month 1.

Performance and Quality
In April 2021 there were 24 Indicators within target (27 in March).

In April 2021 there were 5 areas of inadequate performance (5 in March):

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not Seen

The Executive Chief Operating Officer & Deputy CEO (COO) updated the committee on the 5 areas noted in the report as inadequate performance.

The committee thanked the COO for a comprehensive feed-back on the 5 areas identified as inadequate.

HSSC Mandatory Training Report

The Associate Director of Workforce Development presented the paper on behalf of the Executive director of People & Culture on the current position of mandatory training for the organisation.

The Committee discussed and noted the content of this report.

Appraisals & Supervision

The AD for Workforce Development presented the new Appraisal and Supervision approach to the Trust on behalf of the Executive Director of People & Culture. The AD for Workforce Development informed the group that the appraisal and supervision policy has been revised. The changes implemented are in line with the Trust's objective of ensuring staff are supported and enabled to contribute to the achievement of the quality and performance standards.

The committee discussed the content and supported the new Appraisal and Supervision approach presented.

Financial Position:

The Executive Chief Finance Officer updated the Committee on the key internal financial headlines for M1.

Treasury Management Report

The Executive Chief Finance Officer updated the committee on the Treasury Management performance for 20/21

The Executive Chief Finance Officer informed the committee that the Trust continues to use the Government Banking Service (via RBS) for its main banking functions. The impact of Covid on interest receivable was noted.

The committee discussed and noted the contents of the report.

Code of Governance Review

The Trust Secretary report provided the committee with an update and assurance of the Trust Code and Practice report

James day informed the committee that the purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and also confirm that the Trust 'complies' with the provisions, or if not, provide an explanation as to why it has departed from the Code.

The Committee is asked to approve the self-assessment documentation to confirm in the assurance report to the Board of Directors that the Trust complies with the provisions of the Code in the Trust Annual Report for 2020/21.

The committee approved the self-assessment documentation and confirmed that they were assured that the Trust complied with the provisions of the code in the Trust's annual report 20/21. The committee also noted the minor amendments to the self-assessment documentation highlighted by the COG and noted that they had been incorporated into the documents provided by the Trust secretary.

NHS England/ Improvement Self-Certification Requirements 2020-21 – Conditions G6 and CoS7

The Trust Secretary provided the committee with a progress report on the EPUT NHS England/ Improvement Self-Certification for 2020/21 and final draft self-assessment template for Licence Conditions G6 and CoS7

The Trust Secretary informed the Committee that self-certification is required against G6 and C0S7 by 31st May 2021. Self-certification is required against FT4 and Governor Training by 30th June 2021 and these will be included in a report to F&PC at its June meeting.

The committee was asked to take this opportunity to consider compliance with the provider licence requirements prior to finalisation at Board at its meeting on 26th May 2021. The Council of Governors will consider EPUT's proposed self-certification for G6 and CoS7 at its meeting on the 28th May 2021, which will also consider the compliance with the FT4 and Governor Training as a draft.

The Committee approved the detailed review of Trust against the provider licence and supported the recommendation to the Board of compliance with G6 and CoS7.

Finance & Performance Committee Workplan 20/21

The Trust Secretary presented the final position of the Finance and Performance work-plan for 2020/21. The Committee thanked members in achieving the objectives of this work-plan.

Policy Extensions Report

The Committee approved the extension of the policies listed below.

- Appraisal and Development (Medical Staff) Policy
- Code of Conduct for Members of the Board of Directors
- Organisational Change Policy
- Time Off for Trade Union Duties
- Grievance Policy
- Maintaining High Professional Standards Conduct & Capability Policy for Medical Staff
- Flexible Working Policy
- Time off in Lieu Policy

Any risks or Issues

There were no risks or issues identified.

Any Other Business

There was no other business

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	
Data quality issues	
Involvement of Service Users/Healthwatch	
Communication and consultation with stakeholders required	

Service impact/health improvement gains			
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Add signature **Name; Manny Lewis** **Job Title: Non Executive Director**

Agenda Item 8(b)ii
Board of Directors Meeting Part 1
26 May 2021

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Manny Lewis to provide assurance to Board members that the performance operational, financial and governance as at Month 12 March 2021 and month 1 April 2021

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

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

2.0 Quality and Performance Report

Performance Report

This report covers the position for month 12 and month 1.

Performance and Quality

In April 2021, there were 24 Indicators within target (27 in March).

In April 2021, there were 5 areas of inadequate performance (5 in March):

- Timeliness of Data Entry
- CPA 12 Month Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not Seen

The Executive Chief Operating Officer & Deputy CEO (COO) updated the committee on the 5 areas noted in the report as having been identified as inadequate performance. Each of these areas have dedicated task and finish groups supporting an improvement plan for these areas.

The committee thanked the COO for a comprehensive feed-back on the 5 areas identified as inadequate.

3.0 HSSC Mandatory Training Report

The Associate Director of Workforce Development presented the paper on behalf of the Executive Director of People & Culture on the current position of mandatory training for the organisation.

The committee discussed the content of the report and supported the piece of work on reviewing the Mandatory training programme.

4.0 Appraisals & Supervision

The AD for Workforce Development presented the new Appraisal and Supervision approach to the Trust on behalf of the Executive Director of People & Culture. The AD for Workforce Development informed the group that the appraisal and supervision policy has been revised. The changes implemented are in line with the Trust's objective of ensuring staff are supported and enabled to contribute to the achievement of the quality and performance standards.

In line with the People Plan, all staff will be offered a Wellness Plan and Policy also ensuring that Talent and Development conversations are held at every appraisal. The term 'supervision' will only be used for clinical supervision; managerial supervision will now be termed managerial support.

The committee discussed the content and supported the new Appraisal and Supervision approach presented.

5.0 Financial Position

The Chief Finance Offer updated the Committee on the current financial position for Month 1. Financial returns are not required by NHSE/I for M1 and therefore presented the key internal financial headlines to the Committee.

6.0 Treasury Management Report

The Executive Chief Finance Officer updated the committee on the Treasury Management performance for 2020/21

The Executive Chief Finance Officer informed the committee that the Trust continues to use the Government Banking Service (via RBS) for its main banking functions. In addition, a commercial account continues to be held with Lloyds although balances are kept to a minimum due to the reductions on PDC Dividend, which are achievable on GBS accounts.

The committee noted the contents of the report.

7.0 Code of Governance Review

The Trust Secretary report provided the committee with an update and assurance of the Trust Code and Practice report

The Trust Secretary informed the committee that the purpose of the Code is to provide guidance to help Trusts deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Trust's Annual Report must include a statement as to how the Trust applies the Code and also confirm that the Trust 'complies' with the provisions, or if not, provide an explanation as to why it has departed from the Code.

The review process is as follows:

- Self-assessment against the Code of Governance

- Internal independent assessment by the Council of Governors Governance Committee (6 May)
- Assurance report to Finance & Performance Committee (20 May)
- Report to Council of Governors (28 May)
- Final annual report, including relevant statement to Board of Directors (25 June)

The CoG Governance Committee scrutinised the Code of Governance Self-Assessment and were satisfied there was strong evidence that the Trust was compliant with all provisions in the Code without exception. The Committee suggested some minor amendments to the self- assessment documentation and these have been incorporated into the documents attached to the report.

The Committee is asked to approve the self-assessment documentation to confirm in the assurance report to the Board of Directors that the Trust complies with the provisions of the Code in the Trust Annual Report for 2020/21.

The Trust secretary therefore asked the committee to

- Note the findings of the internal review of the Trust compliance with the Code as a prerequisite assurance to the Board of Directors in the preparation of the Trust's Annual Report 2019/20
- Confirm acceptance of assurance given as evidence that the Trust complies with the provisions of the Code and/or there is sufficient explanation as to why it has departed the Code if applicable
- Agree that the action plan to strengthen compliance should be implemented
- Confirm in the assurance report to the Board of Directors that the Trust complies with the provisions of the Code in the Trust's annual Report for 2020/21.

The committee approved the self-assessment documentation and confirmed that they had received assurance that the Trust has complied with the provisions of the code. The Committee also noted the minor amendments to the self-assessment documentation highlighted by the COG and noted that they had been incorporated into the documents provided by the Trust secretary.

8.0 NHS England/ Improvement Self-Certification Requirements 2020-21

The Trust Secretary provided the committee with a progress report on the EPUT NHS England/ Improvement Self-Certification for 2020/21 and final draft self-assessment template for Licence Conditions G6 and CoS7

The Trust Secretary informed the Committee that self-certification is required against G6 and C0S7 by 31st May 2021. Self-certification is required against FT4 and Governor Training by 30th June 2021 and these will be included in a report to F&PC at its June meeting.

The committee is asked to take this opportunity to consider compliance with the provider licence requirements prior to finalisation at Board at its meeting on 26th May 2021. The Council of Governors will consider EPUT's proposed self-certification for G6 and CoS7 at it's meeting on the 28th May 2021, which will also consider the compliance with the FT4 and Governor Training as a draft.

A detailed review of Trust compliance against the Provider Licence has been undertaken by the Trust Secretary's Office. A recommendation is made to declare compliance with G6 and CoS7.

The Committee approved the detailed review of Trust compliance against the provider licence and supported the recommendation to the Board of compliance with G6 and CoS7.

9.0 Finance & Performance Committee Work-plan 2020/21

The Trust Secretary presented the final position of the Finance and Performance work-plan for 2020/21. The Committee thanked members for achieving the objectives of this work-plan.

Policy Extensions Report

The Committee approved the extension of the policies listed below.

- Appraisal and Development (Medical Staff) Policy
- Code of Conduct for Members of the Board of Directors
- Organisational Change Policy
- Time Off for Trade Union Duties
- Grievance Policy
- Maintaining High Professional Standards Conduct & Capability Policy for Medical Staff
- Flexible Working Policy
- Time off in Lieu Policy

10.0 Any risks or Issues

There were no risks or issues identified.

11.0 Any Other Business

There was no other business

Report prepared by:

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

Manny Lewis
Chair of the Finance and Performance Committee

		Agenda Item No: 8 (b)iii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Quality Committee Assurance Report**					
Executive/Non-Executive Lead:	Amanda Sherlock, Non-Executive Director					
Report Author(s):	Natalie Hammond, Executive Chief Nurse					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report provides mandatory information on EPUTs quality performance for 2020/21 and as such covers a number of risks that appear on its Board Assurance Framework
State which BAF risk(s) this report relates to	BAF45 CQC BAF63 Learning BAF10 Ligature Reduction BAF58 Recordkeeping BAF50 Skills resource and capacity
Does this report mitigate the BAF risk(s)?	Yes
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors with assurance on actions being taken by Sub-Committees to progress key aspects of the quality agenda and identify any risks associated with the current COVID-19 Pandemic and the associated pressures on services.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1 Note the content of this report.
2 Confirm acceptance of assurance given in respect of actions identified tomitigate risks.
3 Request any further information and or action.

Summary of Key Issues

The Quality Committee has reviewed the work of all sub-committees accountable to the Quality Committee. This report is provided to give assurance of the review, monitor and challenge initiated. Overall the Quality Committee has been given assurance that all work streams are in place and actions are being taken to mitigate risk. In addition the Committee commended a number of areas for their best practice. Due to COVID-19 arrangements to drive improvement and give assurance are as follows:

- All sub-committee formal meeting arrangements have taken place virtually as a result of COVID-19.

- All sub-committees have identified priority areas where work is essential to the safe delivery of services.
- Positive progress continues to be against core areas of delivery.
- Corporate teams are focusing their efforts on supporting operational teams with both frontline delivery and putting arrangements in place to reduce risk.
- Against each sub-committee agenda risks have been identified and where possible actions to mitigate have been taken.
- Due to the rapidly changing landscape the scope of work is reviewed against each sub-committee and actions taken to mitigate risk on an on going basis.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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

Acronyms/Terms Used in the Report			
EPUT	Essex Partnership University NHS FT	PD	Personality Disorder
PICU	Clinical Commissioning Group	SMI	Severe Mental Illness
ALOS	Average length of stay	CQC	Care Quality Commission
OPEL	Operational Pressure Escalation Level	BAF	Board Assurance Framework

Supporting Documents and/or Further Reading

Lead
Amanda Sherlock Non-Executive Director

Agenda Item 8(b)iii
Board of Directors Meeting
26 May 2021

ESSEX PARTNERSHIP UNIVERSITY NHS TRUST

QUALITY COMMITTEE ASSURANCE REPORT

1 Purpose of Report

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

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

2 Executive Summary

2.1 Minutes of previous meetings

The minutes of the Quality Committee meeting held on 15 April 2021 and 13 May 2021 were approved as correct accounts of the meetings.

Summary of discussions and issues identified as well as assurances provided at the April and May meetings:

2.2 <u>15 April 2021</u>

2.2.1 Quality Performance Report: The Committee received the report that gave an updated position as at February 2021. 23 indicators were within target. There were 3 areas of inadequate performance:

- CPA 12 Month Reviews – Performance in February was below the national 95% target at 94%. Performance remains inconsistent with monthly fluctuations below and above target. Performance is required to meet target for three months until this indicator can be downgraded. The Committee was advised that this indicator remained under review with Commissioners. The Committee was assured that there is big drive underway with validation work being carried out in terms of data quality.
- Inpatient MH Capacity (Adults & PICU) – Increases in staff and patient COVID outbreaks are resulting in ward closures, which are driving need for out of area placements. The Committee was advised that EPUT is not alone with the pandemic causing a major incident across Essex. As well as ALOS and Occupancy breaching targets, there was one day at OPEL 4 in February.
- Waiting lists: It was noted that work continues to be undertaken to reduce waiting lists. Constructs of the medical caseload waits have been reviewed to include telephone contacts that have greatly improved performance. Through commissioner arrangements funding has been sourced with approval to recruit additional staff in south west Essex and south east Essex, in addition to the new PD&CN and trauma funding.

In February 3 areas were identified requiring improvement

- Bullying and Harassment – These incidents currently represent a concern for

the Trust with 21 cases raised to HR year to date. No new cases were raised in February. The Trust has been working to increase the number of staff who report bullying and harassment incidents by introducing anti-bullying ambassadors. The Committee was advised that staff survey results are expected and initial indications are showing some improvement in this area.

- Cardio Metabolic Assessments/SMI indicators continue to be at variance with local targets however improvement is being seen across all indicators since the introduction of analysers
- Inpatient MH Capacity Older Adult.

It was noted that incident reporting rates continued to decline and assurance was sought that this issue was being addressed. It was noted that a deep dive is being undertaken to see if this is due to a genuine decrease or under reporting.

An increase in ligature incident reporting was acknowledged in Ardleigh Ward and CAMHS. The Committee heard that extra support was going into the services to understand, support and implement approaches to reducing self-harming behavior.

2.2.2 Quality Committee Review The Committee received an update on the current position of the internal governance review. Further work would be undertaken throughout May and June and outcomes would be aligned with work taking place in relation to the Accountability Framework. The Committee supported the approach being taken with the review commencing with a blank piece of paper.

2.2.3 Clinical Audit Programme 2021/22: The Committee received the programme that sets out the priorities over the next 12 months. It was commended on its diversity and the links to the CQC domains.

2.2.4 CQC Exception Report: The Committee received an update report outlining assurance on the key CQC related activities that are being undertaken within the Trust. The report also gave details of CQC guidance/updates that have been received since the last report.

- Meeting Registration Requirements – The Committee was advised that the CQC had been notified of the appointment of a new NED and had de-registered a NED. In addition Topaz Ward had been re-instated as an adult acute ward and notice had been given of additional mass vaccination centres.
- CQC Inspections: There have been no new CQC inspections in the reporting period. All action plans following CQC inspections have been closed.
- Mass Vaccination Mock Inspection: The Compliance Team undertook a mock inspection of the vaccination centre at The Lodge as a baseline. No significant concerns were found and some improvement recommendations have been made.
- CQC Guidance/Updates. It was noted that a range of new publications have been issued by the CQC. The CQC has one consultation open which proposes changes to how the CQC will regulate. The Trust has provided a response welcoming the flexible regulations and raising some queries around how it will work in practice.

It was noted that compliance team supported by the quality team have been focusing work on the following areas:

- CQC preparation support visit
- Inpatient Clinical Support Group (overseeing learning from Finchingfield Inspection)
- Action Plan Testing – CQC Well Led Inspection (July-August 2019).

Assurance was sought that learning was being cascaded. It was confirmed that the team were focusing on sharing the learning on all ward visits alongside focusing on observation, recording and handover. In addition the communication team are putting in place further arrangements to cascade learning.

2.2.5 Mortality Data & Learning: The Committee received an update of deaths that fell within the scope of the mortality review. It was noted that the number of deaths are broadly consistent with the same quarter in 19/20. Themes around learning were discharge follow up, sharing clinical information through different clinical systems and destination of discharge.

The Committee commended the layout of the report that was now inclusive of additional notes giving a more comprehensive picture. Further information was sought in relation to the review that remains outstanding and a narrative in relation to nursing home deaths due to COVID was requested**.**

2.2.6 Ligature Process Update: An update was given on the changes to the ligature inspection programme that has moved to an annual inspection from April 2021. Each ward will have a full inspection attended and undertaken by the ward manager alongside members from Health and Safety and Estates. There will also be a six monthly review visit in addition to opportunities for coaching and sharing learning. It was noted that staff had received the new process positively.

A member of the compliance team had developed an electronic tool and it was agreed that this would be shared with the Non-Executives. It was noted that the policy had been updated and following a pilot of the tool it would be incorporated into the policy.

It was noted that ligature continues to be a core element of the internal audit programme and it was agreed that this year's audit should be focused on policy and practice on inpatient units.

2.3 <u>13 May 2021</u>

2.3.1 Combined Assurance Report: The Committee received an update of key actions being undertaken receiving assurance that all actions were progressing on target. It was noted that a number of risks remained evident as follows:

- MHA: Due to changes in legislation and the Devonshire Judgement resourcing is an issue within the MHA team. Electronic scrutiny is progressing but continues to add to resource pressures.
- Safeguarding: Tier 4 bed availability is a national pressure and daily engagement across the system continues to elevate pressure. There is also an increase in gang activity regarding children within the area.
- Information Governance: The Trust remains non-compliant with a completion rate of 90%. The deadline has been extended to 30 June 2021 and to boost completion rates the IG team are making telephone and email contact to all individuals that have outstanding returns.
- Health, Safety & Security: A number of risk areas have been identified in relation to overdue safety alert sign off, CCTV access in south wards and the magnetic plates on soap and hand towel dispensers.

The Committee was assured that proactive action was being taken against all risks.

2.3.2 CQC Compliance Report: The report provided a full overview of all actions

being undertaken to ensure compliance with CQC regulations. It was noted that EPUT is fully registered with the CQC. At the point of the report being drafted there had been no new inspections but subsequently a two-day visit had been undertaken to St Aubyn's Centre. The report is expected with the next two weeks but it was highlighted that there had been a focus on workforce. The Committee were advised that this is an area of concern with the Trust and specialist training pathways did not exist. It was noted that work had already commenced across the Trust to address workforce issues and due to the pressure across CAMHS this area was considered a priority for action. Advice had been sought from national advisors.

In other areas work has been undertaken to review the internal action plan, test the CQC action plan and continues preparations for a CQC visit. It was noted that there has been an increase in CQC information requests that has previously indicated that an inspection is being prepared.

The Committee explored the unfortunate incident that had occurred on Longview seeking a greater understanding of events and the initial learning from the event. A full report has not yet been received but a number of issues have been raised and work is being undertaken to increase understanding and mitigate future risk. A clinical support group has been established and is doing a deep dive that will lead to a comprehensive action plan that will have organizational wide support to deliver with engagement of all. Support to the team has also been provided.

2.3.3 Quality Account: The Committee received a draft copy of the Quality Account that is due for submission on 30 June 2021. There had been mixed messages regarding schedules for submission and the report was now out to stakeholders for feedback to meet the timeline. The Committee was advised that the focus of the Quality Account was in relation to the new Patient Safety Strategy whilst retaining priority areas of delivery in relation to improvement, innovation and transformation. The Committee was requested to review and forward any feedback.to Natalie Hammond.

2.3.4 COVID 19 Board Assurance Framework: The Committee received an update report to give assurance on the Trust position regarding infection, prevention and control during Covid-19 Pandemic. Following the first presentation, the assurance template has been updated nationally in response to emerging Covid-19 evidence and the effective infection prevention and control measures. The framework is a live and dynamic collection of evidence, risks, gaps and mitigation that is updated as new guidance is received.

2.3.5 COVID 19 Mass Vaccination Sites: An update was provided in relation to the implementation of mass vaccination sites. The Trust has opened 14 sites, all of which have had pre and post opening assessments in line with CQC and audit requirements. Risk registers have been combined across all sites and confirmation was given that risks were reducing with issues being rated at 6.

Assurance was given that education and training was a priority and covering 5,000 members of staff. Communication is also a priority for staff and the public and systems are in place. All feedback has been considered and communication systems developed to meet needs.

EPUT has made a number of innovations making enhancement to the national model. Alternative ways of working to efficiently utilise the registered and unregistered workforce whilst adhering to national protocol has successfully saved 6 minutes on appointment times producing significant financial savings on a weekly

basis. Bespoke delivery programmes have also been using buses and drive through arrangements to get to hard to reach areas and there has been successful delivery of a vaccination programme for individuals with Downs Syndrome with the second vaccination being given on Downs Syndrome Day.

Assurance was sought regarding ongoing delivery as venues currently used reopen with business as usual. It was confirmed that plans were in place to move sites into town centres using empty shop fronts and use of buses and drive through sites.

The Committee commended the outstanding work that had been undertaken and noted that national recognition had been given.

2.3.6: Complaints Annual Report: The Committee received the annual report that provided a review of the overall performance of complaints handling in EPUT. It was noted that with the introduction of 'I Want Great Care' there would be greater access to complaints and compliments of services and individual members of staff. Assurance was received that a systematic review of complaints fed into systems for learning. It was also noted that were possible there was local resolution of complaints with support being given to staff.

2.3.7 Ligature Risk Management: A report was presented providing an update and assurance of actions undertaken in 2020/21 and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

Assurance was given that the Trust is committed to continuously improve systems and processes. Ligature risk remains on the Board Assurance Framework as a significant risk and a full action plan continues to be monitored regularly.

2.3.8 Patient Story: The Committee heard a patient story in relation to a gentleman with complex needs who was at the end of his life. It was very important to the gentleman and his family that he was able to die at home. A wide range of agencies were involved that met his needs enabling his wishes to be fulfilled. The focus was in line with the principles of 'Dying Matters'. Dying matters week was 10-16 May 2021 and the Committee was assured that a range of actions continued to be taken to raise awareness.

2.4. Policies and Procedures

The Committee approved the following policies and procedures:

- CLP41 – Seclusion and Long Term Segregation Policy
- RM05 – Restrictive Practice Policy
- RM03 Moving and Handling Policy
- CP82 Recompensed for Lived Experience Work Policy
- CP50 Information Governance & Security Policy
- CPG50C Safe Haven Procedure
- CPG50G Information Asset Register Procedure
- CPG59C Confidentiality Audit Procedure
- RM02 Fire Safety
- CLP8 Engagement & Supportive Observation
- (Inpatients)
  CLP69 18 Week Referral to Treatment Access MT Attached Approval
- CP75 Ligature (Appendix 9) Attached Approval

- Pseudonymisation Policy

Policy extensions were agreed for the following:

- Research Conduct & Processes Policy
- 7 Day Follow-Up Policy
- Joint Working and the Provision of Services between MH and LD Policy
- Infection Control Procedure Section 1 – Infection and Common Infectious Diseases
- Infection Control Procedure Section 3 – Infection Prevention and Control in Clinical Practice
- Infection Control Procedure Section 9 – Prevention and management of Sharp Injuries
- Section 136 Policy

2.5. Risks/Hotspots:

The Committee identified:

- No risks to be escalated to the corporate risk register
- No risks or issues to be raised with other outstanding committees
- No recommendations to the Audit Committee linked to the internal audit programme

The Committee identified the following areas of good practice:

- New ligature tool developed internally – Member of staff to be commended
- Positive feedback in relation to quality performance deep dives
- Reduction in restrictive practices particularly prone restraints
- Compliance/senior nurse team back on wards undertaking support visits
- The work undertaken in relation to vaccination centres that has the centres established as areas of best practice influencing national guidance and reducing costs..

Report prepared by:
Natalie Hammond, Executive Nurse

On behalf of:
Amanda Sherlock, Non-Executive Director Chair of the Quality Committee

		Agenda Item No: 8b (iv)
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**People, Innovation & Transformation Committee Assurance Report**					
Executive/Non-Executive Lead:	Dr Alison Rose-Quirie Non-Executive Director and Chair of Committee					
Report Author:	Emma Bullard PA to Executive Director Strategy & Transformation					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	None.
State which BAF risk(s) this report relates to	BAF18.
Does this report mitigate the BAF risk(s)?	No.
Are you recommending a new risk for the EPUT BAF?	No.
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	n/a.
Describe what measures will you use to monitor mitigation of the risk	n/a.

Purpose of the Report		
This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the identification and/or achievement of the organisation's objectives are being managed effectively.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

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

Summary of Key Issues

The People, Innovation & Transformation Committee met on 5 May 2021 and discussed the following key issues:

- The Trust's Strategic Objectives
- Cambridge University Ligature Risk Reduction Feedback
- Boundary Changes
- People, Innovation & Transformation Committee Approach 2021/22

A summary of these discussions is outlined in the attached report.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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?	**NO**	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
None

Lead

Dr Alison Rose-Quirie
Chair of the People, Innovation & Transformation Committee

Part 1 Agenda Item: 8b (iv)
Board of Directors
26 May 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PEOPLE, INNOVATION & TRANSFORMATION COMMITTEE

PURPOSE OF REPORT

This report is provided to the Board of Directors by the Chair of the People, Innovation & Transformation Committee. It is designed to provide assurance to the Board of Directors that risks that may affect the achievement of the organisation's objectives are being managed effectively.

EXECUTIVE SUMMARY

People, Innovation & Transformation Committee 5 May 2021

The People, Innovation & Transformation Committee met on 5 May 2021, where Committee members had a successful and positive debate on a number of key areas.

Governor Keith Bobbins was in attendance as an observer.

The following matters were considered:

1. The Trust's Strategic Objectives

Committee members received a presentation on the upcoming refresh of the Trust's Strategic Objectives, for information and discussion.

Key themes arising from the discussion included:

- The need to align the Trust's Strategic Objectives with system working.
- The requirement for a communications campaign aimed at staff and service users, incorporating artistic and digital solutions, to ensure that all stakeholders understand the 'what, why and how' of the Trust's Strategic Objectives.
- The need for analysis of specific success stories and any improvements required, with ongoing publicity to ensure that the Strategic Objectives are continually 'brought to life'.
- The focus on service users as the 'anchor' for the Trust'.

The document would be developed further, taking into consideration all of the feedback received, and an update would be provided at the next meeting.

2. Patient Safety – Cambridge University Ligature Risk Reduction Feedback

Committee members were presented with the outcomes of a recent project with Cambridge University students on ligature risk reduction, for information and discussion.

Committee members agreed that the research was an excellent example of innovation and joint working, with the potential to place EPUT in a leading position within the system. Committee members agreed that further investment in the initiative, in order to replicate it in other areas of the Trust, would be very worthwhile.

3. Boundary Changes

Committee members received a brief update on potential upcoming boundary changes, for information.

It was noted that changes were anticipated following the resignation of the NHS Chief Executive, including the potential development of a Greater Essex ICS. The opportunity to negotiate with partners around changes to primary and secondary care would be maximised.

Committee members would hold a more detailed discussion at the next meeting, when it was expected that more information would be available.

4. People, Innovation & Transformation Committee Approach 2021/22

Committee members reflected on the objectives of the Committee, and discussed what they would like to achieve over the coming year.

It was agreed that the meetings should provide a platform for open strategic discussion, and therefore the Interim Trust Secretary would arrange for current regular assurance items to be diverted to alternative committees where possible, in order to free up discussion time. The Terms of Reference and Risk Register would also be updated accordingly.

ACTION REQUIRED

The Board of Directors is asked to:

1. Note the summary of the meeting of the People, Innovation & Transformation Committee held on 5 May 2021.
2. Confirm acceptance of assurance given in respect of risk and the action identified.
3. Request further action/information as required.

Report produced by:
Emma Bullard
PA to Executive Director of Strategy & Transformation

On behalf of:
Dr Alison Rose-Quirie
Chair of the People, Innovation & Transformation Committee

		Agenda Item No: 9i
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	26 May 2021

Report Title:	**Covid 19 Assurance Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Jane Cheeseman, Head of Compliance and Emergency Planning					
Report discussed previously at:	Executive Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	This report outlines current response to Covid 19 national pandemic
State which BAF risk(s) this report relates to	• BAF38 Emergency Planning • BAF50 Skills Resource and Capacity • BAF42 Financial Plan • BAF43 Surge Planning • BAF44 Learning from C19
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides the Board of Directors with assurance in relation to the actions taken in response to the Covid 19 pandemic.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1).
4. Request any further information and or action

Summary of Key Issues

Background

- The country has now been dealing with the corona virus outbreak for one year. The Trust's arrangements continue to be in place and are working effectively.
- A further decrease of prevalence across the country continues as we also see a complete reduction in the need for Covid beds within the trust.
- This decrease has enabled us to open our doors to facilitate a slight increase in visitors to our nursing home services, providing they test negative for Covid-19 and further reviews are expected as the lockdown is gradually lifted.
- Nationally pressures on the NHS have reduced significantly and we have therefore seen a reduction from a level 4 incident response to level 3 since last reporting. Alert level three means that although the virus is still in general circulation, transmission is no longer high or rising exponentially.

- We continue to monitor prevalence amongst our patients and staff with an awareness of the potential for a third wave and have the ability to step back up to support any system pressures if needed. Close monitoring is underway across the region in response to the Indian variant that has been identified within Bedfordshire, Luton and Essex.

Command Structure

- The Gold, Silver and Bronze Command meetings continue with frequency of meetings reviewed and adjusted to reflect the current risk. The command structure is currently meeting once per week. A new Covid Dashboard which aims to monitor prevalence and potential risk has been developed to enable timely decision making for standing up/down command as required.
- The (virtual) Incident Control room operational times have had a slight decrease on weekdays to now run 8am until 6pm in line with the previous weekend changes.
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.
- 25 staff are scheduled onto either a full or refresher course during the remainder of 2021 for the Strategic Command Training.

Impact to Date

- There have been no further reported outbreaks within the trust and regular lateral flow testing of both our patients and asymptomatic patient facing staff continues across the trust.
- We previously reported a total of 44 patients who sadly passed away within our inpatient services as a result of Covid-19 as a direct or indirect cause since the pandemic began. This has sadly increased to 45.
- At time of writing we have a total of 16 staff off sick due to covid-19 (a significant reduction from 85 at last report) and 1 Covid-19 confirmed patient within a Specialist Mental Health Ward.
- Since the commencement of lateral flow testing for staff we have now recorded a total of 74,776 test results, from approximately 5500 different staff, which has proven to be a reliable indication of Covid-19 with only 16 false positives. The programme to date has successfully identified 246 cases of staff testing positive.
- The Trust Committee and Governance Structures reduced over the height of the second Covid Wave have now resumed and have continued through the utilisation of Microsoft Teams on a virtual basis.

Trustwide Response

- There has been further progress on wards returning back to their original functions. Poplar Ward (St Margaret's) initially reduced back to having 5 Covid-19 beds open and back to an amber pathway from 22nd February 2021 and has since been able to close the last remaining covid-19 beds with agreement of our system partners and approval by Gold command on the 4th May 2021.
- We continue to monitor the pandemic situation with ability to revert back should the need arise to support demand or any system pressures.
- As from 31st March 2021 we have successfully been able to open Topaz ward as an adult acute ward at Broomfield with gradual admissions to the 18 beds.

Communication

- On 23rd March the trust held a National Day of Reflection marking one year on from the first day of the national lockdown.
- The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives.
- A number of different live events have continued to be held including staff support events

Risks

- There are 3 extreme risks on the Covid 19 Risk Register (Skills, Resource and Capacity and implementation of C19 vaccination programme). Mitigating actions are in place for all three risks.

Learning

- Silver Command undertook a reflection on changes made throughout Covid-19, with the aim of identifying those that have been of benefit to the service and those that have been a challenge.
- The majority of the changes have been areas that have supported home working and still being able to provide a full service whether that be for our patients or corporate functions of the Trust.
- There were numerous reflections where there had been an actual change to a service or new service started however these were areas that are already being taken forward by the Trust in working more effectively and efficiently so have not been included.
- Through the reflections it appears that staff are keen for Microsoft teams to continue; they would like to see a balance of home working and working from a Trust base and to be able to offer a hybrid of virtual and clinical visits for the people that use our services.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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 The Government has confirmed any appropriate and reasonable expenditure related to Covid-19 will be supported. All costs identified in year ended 31/3/20 have been agreed and funded.			✓
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			✓
Equality Impact Assessment (EIA) Completed?	**~~YES~~/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
PPE	Personal Protective Equipment	IPC	Infection Prevention and Control
MSE	Mid and South Essex	STP	Sustainably and Transformation Partnership

Supporting Documents and/or Further Reading
Covid Assurance Report Gold Command Covid Risk Register Summary

Lead
Nicola Jones **Interim Director of Risk and Compliance**

Agenda Item 9i
Board of Directors
26 May 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FT

COVID 19 ASSURANCE REPORT

Purpose of Report

The purpose of this report is to provide the Executive Group with an update on how the Trust continues to respond to the Covid 19 pandemic, and assurance that the actions being taken are mitigating the risks identified.

Background

A further decrease of prevalence across the country continues as we also see a vast reduction in the need for Covid beds within the trust. Nationally there is progress with the road map and further easing of the lockdown restrictions taking place. Reportedly, pressures on the NHS have reduced significantly and we have therefore seen a reduction from a level 4 incident response to level 3 since last reporting. Alert level three means that although the virus is still in general circulation, transmission is no longer high or rising exponentially.

This progress has enabled us to open our doors to facilitate a slight increase in visitors to our nursing home services, providing they test negative for Covid-19 and further reviews are expected as the lockdown is gradually lifted.

We continue to monitor prevalence amongst our patients and staff with an awareness of the potential for a third wave reportedly estimated between 22nd June and 21st August 2021 with the ability to step back up to support any system pressures if needed. The predications are that if there is a third wave that it will be slower with differences in different areas.

The improvement in Covid numbers is said to be as a result of lockdown and not as a result of the vaccination. However, the vaccination has reportedly accounted for a greater fall in numbers of those admitted to hospital over the age of 50.

We are mindful of the news that Bedfordshire and Luton along with Essex have been identified as a high risk area for the Indian variant, and as such the vaccination programme has stepped up in these areas.

Command Structure

As the Lockdown has been gradually lifted and a reduction in the receipt of national and regional guidance has continued. From 10th May we have been able to reduce the command meetings down to one joint Silver and Gold meeting a week which will take place every Monday. Bronze commands have mirrored this.

The (virtual) Incident Control room remains operational 7 days a week however, the hours have reduced from 8am until 8pm Monday to Friday to 8am until 6pm as the NHS response level reduced to Level 3 on the 25th March. Weekends continue to operate 8am until 6pm in line with the East of England Operational Centre working hours.

There remains a number of regular sit reps required by the Centre including the National Covid daily sitrep, Community discharge daily sit rep, regular Lateral Flow Testing numbers and Long Covid activity.

There is a noted decrease in the national and regional information and guidance into the incident

control inbox. However there continues to be information asks with short timeframes for responses which are challenging for the organisation. We continue to cascade all national and regional guidance, information and requests to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required.

The Covid Risk Register continues to be regularly reviewed and refreshed with mitigation updated by the Command structure and the equalities network leads continue to attend the command meetings to ensure that issues are captured and a reflection on risks and impact is undertaken to safeguard that no staff group is adversely affected by decisions made.

As previously reported, we were given the opportunity for Strategic Command training for all staff that have a command role during incident or emergencies and have been able to secure places for all those who work at Strategic Level and have overall responsibility for the command, response and recovery of an incident. A total of 25 staff are scheduled onto either a full or refresher course during the remainder of 2021.

Impact to Date

Since last reporting in March, there has been a significant Reduction in our reporting of both Covid-19 positive patients and staff sickness. At the time of writing we have 1 Covid-19 confirmed patient within our specialist mental health ward and 16 staff off sick due to Covid-19 related illness (a reduction from 85 at last report)

We have reported an additional patient death onto the Covid-19 Patient Notification System (CPNS). It was identified that even though the patient had passed away outside of the 28 days from testing positive, Covid-19 was cited on the Death Certificate therefore this now meets reporting criteria set. Therefore, the previously reported 44 patients sadly passed away since the crisis began has increased to 45 deaths (2 in Mental Health Services and 43 in Community Beds)

There have been no further reported outbreaks within the trust and regular lateral flow testing of both our patients and asymptomatic patient facing staff continues across the trust.

Since the commencement of lateral flow testing for staff in late November 2020. We have now recorded a total of 74,776 test results, from a total of approximately 5500 different staff, which has proven to be a reliable indication of Covid-19 with only 16 false positives. The programme to date has successfully identified 246 cases of staff testing positive.

The Trust Committee and Governance Structure was reduced over the height of the second Covid Wave with a focus remaining on patient safety. The Committees have now resumed and have continued through the utilisation of Microsoft Teams on a virtual basis.

Trustwide Response

Since last reporting there have been further progress on wards returning back to their original functions. Poplar Ward (St Margaret's) initially reduced back to having just the 5 Covid-19 beds open and were back to an amber pathway from 22nd February 2021. Since then the ward has now been able to close the last remaining covid-19 beds with agreement of our system partners and approval by Gold command on the 4th May 2021. We continue to monitor the pandemic situation with ability to revert back should the need arise to support demand or any system pressures.

As from 31st March 2021 we have successfully been able to open Topaz ward as an adult acute ward at Broomfield with the gradual admissions to the 18 beds.

Communication

Decisions made by the Command meetings continue to be communicated to all staff through the regular production of the Live briefings and the Wednesday Weekly publication which has undergone

a new look which combines the latest news stories, COVID-19 updates and notices from around the Trust with a more modern design to engage with staff.

On 23rd March the trust held a National Day of Reflection marking one year on from the first day of the national lockdown. The event included a minute's silence to remember those who have died in the pandemic. All staff across the trust were invited to join where we were able to reflect on our own experiences and our journey over the past 12 months including stories from colleagues that were shared at the event.

The success of the weekly Live events and time hosted by the Chief Executive with the Executive Directors, continues as a means to keep staff updated on the current status and for staff to raise questions directly with the Executives. In addition to this there has also been the implementation of numerous virtual events made available to support staff and their wellbeing.

Risks

The Trust Covid risk register has remained a live document with the risks constantly being updated to reflect the changing environment and are detailed in the summary Covid Gold Risk Register in Appendix 1. There are currently 3 Extreme Risks, 8 High Risks and 5 Medium Risks open.

From this it can be seen that major risks currently facing the Trust are: -

Skills, Resource and Capacity, the following controls have been noted

- This risk has full engagement in the EOSC BAF sub group; the demands and pressures on EPUT are immense with very high stakes projects and issues
- Participation by EPUT on system calls
- Discussion at Command around managing the different system (internal and external) requirements and agreement to have a reduced Committee process for Dec/Jan 21 with focus remaining on patient safety related committees
- Discussions at Command around significant staffing risks in January 2021. Mitigating actions being put into place including staff redeployment from corporate services and wider use of agency staff

Implementation of C19 Vaccination Programme, the following controls have been noted

- A risk register is being set up specifically related to the Mass Vaccination programme to strengthen governance around the project
- Urgent work underway to develop new BCPs ready for testing as part of a table-top exercise to look at emergency planning for each centre as it comes on line
- No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations
- Programme Board in place to manage this
- Looking to consolidate Mass Vaccination risks on BAF

Adherence to PPE, the following controls have been noted

- Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc.
- Training including PPE Self Assessment

Learning

Silver Command undertook a reflection on changes made throughout Covid-19, focussing on what had worked well and what had not. The aim was to identify those that have been of benefit to the service and those that have been a challenge. The feedback has been shared to explore areas that could be built on to inform the Trusts Operating Model of areas where change led to working more

efficiently and effectively.

The majority of the changes have been areas that have supported home working and still being able to provide a full service whether that be for our patients or corporate functions of the Trust.

The introduction of Microsoft Teams has been the biggest impact cited by many teams as beneficial for reasons such as:

- Less travelling to meetings giving back more time for work/clinical care and environmentally friendly
- Improved attendance and productiveness of meetings
- Flexibility of communication and improved communications
- Enabled virtual supervision and improved staff morale as able to check in with staff more frequently
- Increased engagement at team meetings and wider trust meetings
- More privacy of meetings and eliminates need for demand of room bookings
- Ability to hold larger meetings

The only challenges to this being the ease of booking meetings has led to staff being on back to back meetings with little or no breaks. Virtual contact in certain situations has felt less personal and it has been difficult to organise patient group activities.

Staff have adapted to home working and the following have been identified as positive aspects of this change:

- Staff felt able to be more productive
- Decreased staff absence
- Improved work / home life balance
- Improved staff communication, engagement and participation in meetings
- Ability to focus on work without interruptions or distractions of a noisy office environment
- Ability to spend more time clinical time with patients as not having to travel to patient homes
- Less travel supporting the eco-friendly approach

Challenges were highlighted when it came to new starters and making them feel involved in the team. Not everyone's environment at home is suitable for home working therefore concerns were raised in regards to suitable working conditions and confidentiality and for some individuals the feeling of isolation.

The restrictions on face 2 face appointments enabled to Trust to identify different contact methods to enable to patient care/consultation to continue and teams have seen this as a benefit as:

- Provided a greater flexibility for patients to have assessments via other methods
- Decrease in DNA due to remote consultations
- Appointment times were able to be increased therefore improving on the time spent with patients
- Enabled a focus on service spec and ability to filter out non-complex patients that were historically on the caseload resulting in efficiencies within the service and an improved outcome for complex patients.
- Patients benefited from having continuity to their care from the service
- Patients not having to travel to the clinics

However there have been some challenges due IT requirements, availability and support for both staff and patients, unable to undertake physical checks and some patients not wanting do via video call therefore had to opt for telephone which meant the clinician had no visual contact with the patients. Many felt that adopting a mix of different methods would be beneficial moving forward and should be led by individual patient clinical need.

There were numerous reflections where there had been an actual change to a service or new service started however these were areas that are already being taken forward by the Trust in working more effectively and efficiently so have not been included.

Having summarised the reflections it appears that staff are keen for Microsoft teams to continue; they want the balance of mainly home working and the option to work from base on occasion and to be able to offer a hybrid of virtual and clinical visits for the people that use our services.

Action Required

The Board of Directors are asked to:

1. Note the content of this report.
2. Confirm acceptance of assurance given in respect of actions identified to mitigate risks.
3. Note the Covid 19 Gold risk register and summary mitigations (Appendix 1).
4. Request any further information and or action

Report compiled by:

Jane Cheeseman,
Head of Compliance and Emergency Planning

On Behalf of

Paul Scott
Chief Executive

COVID19 Gold Command Risk Register Summary of Risks as at May 2021

Legend Risk scoring status (aligned with 5x5 matrix): ■ Extreme ■ High ■ Medium ■ Low

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 38	If EPUT does not implement effective emergency planning arrangements for managing the COVID19 outbreak in line with national and local requirements then the ability to deliver services reduces resulting in a lack of containment of the pandemic. Proposed wording: If EPUT does not manage Covid19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	NL	• Executive Lead in place for emergency planning • BCPs under ongoing review • Gold, Silver Bronze Command well established • Sit rep daily monitoring • COVID Intranet Page and range of staff training in place • Covid Dashboard issued weekly to monitor prevalence	Risk Score 5 x 2 = 10	Target Ongoing during COVID19 pandemic 5 x 2 = 10	Gold, Silver and Bronze Command Structure Board of Directors COVID19 Command Structure Risk at threshold
BAF 50	If EPUT does not have the skills, resource and capacity to deliver high quality business as usual care and services, manage the C19 pandemic, mass C19 vaccination programme, EU Exit Transition, regulatory responses, independent inquiry and increased variation of demands on corporate services then it may not achieve the deliverables on this wide range of priorities and pressures resulting in not achieving organisational objectives, unsustainability in corporate services, stagnation of risks and failure to maintain our position within the wider health economy	PS and all EDs	• There are 14 actions on the consolidated action plan • Nine actions are completed • Five actions are in progress to timescale • This risk has full engagement in the EOSC BAF sub group; the demands and pressures on EPUT are immense with very high stakes projects and issues • Participation by EPUT on system calls • Discussion at Command around managing the different system (internal and external) requirements and agreement to have a reduced Committee process for Dec/Jan 21 with focus remaining on patient safety related committees • Discussions at Command around significant staffing risks in January 2021. Mitigating actions being put into place including staff redeployment from corporate services and wider use of agency staff	Risk score C5 x L4 = 20	Ongoing during C19 pandemic 5 x 2 = 10	Command structure EOSC Trust Board PIT F&PC Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 42	If the COVID19 crisis continues then EPUT may experience an adverse impact on its financial plan as a knock on from system wide financial planning resulting in additional risk for EPUT to its sustainability	TS	• The revised planned deficit for 20/21 is £8.3m • In December 2020 **M9**, the Trust recorded a deficit of £1.2m against the planned deficit of £1.4m (year to date deficit £2.9m against the planned deficit £3.9m) • The forecast outturn is £13m • Year to date M9 Covid19 costs of £10.1m with M7-M12 recovery anticipated from M&SE and H&CP. Cash was £103.5m in M9, which remains better than planned	Risk Score 4 x 3 = 12	Target March 2021 4 x 2 = 8	Finance and Performance Committee Board Above threshold
BAF 43	If EPUT does not plan for an expected surge in demand for Mental Health services (or physical CHS) during or post C19 then skills and capacity may not be in place resulting in long waiting lists and self-harm in the community Consider closing this risk (discussion with AG) – more about the right capacity for post-Covid surge and reducing out of area placements	AG	• A phased plan is in place to manage the surge demand alongside winter planning • From October – April 2021 existing capacity, flow and escalation initiative are in place • Contingency plans include exploring opportunities with local private providers to purchase additional inpatient capacity and exploring further use of other estate options for additional beds (Kelvedon) or a COVID19 ward for unwell patients who are not a ligature risk • Allocation of additional funding confirmed on STP/ICS footprints to support capacity and flow; schemes in development which address both process and capacity • This may be a longer term risk but all current resources are targeted at management of the pandemic incident • Topaz Ward re-opened to provide additional mental health surge capacity • 18 spot purchase beds available at The Priory	Risk Score Reduced 5 x 2 = 10	Target March 2021 5 x 2 = 10	Command Structure EOSC and Board plus Standing Committees At threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
BAF 51	If EPUT does not have sufficient oversight to effectively direct and implement the mass C19 vaccination programme across MSE and SUNEE systems then it may not meet the deliverables and timescales requested by NHSE/I resulting in the potential failure of the programme Proposed wording: If EPUT does not effectively direct and implement the mass vaccination programme then it will not meet its deliverables/ timescales resulting in a failure of the programme in MSE and SUNEE	NL	• A risk register is being set up specifically related to the Mass Vaccination programme to strengthen governance around the project • Urgent work underway to develop new BCPs ready for testing as part of a table-top exercise to look at emergency planning for each centre as it comes on line • No contracts have been issued to us and at this stage we are unable to sub-contract any elements of the service to other organisations • Programme Board in place to manage this • Looking to consolidate Mass Vaccination risks on BAF	Risk score C5 x L4 = 20	Ongoing during C19 vaccination programme 5 x 2 = 10	Command Structure EOSC Quality Committee Trust Board Above threshold
CVG 19	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	NH	• Assurance visits being undertaken and clinically held action plans • IPC Board Assurance Framework (national document) updated bi-monthly • New guidance reviewed and implemented through Command structure as received • National recommendations derived from other organisations during C19 are reviewed against EPUT measures • C19 secure procedures are in line with IPC guidance • IPC Dashboard developed to monitor potential risk areas	Risk Score 4 x 2 = 8	Ongoing for duration of crisis 4 x 2 = 8	Command Structure IPC Board Assurance Framework - EPUT response At threshold
CVG 33	If EPUT does not ensure that staff are Fit Tested for the variation of FFP3 masks coming through the PPE push system then it may delay the utilisation of these masks resulting in lack of PPE for aerosol generating procedures	NH	• Plan in place for the ongoing requirement for fit testing	Risk Score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 51	If EPUT staff do not follow the rules and guidance issued around PPE then there will be breaches resulting in the potential for outbreaks and related staffing issues and harm to patients	NH AG	• Staff continuously reminded that they must not breach PPE by car sharing, removing masks in handover meetings etc. • Training including PPE Self Assessment	Risk score Reduced 5 x 4 = 20	March 21 5 x 2 = 10	Command structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 37	If EPUT is unable to ensure that premises are COVID19 secure then community based services cannot restart resulting in further delays in service delivery	PS/ TS	• COVID19 Secure guidelines – differences between organisations escalated to region • Any concerns are identified via command structure	Risk Score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 10	If EPUT is unable to maintain its planned capital programme through lack of contractor access then delays or deferments may occur resulting in increased pressure on the capital programme in recovery	TS	• Second lockdown impacting on capital programme	Risk Score 3 x 3 = 9	Jul-20 3 x 2 = 6	Command Structure Above threshold
CVG 45	If EPUT does not manage clinical waste during COVID19 then hazardous material may be stored longer at a local level resulting in the potential for spread of infection and harm to patients and staff	TS	• Procurement put in place alternative storage arrangements whilst there was an issue with the contractor • Contact maintained with contractor • Environment agency are aware of any issues and understand the necessity to store waste on site in locked cages	Risk score 4 x 2 = 8	December 20 4 x 2 = 8	Command Structure At threshold
CVG 48	If EPUT does not manage staff levels, staff engagement and input for recording of lateral flow staff testing then resource requirements may not be met resulting in failure to deliver the staff testing project and asymptomatic testing	NH	• Staffing risk assessment completed with identified mitigating actions • NHS Lateral Flow Testing Webinar attended • Range of learning from other Trusts produced regionally • Some gaps in staff reporting their LFT	Risk score 4 x 3 = 12	Ongoing for duration of crisis 4 x 2 = 8	Command Structure Above threshold
CVG 52	If EPUT does not have sufficient resource to effectively project manage and deliver the asymptomatic testing programme across the Trust then it may not meet the deliverables and timescales and potential failure of the programme	NH NL	• EPUT distributes Covid19 swab testing kits for asymptomatic patient facing staff • Page dedicated to asymptomatic testing on InPut including video guides, manager action lists, FAQs and self-testing guide • Live event held on asymptomatic testing including the video	Risk score 5 x 2 = 10	March 21 4 x 2 = 8	Command structure Above threshold

Risk ID	Potential Risk	Exec Lead	Overview update	Current Risk scoring status (consequence x likelihood)	Target Score/ Completion Date	Assurance threshold
CVG 55	If EPUT continues to experience ward closures due to Covid19 outbreaks then availability of beds to acutely ill patients may diminish resulting in additional community/virtual support and potential harm to patients	AG	• Mitigation in place for swabbing, lateral flow testing on wards • ICP Dashboard developed to help identify wards at potential risk • Daily sit reps provide information on any Covid positive patients/Staff • Outbreak management process in place • No current outbreaks as at 14th May 2021 • Extend completion date in line with national lockdown easing	Risk score 5 x 3 = 15	March 21 June 21 5 x 2 = 10	Command structure Above threshold
CVG 24	If EPUT does not ensure that staff have the new range of skills required to deal with the C19 crisis then appropriate care may not be delivered to patients resulting in potential harm to patients and challenges for staff	NH AG	• Competency skills assessment carried out in wave 1 reviewed • IPC competency self-assessments	Risk score 5 x 3 = 15	Ongoing for duration of crisis 5 x 2 = 10	Command Structure Above threshold
CVG 46	If EPUT does not manage the delivery of valid server generated emails to staff outlook inboxes (following NHS mail national update) then important or urgent COVID19 emails may be missed resulting in a delay in information cascade or the submission of urgent returns	TS	• ITT working with NHS Digital to resolve this issue for EPUT • Staff have been reminded to check their junk email boxes for any important missed information • National problem and all efforts being made to resolve • No further updates on this risk – maintain watching brief • Recommend reduction in score to 4 x 2 = 8	Risk score 4 x 2 = 8	Dec 20 Mar 21 4 x 1 = 4	Command Structure Above threshold
CVG 56	If EPUT does not prepare for potential strike action then then there may be a shortfall of staff resulting in a lack of sustainability to run local services	All	•	Risk Score 5 x 3 = 15	Ongoing 5 x 1 = 5	Command Structure Above threshold

Table 2: Mapping of risks against 5 x 5 scoring matrix

	RISK RATING					
	Consequence					
		1	2	3	4	5
Likelihood	1					
	2				CVG19 CVG45 CVG46	BAF43 ↓ CVG52
	3		BAF38	CVG10	BAF42 CVG33 CVG48	CVG55 CVG24 CVG56
	4					BAF50 BAF51 CVG51 ↓
	5					

Risks Closed since last report

BAF44	Closed Feb 21
BAF52	Closed Feb 21
CVG20	Closed Jan 21
CVG44	Closed Jan 21
CVG32	Closed Jan 21
CVG14	Closed Jan 21
CVG47	Closed Jan 21
CVG49	Closed Jan 21
CVG50	Closed dec 20
CVG53	Closed dec 20
CVG54	Closed Jan 21

		Agenda Item No: 9ii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**EU Exit**					
Executive/Non-Executive Lead:	Nigel Leonard Executive Director of Strategy & Transformation					
Report Author(s):	Lara Brooks Head of Risk Management and Legal Services					
Report discussed previously at:	Executive Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	EU Settlement scheme
State which BAF risk(s) this report relates to	BAF23
Does this report mitigate the BAF risk(s)?	Yes (part)
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report presents an update on EPUT's position in regards to the EU Exit and highlights any risks.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Trust Board is recommended to:

1. Note the content of this report
2. Request any further information or action as necessary

Summary of Key Issues

This report presents an update on EPUT's monitoring of the Exit trade deal areas without agreements or awaiting further guidance and provides details of any impact on service delivery and assurance on the Trust's continued response to this.

The UK government has agreed a trade agreement with the EU. There will still be changes following the end of the transition period and having left the Single Market and Customs Union.

The Trust's preparations for the end of the transition period and post transition have been taking place alongside our response to Covid-19 and winter pressures. The Trusts EU Exit Task & Finish Group continues to meet on a monthly basis alongside monthly admin meetings. There will still be changes post transition and the Task & Finish Group will continue to meet to discuss and monitor any requirements that are relevant to the Trust and our services.

EU Exit correspondence continues to be managed through the EPUT Incident Control Centre. With effect from the 23 December 2020 the Trust were asked to highlight any areas of concern in our Covid19 National Daily Sit Rep return to NHSEI positively or negatively. Members of the Task & Finish Group are in attendance at Silver Command and confirmation is obtained on the above requirements for the daily returns. To date no concerns have been raised on these areas.

The risk score on the BAF has been reduced in January from 16 to 12 (4(C) X 3(L)) and the action plan has been revised and completed. The BAF action plan and risk register is considered by the task and finish group and is available on request to Board Members.

The Task & Finish group are able to confirm that it met the majority of requirements for preparedness that NHSEI has identified. Whilst difficult to predict, the Task & Finish Group believe the following to be the key areas of concern:

- EU Settlement Scheme and new immigration system from 1 January 2021

  The Settlement Scheme will allow EU Nationals to continue to live and work in the UK beyond June 2021, meaning they will not need to apply for visas when the new immigration systems takes effect. The scheme will also lock in the rights of EU nationals, meaning they will be able to access healthcare, benefits and other government services in the same way they currently do. They have the right to remain until June 2021.

  The risk identified is if staff needed to apply to the settlement scheme do not do so or are unable to do so they will not be able to remain in the UK. The impact is particularly noticeable for operational staff and estates and facilities staff. To mitigate all staff have been asked to update the Trust before June 2021 on their status. HR is continuing to assist staff on a regular basis and encouraging them to apply to the EU Settlement Scheme.

  - 107 staff have settlement status
  - 47 staff are in application process
  - 33 awaiting update on application / settlement status

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

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

Acronyms/Terms Used in the Report			
EU	European Union	NIHR	National Institute for Health Research
BAF	Board Assurance Framework	MHRA	Medicines and Healthcare products Regulatory Agency
EHIC	European Health Insurance Card	ICC	Incident Control Centre
GHIC	Global Health Insurance Card	HR	Human Resources
BAU	Business as usual	ITT	Information Technology
NHSEI	NHS England/Improvement	CCG	Clinical Commissioning Group
PHE	Public Health England	EEA	European Economic Area

Supporting Documents and/or Further Reading
EU Exit Report

Lead
 Nigel Leonard Executive Director of Strategy & Transformation

Agenda item 9ii
Trust Board of Directors
26 May 2021

EU Exit

1.0 PURPOSE OF THE REPORT

This report presents an update on EPUT's position within the Trust for EU Exit, post transition and assurance on EPUT's continued response to this.

2.0 BACKGROUND

This report presents an update on EPUT's monitoring of the Exit trade deal areas without agreements or awaiting further guidance and provides details of any impact on service delivery and assurance on the Trust's continued response to this. The UK government has agreed a trade agreement with the EU. There will still be changes following the end of the transition period and having left the Single Market and Customs Union. The Trust's continued monitoring for the end of the transition period and post transition have been taking place alongside our response to Covid-19 and winter pressures.

3.0 EU Agreement

3.1 NHSEI highlighted key messages to Trusts on the exit immediately post the transition period and following the agreement with the EU on the relationship for future. The below were the key messages received:

- **Medicines**
  Prescribe and dispense as normal.
  Don't stockpile locally.
  Report shortage through usual routes.

- **Medical Devices, clinical consumables, non-clinical goods and services**
  Measures are in place to help ensure stocks continue to be available even if there are transport delays.
  Don't stockpile products (adjust lead times for ordering process).
  Ensure all staff are aware of changes to delivery lead times.

- **Workforce**
  Government and the NHS support staff from the EU to continue to work in the NHS.
  The EU Settlement Scheme is open to all EU citizens, encourage staff to apply to EU Settlement Scheme.
  Recognition of professional qualifications will apply for at least two years after the end of the transition period.
  Most healthcare roles are exempt from the restrictions imposed by the Immigration Bill.
  The immigration surcharge does not apply to registered professionals and their family members.

- **Data**
  NHS organisations and staff should continue to handle data as they currently do.
  The agreement the Government has reached includes a provision to provide for the continued free flow of personal data from the EU and EEA until adequacy decisions are adopted (and for not longer than 6 months).

- **Reciprocal healthcare and cost recovery**
  A new UK Global Health Insurance Card (GHIC) will be available for the new year in recognition of the new agreement with the EU. This will replace the EHIC.
  The agreement the Government has reached with the EU ensures that UK residents will continue to have access to emergency and necessary healthcare cover when they travel to the EU. This will operate like the current EHIC scheme. Current EHIC will still be able to be used when travelling to the EU and remain valid until their expiry date.

- **Vaccines**
  Don't stockpile vaccines beyond BAU levels.
  Pharmacists and emergency planning staff should meet at a local level to discuss and agree local contingency and collaboration agreements.
  Local cross-system medicines supply continuity plans should be developed and agreed at trust/CCG board level.
  There is a Vaccines Shortage Response Group for nationally and locally procured vaccines, co-ordinated by PHE and NHSEI with membership from the Devolved Administrators.
  Any COVID-19 vaccine will be included in the mitigations set out in the Medicines section above.

- **Research and clinical networks**
  Continue participating in and recruiting patients to clinical trials and investigations.
  Principal investigators are encouraged to work with their suppliers to review their existing supply chains for clinical trials.
  Continue to monitor and follow guidance from NIHR and MHRA in relation to how to operate from 1 January 2021.
  Clinical trial sponsors should ensure appropriate supplies of trial drugs and medical products are in place.

- **Health Security**
  The agreement will ensure we can continue to cooperate, exchange information and coordinate on measures to protect public health. This includes a framework for the UK's ad-hoc access to the EU's Early Warning System, which will strengthen cooperation in the event of a cross-border threat to health.

The above areas are monitored by the Task & Finish Group members who provide assurance that there are no risks or concerns from these key messages.

4.0 EU Exit Task and Finish Group

4.1 Frequency

The Trusts EU Exit Task & Finish Group continues to meet on a monthly basis alongside monthly EPRR admin meetings.

There will still be changes post transition and the Task & Finish Group will continue to meet to discuss and monitor any requirements that are relevant to the Trust and our services.

4.2 Review of Guidance

EU Exit correspondence is included in the daily ICC procedures covering the mailboxes between 8am-8pm Monday to Friday. With effect from the 23 December 2020 the Trust have highlighted any areas of concern in our National Daily Sit Rep return to NHSEI positively or negatively to the below:

Are there any EU Exit related issues which are expected to impact business critical services until the next daily sitrep is due, for each of the following areas:

- Supply of Medicines & Pharmacy
- Supply of Medical Devices & Clinical Consumables
- Supply of non-clinical consumables, goods and services
- Supply of blood products, transplant organs and tissues
- Workforce
- Estates & Facilities
- Clinical Trials
- Data sharing, processing & access
- Reciprocal Healthcare
- Cost recovery
- Partner organisations that are essential to delivery of healthcare

Members of the Task & Finish Group are in attendance at Silver Command and confirmation is obtained daily on the above requirements for the daily returns. To date no concerns have been raised on these areas.

4.3 BAF23 Action Plan

The risk score on the BAF in January was reduced from previous scores to 4(C) X 3(L) = 12 and the action plan has been revised.

The BAF action plan and risk register is considered by the task and finish group and is available on request to Board Members.

The Task & Finish group are able to confirm that it met the majority of requirements for preparedness that NHSEI has identified. Whilst difficult to predict, the Task & Finish Group believe the following to be areas of concern:

EU Settlement Scheme and new immigration system from 1 January 2021

The Settlement Scheme will allow EU Nationals to continue to live and work in the UK beyond June 2021, meaning they will not need to apply for visas when the new immigration systems takes effect. The scheme will also lock in the rights of EU nationals, meaning they will be able to access healthcare, benefits and other government services in the same way they currently do. They have the right to remain until June 2021.

The risk identified is if staff needed to apply to the settlement scheme do not do so or are unable to do so they will not be able to remain in the UK. The impact is particularly noticeable for operational staff and estates and facilities staff. To mitigate all staff have been asked to update the Trust before June 2021 on their status. HR is continuing to assist staff on a regular basis and encouraging them to apply to the EU Settlement Scheme.

The below provides information on the current status of settlement status for staff, applications in progress and those awaiting update on application/status and the areas that they apply to.

- 107 staff have settlement status
- 47 staff are in application process
- 33 awaiting update on application / settlement status

Breakdown by contract type from those whom we are awaiting updates on settlement status

Permanent	4 Staff
Bank / Locum	29 Workers

Breakdown by directorate (Permanent Staff Only)

MH – NE and West	2
Specialist Services	2

Breakdown by Speciality (Permanent Staff Only)

Admin / Management	1
Mental Health Qualified	2
Occupational Therapists	1

Breakdown by Speciality (Bank and Locum only)

Administrational	1
Ancillary	2
Healthcare Support Worker	9
Medical	1
Qualified Nursing	6
Mass Vaccination Programme Unqualified	6
Mass Vaccination Programme Qualified	4

Breakdown by staff in application Process

Permanent	18 Staff
Fixed term Contract	3 Staff
Bank / Locum	26 Workers

Breakdown by directorate (Permanent/fixed term Staff in application only)

MH – NE and West	8
MH – South and Mid	3
Specialist Services	3
Medical	1
Finance & Resources	2
People & Culture	1
Research & Development	1
West Essex Community Health Services	1
South East Essex CHS	1

Breakdown by speciality (staff in application)

	Permanent / Fixed term	Bank / Locum
Administrational	3	
Ancillary	3	
Healthcare Support Worker	7	11
Medical	1	
Qualified Nursing	3	4
Occupational Therapist	1	
Psychology	3	1
Physiotherapist		1
Social worker		1
Mass Vaccination Programme Unqualified		9
Mass Vaccination Programme Qualified		3

In addition HR continue to have regular communications with the staff and their managers on the scheme and undertake additional follow ups with the permanent staff.

5.0 RECOMMENDATIONS

The Trust Board of Directors are recommended to:

1. Note the content of this report
2. Request any further action or information as necessary

Prepared by:

Lara Brooks
Head of Risk Management & Legal Services

On behalf of:

Nigel Leonard
Executive Director of Strategy & Transformation

		Agenda Item No: 9iii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Ligature Risk Management Year End Learning Report 2020-21**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Catriona King, Ligature Risk Coordinator Jane Cheeseman, Head of Compliance & Emergency Planning					
Report discussed previously at:	Ligature Risk Reduction Group Quality Committee Executive Safety Oversight Group					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	No new risks identified
State which BAF risk(s) this report relates to	BAF10 - If EPUT does not reduce ligature risks then serious incidents will occur resulting in a failure to deliver our Safety First, Safety Always ambitions
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
The purpose of this report is to provide an update and assurance of actions undertaken in 2020/21 and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate	**Approval**	
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors are asked to:

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

Summary of Key Issues

The Trust is committed to continuously improving systems and processes that facilitate robust risk identification and management, carrying out patient safety improvement works to create safer physical environments and to creating a risk aware culture. Ligature risk remains on the Board Assurance Framework as a significant risk and the full action plan continues to be monitored regularly.

Independent Assurance

BDO, the Trust's internal independent auditors carried out testing of the Trust's implementation of its ligature risk management policy and procedures in 2020 and overall concluded substantial assurance for the design of the controls and moderate assurance on the effectiveness of the controls in place at the Trust.

It was agreed to expand the audit to test that policy and procedure is being implemented at ward level. The expanded audit will cover 19 wards and is planned to take place in 2021.

The CQC produced an updated briefing guide (August 2020) on ligature points for inspection

teams which guided inspectors on the evidence required for inspections, the reporting and the policy position. The CQC have not undertaken any ligature inspections at EPUT, however work was undertaken internally to review the EPUT position against the CQC criteria.

In addition to testing against new CQC inspection criteria, EPUT has continued to test embedding of actions and learning identified at previous inspections. Testing in 2020/21 has identified that there is sufficient evidence for a majority of the actions and learning from previous CQC inspection being met, embedded and sustained. However, there are some areas where the embedding of the original action taken could not be fully evidenced.

In 2020/21 EPUT has been working with East London Foundation Trust (ELFT) to undertake peer reviews. The purpose of the ELFT review is to identify improvements that could be made to EPUT ligature processes through shared learning with ELFT. The review was undertaken with onsite ward visits to assess the environments and to compare processes The outcome report is still awaited and plans to visit ELFT to be arranged to ensure that learning can be identified from comparison.

Where gaps and/or learning has been identified from independent assurance actions has been taken.

Leadership
The Executive Chief Operating Officer was appointed as the new chair to the Ligature Risk Reduction Group (LRRG) and brought a new challenge and integration to the group drawing focus to the Safety First, Safety Always Strategy

Governance
The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Executive Chief Operating Officer. Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

The Ligature Policy and Procedure has continued to be reviewed as new guidance and learning is published.

Ligature Environmental Risk Assessments of all MH and LD wards has continued in 2020/21 undertaken by a team of professionals from H&S, Estates and the Ward. A review of the assessment tool has been undertaken to ensure this considered all national safety alerts when received and a pilot is underway of a new electronic assessment tool.

Continuous Learning
During 2020/21 there were 16 Safety Alerts relating to ligature risks identified and issued to inpatient areas across the Trust. Actions has been taken where required and monitored via the LRRG

A Review of serious incidents due to ligature has been undertaken to identify if there were any key theme and to review learning. The number of inpatient incidents meeting the current serious incident criteria is small and it was therefore difficult to draw any common themes. The review found a number of changes had been made following Sis including changes to Trust environmental standards for collapsible bins and changes to garden management.

Ligature incident dashboards on Datix have been developed and rolled out to all mental health, LD and specialist service ward managers to provide live data.

Incident data is analysed by the LRRG bi-monthly to identify trends and learning. During 2020/21 there have been a total of 34 incidents using a fixed ligature point reported compared to 47 during 2019/20. The majority (97%) were rated as either ‘No Harm’ or ‘Low Harm’ however one resulted in a death on one of our older person’s functional wards which is being investigated.

Trend analysis has shown a sustained decrease in ligature related incidents on EPUT PICU

wards. PICU and Older Adult ward ligature incident rates remain below the national benchmark. Adult ward ligature incident rates has fluctuated and sits consistently above the national benchmark.

Enhancing Environments
The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme.

The EPUT risk stratification programme aims to identify all environmental standards set and assess each ward against the requirement, where gaps are found a programme of works is agreed. .

Culture - Staff Training
EPUT aims to develop a culture of risk awareness and continuous learning when incidents happen. An essential part of developing this culture is having robust training programmes for staff. Ligature training is delivered via a range of courses including Ligature Risk Awareness e-learning. Overall trust compliance with the eLearning ligature risk awareness training as of the 6th April 2021 was 71%. Compliance is monitored via LRRG and has been escalated as a potential risk while we are below Trust target.

The Trust also provides bespoke ligature risk assessment training for EPUT staff who undertake ligature risk inspections within out mental health wards, the training is being delivered over two days by Tidal Training.

Innovation
The Trust has been working in partnership with technology provider, Oxehealth, to implement and utilise Oxevision, a digital tool that allows for contactless monitoring of vital signs and movement to improve patient safety, quality, and efficiency of care within inpatient wards.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:	
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives	✓
Data quality issues	
Involvement of Service Users/Healthwatch	

Communication and consultation with stakeholders required			
Service impact/health improvement gains			✓
Financial implications: **Capital £** **Revenue £** **Non Recurrent £**			
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**YES/NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
BAF	Board Assurance Framework	LRRG	Ligature Risk Reduction Group
CQC	Care Quality Commission	ELFT	East London Foundation Trust

Supporting Documents and/or Further Reading
Ligature Report

Lead
Nicola Jones **Director of Risk and Compliance (Interim)**

EPUT

Ligature Risk Management Year End Learning Report 2020-21 to Trust Board

1.0 Introduction

This year-end report provides an update of the work that has been undertaken and areas that are planned going forward to continue to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate.

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

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

2.0 Independent Assurance

2.1 Internal Audit

BDO, the Trust's internal independent auditors carried out testing of the Trust's implementation of its ligature risk management policy and procedures during July, August and September 2020; the findings were shared with the Trust in December 2020. Overall, the auditors concluded substantial assurance for the design of the controls and moderate assurance on the effectiveness of the controls in place at the Trust. The following actions were taken to address recommendations made:

- Ensure ligature awareness training compliance (including breakdown by location) is a standing agenda item and monitored at every monthly LRRG meeting.
  Response: added as standard agenda item
- Suicide awareness and response training should be mandatory for all inpatient staff (except Community Health Service staff), set a compliance target and ensure it is monitored.
  Response: Ligature ELearning training is already essential training for inpatient staff and suicide awareness training is monitored via supervision.
- Update the Ligature Risk Assessment Management procedure to include the frequency of Ligature reporting to the Health, Safety and Security Committee (HSSC).
  Response: procedure updated

It was agreed to expand the audit to test that policy and procedure is being implemented at ward level, the scope of this review will cover the following control objectives:

- Interview key staff members (wards, estates and risk management staff) and identify whether they are aware of their roles and responsibilities in accordance with policies and procedures.
- Visit wards and select a sample of staff (including Temporary, Bank and Agency) to confirm that staff are aware of their duties and responsibilities and sign Local Induction Checklist Select a sample of wards and obtain the Ligature red tabbed wallets, review the contents and interview staff to ensure they are compliant with Appendix 4 of the policy and procedure

- Select a sample of wards and confirm the ligature cutters are compliant with Appendix 5 of the policy and procedure
- Review the guidance available to staff when preparing, completing and issuing the Ligature risk assessment tool and reports and confirm whether it is appropriate.
- Select a sample of actions from ligature inspections and confirm they have been implemented and monitored within a timely manner (using Datix and the Estates 3i system)
- Review the local risk procedures and processes in place for identifying, monitoring and escalating risks and confirm they are appropriate.
- Discussion with staff to assess understanding of room risk ratings, mitigation actions and management requirements

The expanded audit will cover 19 wards and is planned to take place between the 10th and 20th May 2021. Ligature will remain a constant on the internal audit programme.

2.2 Care Quality Commission

In August 2020 the Care Quality Commission (CQC) produced an updated briefing guide on ligature points for their inspection teams which guided inspectors on the evidence required for inspections, the reporting and the policy position. The update highlighted that the CQC remain concerned about a number of organisations where there is a lack of improvement in some estates and the absence of a sense of urgency that change is needed.

Since March 2020 the CQC confirmed immediate cessation of all routine inspections limiting any visits to focused inspections where risks had been identified. Therefore, within EPUT; an inspection using the ligature point guide has not as yet been undertaken by the CQC. The briefing guide is currently under further review by the CQC.

While a CQC inspection has not been undertaken work was undertaken internally to review the EPUT position against the CQC criteria within the briefing. The Compliance Team undertook a mixture of virtual meetings and evidence gathering to provide assurance of whether any non-compliances would be found in the event of CQC undertaking an inspection against the criteria.

Only a limited number of wards were selected for the review however, the findings were useful in indicating that there was an issue with the staffs understanding of the room RAG ratings on the Ligature inspection risk assessment tool. Staff were able to identify the high-risk rooms (unsupervised), the supervised rooms and the no access rooms however at the time of the review were unable to correlate the correct RAG colour to the room.

All wards confirmed their understanding of anchor points and that they can be at any height. Within each Ligature Inspection, any height anchor point is noted as a non-compliance (against the standards) therefore action is required to be undertaken to remove or reduce the ligature risk. The action, dependant on room type, could be a full replacement, repair or awareness and identification within the ward hot spots photo gallery.

The full findings of the review were highlighted to the Ligature Risk Reduction Group (LRRG) where actions were agreed to address the findings.

In addition to testing against new CQC inspection criteria EPUT has continued to test embedding of actions and learning identified at previous inspections. Testing in 2020/21 has identified that there is sufficient evidence for a majority of the actions and learning from previous CQC inspection being met, embedded and sustained however; there are some areas where the embedding of the original action taken could not be fully evidenced.

Further strengthening of two actions identified previously was required and is being taken forward by the Estates Team monitored by LRRG:

- Risk Team being notified when the Ward environment changed so that a Ligature Risk Inspection could be undertaken
- Ensuring all Floor Plans included the garden area

2.3 ELFT Review

In 2020/21 EPUT has been working with East London Foundation Trust (ELFT) to undertake peer reviews. The purpose of the ELFT review is to identify improvements that could be made to EPUT ligature processes through shared learning with ELFT. The review was undertaken with onsite ward visits to assess the environments and to compare processes followed in the two organisations with a focus on:

- Ligature risk identification
- Action identified and plan to complete
- Mitigation and management of ligature risks which cannot be removed and
- Staff ownership of the ligature process on the wards

The outcome report is still awaited from the ELFT visit and plans for EPUT staff to visit ELFT are in progress. On receipt of the report the outcomes from the review will be taken to the EPUT LLRG for full consideration.

3.0 Leadership

Leadership for ligature management has been invigorated in 2020/21 challenging all staff to move towards the common goal of ongoing ligature reduction as a key part of the Trust Safety First, Safety Always Strategy. This year has been a challenging year across the country with the Covid 19 pandemic. Over this time EPUT has continued to maintain a focus on ligature improvement work

The Executive Chief Operating Officer was appointed as the new chair for the Ligature Risk Reduction Group. The new chair challenged the group to ensure ongoing clinical focus at the meetings and responsiveness to actions agreed.

A dedicated Ligature Co-Ordinator was employed by EPUT in July 2020 to provide a dedicated ligature resource.

A new Executive Safety Oversight Group has been established, who receive regular updates on ligature management and have provide an immediate escalation root when needed from the LRRG.

4.0 Governance

4.1 Ligature Monitoring and Reporting

The Trust continues to hold a Ligature Risk Reduction Group (LRRG) each month; chaired by the Executive Chief Operating Officer (deputy chair Director of Mental Health (NE & W Essex). The group reports to the Health Safety and Security Committee and provides a monthly assurance report to the new Executive Safety Oversight Group (ESOG).

The LRRG ensures:

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

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

Quarterly Ligature reports are shared with the Trust Quality Committee and Trust Board of Directors to provide assurance reporting and risk escalation.

4.2 Policy and Procedure Changes

The Ligature Risk Assessment and Management Policy and Procedure (CP75) was launched in April 2019. Following a six-month implementation period, the policy was reviewed in October 2019 and had a full annual review in September 2020 and another full review in March 2021. The policy and

procedure aim to ensure there are robust ligature risk management processes across EPUT.

A summary of review and amendments in 20/21 include:

- A review of the ligature inspection program, frequency from 6 monthly to annual with a 6 monthly formal review midway which will include supporting staff, education, training, coaching and follow up of gaps in compliance.
- A review of the heat maps.
- Appendix 1 amendments to the ligature assessment tool
- Appendix 5 addition of wire cutters to the ligature pack
- Appendix 9 additional environmental standards agreed at LRRG as outlined in section 6.1
- Appendix 10 includes final report sign off process.
- Process in the event of ward closures added to procedure.

4.3 Ligature Environmental Risk Assessment

Regular review of the Ligature Risk Assessment tool is undertaken to ensure learning from safety alerts and incidents is considered. In 2020/21 a project was initiated to explore if an electronic risk assessment tool could be used, different options were explored with a number of companies. A member of the H&S Team took a personal interest in this project and designed a bespoke electronic tool this was also considered alongside other options. The in-house designed tool was agreed to be the best fit for EPUT and piloting of this tool has started in April 2021.

A team of professionals made up of a member of the H&S Team, member of the Estates team and the ward manager undertake each Ligature Risk Assessment. Each assessment is undertaken on the ward over a ½ day period inspecting all un-supervised and supervised areas. Areas on the wards patients cannot access are not included. This ensures robust inspection of the environment and actions identified that require Estates intervention can be taking forward immediately.

A draft inspection outcome report is shared with all parties for agreement and includes action identification. Once all parties agree a final report is issued and actions monitored until completion. Any concerns are escalated to the LRRG. Closing of actions within set timescales has been a challenge in 2020/21 and work is underway between the H&S and Estates Teams to make processes more robust.

The EPUT Executive Team challenged the organisation to look at how an independent ligature risk assessment could be utilised and a proposal is currently being developed for approval. We have approached LERAC (a company recommended by Tidal Training) to undertake the independent assessments in the following format:

- using the trust approved ligature risk assessment tool
- undertaken by at least one NEBoSH qualified professional
- undertake on site ward ligature risk assessments to identify any new and outstanding hazards and evaluate the risk they present in addition to identify control measures required to mitigate the risks.
- LERAC will be part of the ligature risk assessment team with the ward manager and estates representative.
- LERAC will complete a written report which will detail the high-risk areas and risk mitigation through remediation, monitoring and auditing phases. This will be in addition to the Trust approved ligature risk assessment tool.
- LERAC will work with our estates department to identify the ligature risks so they can develop a work plan to remediate the risks and recommend timescales.

A pilot is being proposed to test the effectiveness of LERACs risk assessment and report writing processes and to evaluate the impact this has on ligature risk within the organisation. The pilot is intended to release some capacity within the risk team to facilitate onsite ward visits for ligature risk awareness, coaching, teaching and compliance auditing. It will also provide an opportunity for external assurance regarding our internal processes and risk mitigation in relation to ligature.

4.4 Co-production

Pre-pandemic two ligature risk assessments of inpatient wards have included a person with lived experience (PWLE) as part of the assessment team. A protocol is in place to carry out this activity safely. Unfortunately, there has been limited progress with this initiative since the last report, initially due to availability of persons with lived experience, and later due to the pandemic and the pausing of on-site inspections.

The inspections have now fully recommenced and the inclusion of PWLE is due to be reviewed with the Patient Experience team to ensure involvement going forward and that dates are secured to join the assessments.

5.0 Continuous Learning

5.1 Ligature Safety Alerts

During 2020/21 there were 16 Safety Alerts relating to ligature risks identified and issued to inpatient areas across the Trust. Safety Alerts are issued in EPUT following either a national safety alert via the CAS system or to share learning from organisations and internal incidents.

Once an alert has been issued this is received by key staff including Matrons/Clinical leads who are responsible for reviewing the alert and taking the appropriate action as indicated in the alert. Matrons/Clinical leads then provide assurance that the alert has been received and actioned via the Trust Datix system. All alerts are discussed at LRRG and where Estates assistance is required referred to the EERG.

The Risk Management Team continue to distribute and monitor Safety Alert information for the trust through the DATIX system. Additionally, Ward/Team Managers have been requested to include Safety Alerts as a standing item agenda in their Team Meetings.

5.2 Serious Incident Review

A review of ligature incidents results in patient harm was undertaken in 2020/21 to identify if there were any key themes and review learning. The review looked at all SIs since EPUT was founded and noted:

- There were six ligature incidents resulting in patient harm on EPUT inpatient wards since Trust merger in 2017 to the end of March 2021(less than 2 per year).
- 5 of the incidents resulted in patient death and 1 incident resulted in the patient requiring lifesaving treatment.
- 5 incidents related to female patients and 1 related to male patients.
- All incidents occurred on different wards across the Trust.
- 3 affected patients had a diagnosis of Emotionally Unstable Personality Disorder.
- 4 incidents included the use of a fixed ligature point
- All incidents used different ligature anchor point

The number of inpatient incidents meeting the current serious incident criteria is small; it is therefore difficult to draw any themes. Learning identified from the SI review was considered at LRRG.

Moving forward with the new National Patient Safety Incident Framework, for which the Trust is an early adopter, consideration will be given to the interface between the Patient Safety Incident Team and LRRG's role in the Trusts response to all ligature incidents on inpatient wards. How the level of harm is attributed and how learning from "near miss "incidents is shared.

5.3 Ligature Incident Data

5.3.1 Reporting

Ligature incident dashboards on Datix have been developed and rolled out to all mental health, LD and specialist service ward managers. The dashboard identifies all ligature incidents both with and without an anchor point by date, ward, secure fixture used and items used. This gives staff a real time picture of incident activity relating to ligature incidents to quickly identify any emerging trends for action.

The Trusts inpatient teams do receive significant data regarding all ligature incidents via the Trusts clinical incident report and this is analysed for themes and learning by the Clinical Governance and Quality Committee.

A bi-monthly incident report is presented to LRRG providing an overview of ligature incidents in which a mental health inpatient has attempted/succeeded self-harm. The report details incidents using both a secured point to fix a ligature and an unsecured ligature. The report details incidents from April 2017 to current reporting period for the group.

5.3.2 Fixed Point Ligature

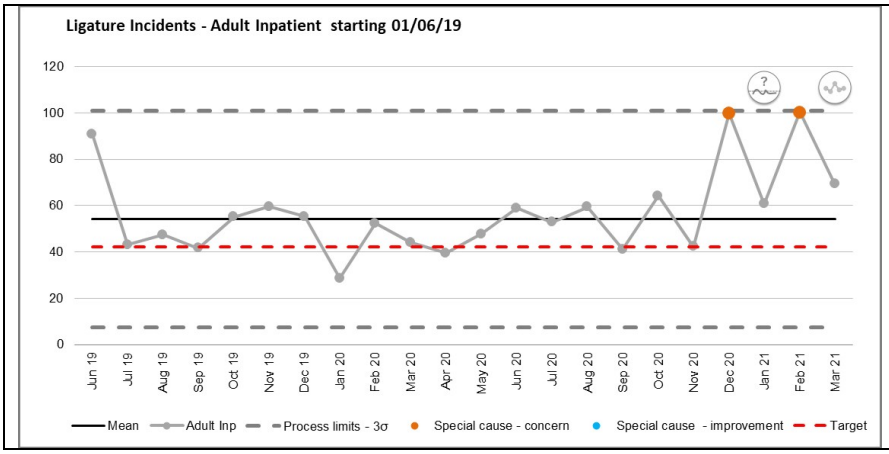
During 2020/21 there have been a total of 34 incidents using a fixed ligature point reported compared to 47 during 2019/20. The majority (97%) were rated as either 'No Harm' or 'Low Harm' however one resulted in a death on one of our older person's functional wards which is being investigated.

Fixed point ligatures are discussed at LRRG where analysis is undertaken to identify any common themes and to ensure shared learning.

5.4 Ligature Incident Trend Analysis

Trend analysis is undertaking on a monthly basis as part of the Trust Quality and Performance Report. Analysis in 2020/21 has shown a sustained decrease in ligature incidents in PICU wards, Adult wards have seen no statically significant changes nor have older adult wards. Please see charts 1-3 below.

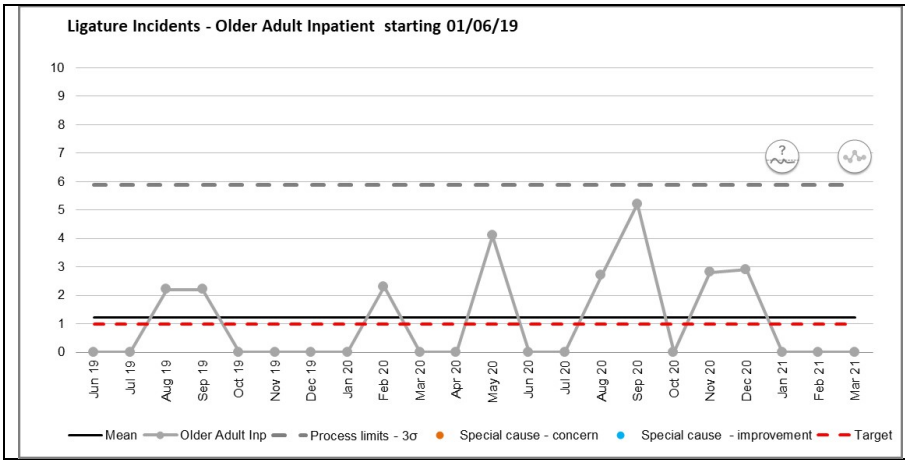
Chart 1: Ligature incidents national benchmarking – Adult inpt 42 per 10,000 BDs



SPC trend analysis shows no statically significant reduction in ligature incident rates. Two peaks are noted in Dec 20 and Feb 21.

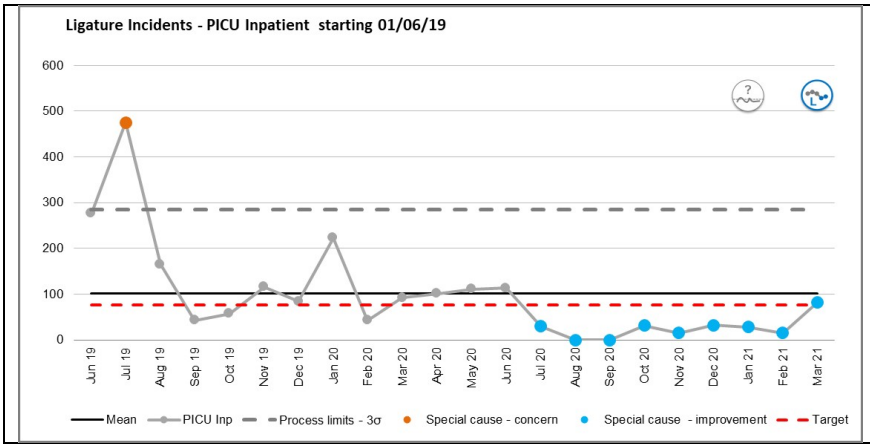
EPUT is sitting on average above national benchmark

Chart 2: Ligature incidents national benchmarking – OA inpt 1 per 10,000 BDs



SPC trend analysis shows no statically significant trends. EPUT is sitting on average below national benchmark

Chart 3: Ligature incidents national benchmarking – PICU inpt 77 per 10,000 BDs



SPC trend analysis shows a statically significant decreasing trend. This indicates a sustained improvement in ligature incident numbers.

EPUT is sitting on average below national benchmark

6.0 Enhancing Environments

6.1 Setting Environmental Standards

The LRRG has and continues to develop agreed risk reduced environmental standards that inform the Trust's investment and patient safety improvement works programme. A range of new standards were agreed during 2020/21 following learning from Safety Alerts, internal incidents and intelligence shared by other organisations.

6.2 Risk Stratification Programme

The EPUT risk stratification programme, in line with policy, is owned by the Director of Estates and presented to the Ligature Risk Reduction group on a monthly basis. The risk stratification programme aims to identify all environmental standards set and assess each ward against the requirement, where gaps are found a programme of works is agreed. A range of works were completed in 20/21.

6.3 Patient Safety Spend

The tables below outline the patient safety spend within EPUT since the Trust was established. Ligature risk reduction work is included within the patient safety spend:

2017/18	
Total Spend	£320,414

2018/19	
Total Spend	£1,191,078

2019/20	
Total Spend	£2,411,342

2020/21 Forecast	
Total Forecast	£1,337,224

7.0 Culture - Staff Training

EPUT aims to develop a culture of risk awareness and continuous learning when incident happened. An essential part of developing this culture is having robust training programmes for staff.

Ligature training is delivered via the following EPUT course:

- Ligature Risk Awareness e-learning
- Clinical Risk
- Suicide Prevention
- Ligature cutters (inc) Grab Bag Training
- Ligature Risk Assessment Training (external provider - TIDAL)

All staff working within a mental health/LD inpatient setting are required to complete the ligature awareness on-line training package "Preventing Suicide by Ligature" (launched in March 2018 and reviewed December 2019 and April 2021) 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.

Overall trust compliance with the eLearning ligature risk awareness training as of the 6th April 2021 was 71%. Compliance is monitored via LRRG and has been escalated as a potential risk while we are below Trust target.

The Trust has procured new bespoke ligature risk assessment training for EPUT staff who undertake ligature risk inspections within our mental health wards in 2020/21. The training is being delivered over two days by Tidal Training; attendees include ward managers, members of the risk team, estates staff and clinical staff band 6 and above who undertake ligature risk assessments.

This training is specifically designed for multi-disciplinary staff groups to understand the context of people using a ligature, both for self-harm or suicidal purposes and to risk assess their own environment to establish potential significant spots where ligature may be possible, but preventable.

The overall aim of the sessions is to equip and skill staff members to be confident in identifying ligature risks and to continue to monitor and update risk assessments for their individual work areas.

To date 47 staff have been trained with positive feedback received. This training will continue to be offered in 2021/22.

8.0 Innovation

The Trust has been working in partnership with technology provider, Oxehealth, to implement and utilise Oxevision, a digital tool that allows for contactless monitoring of vital signs and movement to improve patient safety, quality, and efficiency of care within inpatient wards.

The trust has commissioned the implementation of Oxevision into 25 wards and 5 HPOS's (136 suites x 7 rooms). These wards consist of the two Assessment Units, PICU, Adult, childrens and functional older people. To date Oxevision is fully operational in 10 wards with the remainder scheduled to go live between now and the middle of June 2021.

A new Ligature safety bulletin has been launched to provide a single place summarising all ligature learning from the previous month.

9.0 Action Required

The Board of Directors are asked to:

- Discuss the contents of this report

Report Prepared By:
Catriona King, Ligature Risk Coordinator
Jane Cheeseman, Head of Compliance and Emergency Planning

On behalf of:
Nicola Jones
Director of Risk and Compliance (Interim)
21st May 2021

		Agenda Item No: 10a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	**Mental Health & Community Health Services Transformation Update**					
Executive/Non-Executive Lead:	Alexandra Green Executive Chief Operating Officer					
Report Author(s):	Mark Travella Associate Director Service Improvement and Business Development Russell Middleton Head of Financial Management					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	Recruitment has been an on-going risk over the last two years due to significant UK wide MH investment and in particular neighbouring systems competing for a similar pool of staff. This is mitigated my weekly Operations, Finance, HR, Workforce and Projects Assurance Monitoring
State which BAF risk(s) this report relates to	BAF 50 Skills, Resource and Capacity
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	Continuous recruitment taking place. Working with local system members to recruit into development posts, review skill mix, employ people from VCS where possible. An assurance governance structure has been set up to oversee recruitment across 2021/22. Linking in with Social Care leads to take advantage of other local sector employment modelling particularly 'home grown' initiatives.

Purpose of the Report		
This report provides the Executive Operational Committee: • Overview of transformation service lines. • Progress on 20/21 spend and forecast. • Issues and risks. • Next steps and points to note for 21/22.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required
The Executive Operational Committee is asked to: 1 Note the contents of the report 2 Request any further information or action.

Summary of Key Issues

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place.

Trust and system staff had paused some transformational work to support operational services concentrating on BAU. The Trust, with local commissioners and other stakeholders are now adjusting to the second coronavirus lockdown and resetting clinical services and its transformation activities. Services have attempted to maintain BAU activities during the current second lockdown where possible.

The significant Covid-19 Immunisation programme along with a large number of COVID-19 outbreaks in clinical areas remains an ongoing operational challenge. Transformation has not significantly been impeded during the second lockdown with supported action plans directing continual activity even where some meetings have been cancelled.

Most local systems have planned to adjust to a 'new normal' and the main report updates those positions with a wide range of Mental Health and Community Health Services transformation activities described below.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	✓
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	✓
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	✓

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

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:	**n/a**

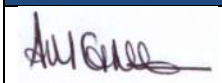
Governance implications			✓
Impact on patient safety/quality			✓
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**No**	**If YES, EIA Score**	N/A

Acronyms/Terms Used in the Report			
IPCC	Integrated Primary Community Care	ECC	Essex County Council
PCN	Primary Care Network	SBC	Southend Borough Council
VCS	Voluntary Community Services	MHIS	Mental Health Investment Standard
PLACE	Local services provided at CCG level		

Supporting Documents and/or Further Reading

Main report - Mental Health & Community Services Transformation Update (May 2021).

Lead



Alexandra Green
Executive Chief Operating Officer

Agenda Item 10a
Meeting of the Board of Directors
26th May 2021

MENTAL HEALTH & COMMUNITY SERVICES TRANSFORMATION UPDATE

1 Purpose of Report

This report provides an update on the Trust's Mental Health and Community Health Services Transformation Programme in three sections;

- Mental Health Transformation
- Community Health Services Transformation - South East Essex
- Community Health Services Transformation - West Essex

It also describes the MH Transformation as a broad and significant portfolio of projects organised within its constituent programmes. This is linked to the national drive to review and redesign primary and secondary care services as part of an Integrated Primary Community Care (IPCC) structure and review and redesign Complex Care as part of the national Mental Health Investment Standard.

2 Executive Summary

Due to the Coronavirus outbreak, NHS England, local CCGs and the Trust operational and support services are carrying out a large number of unplanned activities including regular deep cleaning and taking extra care and time to meet patients emotional, mental and physical health needs. Re-deployment of some staff to support safe, effective and operational resilience has taken place.

Trust and system staff had paused some transformational work to support operational services concentrating on BAU. The Trust, with local commissioners and other stakeholders are now adjusting to the second coronavirus lockdown and resetting clinical services and its transformation activities. Services have attempted to maintain BAU activities during the current national Covid-19 restrictions where possible.

Most local systems have planned to adjust to a 'new normal' and the main report updates those positions with a wide range of Mental Health and Community Health Services transformation activities described below.

2021/23 planning is currently in progress with local commissioners to plan for significant investment across Essex to develop EPUT led local systems integrated care offers. This is due for completion 3rd June 2021.

3 MH Transformation Programme – 2021/2023

1. Urgent and Emergency Care

This programme at STP level is made of three separate crisis response service projects for West Essex, MSE and NE Essex. All three projects went live successfully on or around 1 April 2020 in line with our plan and have been operational throughout Covid19. The Trust was commended by commissioners and NHSE for going live during the first lockdown when other providers put similar plans on hold. This service has provided a much needed MH crisis service at a critical time of high need for the people of Essex.

The model for 24 hour crisis assessment and treatment services links with the current Home Treatment Teams. Crisis Cafes provided by the third sector enable an option to support people

in crisis and interface with EPUT services. Crisis Cafes are located in MSE, NEE & West. In MSE the Crisis Cafes have extended their hours recently and are heavily used by the MSE crisis assessment and treatment service. MSE are considering extending the service to include a separate team that responds just to ambulance calls as a joint response service and conversations between the Trust and commissioners are planned to scope this. The NE Crisis Café based in Clacton has continued to develop during 2020 as a collaborative between MIND, The haven and EPUIT led by MIND and has opened up to a self- referral model for 2021. West Crisis Café – The Sanctuary, launched in January 2021.

Due to Coronavirus the Crisis Cafes have adapted to support the 111 pathways. Instead of providing drop-ins, they have adapted to provide telephone support. EPUT technologies have been developed to provide for automated real time electronic referrals straight through to the Crisis Cafes. Southend Crisis Cafe is currently planning to start providing an adapted safe drop in model shortly.

In light of the coronavirus outbreak, the resources available to the new U&EC services have been focussed on telephone triage and support initially with home visits increasing as time has progressed where required. The police and ambulance services have been directly interfacing with the crisis services to reduce A/E attendances.

This service is considered BAU however ongoing development with some additional investment is proposed for 2021/22. This includes increasing staffing to respond to MH ambulance call outs 24 hours a day in the MSE area. Linked to this service, HTTs and inpatient services is the proposal to set up crisis houses as an admission avoidance care pathway.

The Crisis Response Services will undergo a service evaluation in Q2 2021 led by a Consultant Psychiatrist with recommendations made to further improve this newly embedded Essex service.

2. Personality Disorder and Complex Needs

This Essex wide model will transform the way staff across entire systems understand and treat people with a personality disorder. The model comprises training and consultation support across local systems, from GPs and the third sector to specialist mental health staff in secondary care. New model of care, delivering DBT and CAT and other psychotherapeutic approaches are being introduced and rolled out across the workforce. This outcome is a range of benefits including better supported patients and carers, improved rates of recovery and independence and fewer admissions to hospital. Significant recruitment will be taking place across Essex to boost psychological services and staff training and awareness. Transformational work with psychology and psychotherapy services to create clinically effective care pathways linked to new community mental health team models of delivery will take place 2021/22

The Model is funded separately by the three STPs with three different business cases. West Essex is still considering funding and is therefore the least developed of the four programmes.

An Essex wide implementation plan and governance structure is in place and implementation is being overseen by a steering group that started in May 2021.

3. Older People and Dementia

This programme is at CCG level. SE Essex and Mid Essex have developed and are implementing transformed community teams to manage patients and carers at home instead of hospital. SE Essex data shows very significant falls in inpatient use to the point that admission is now an unusual event. SE Essex is now in its second phase of development that seeks to implement the dementia wrap-around model developed in conjunction with the South East Essex CCG, ECC and SBC.

SW Essex comprising Thurrock and BB CCGs are planning to work together to implement a common transformation solution across the patch based on the SE Essex model. Project teams are being set up to oversee this work and may require further investment through Business Cases depending on the detail of the chosen model and use of existing resources.

NEE older people's transformation is going to be a phased complex piece of work that incorporates the revision plans of Clacton Hospital. A local system steering group has been set up to oversee this work and its relationship with other clinical services as part of the North East Essex Health and Wellbeing Alliance. The plan is to implement the same Dementia & Frailty pathway that has been successfully implemented in West Essex with positive outcomes for older adults. A pilot is currently being trialled for imminent evaluation.

West Essex is advanced in the delivery of dementia services which links closely with community health services. This learning has been shared with other localities to help frame their pathways.

4. Community (Primary Care) IPCC

This programme at CCG level comprises six projects (Southend and CPR CCGs are working together) to transform community mental health services. Mental health community services are being transformed to provide Mental Health expertise at GP surgery level, organised against the newly formed PCNs. This will ensure that physical and mental health will be more integrated with local health, social care and VCS colleagues. This supports early intervention, prevention and care closer to home and GPs and their patients will have rapid access to mental health expertise at surgery level, all supporting the aspirations of Five Year Forward View and the NHS Long Term Plan.

Southend/CPR CCGs have implemented a clinical manager. MH nurses and physical health care support workers in all seven PCNs have been recruited and are currently planning to roll out the model across all PCNs through the remainder of 2021/2022.

Thurrock has piloted MH support in one PCN and now recruited a clinical manager, MH nurses and physical health care support workers for its four PCNs. It plans to fully recruit other planned staff and fully implement the model in 2021/22. Thurrock has a well-developed integrated local system and is planning to support the local system with consultant psychiatrist sessions instead of the current standalone outpatients model. This will require all members of the local system working together to meet psychological and social need who in turn will be supported by the consultants with released capacity.

The West Essex model is part of a national early implementer pilot. This pilot along with the other national pilots will be evaluated and will inform clinical models for the future across England by 2024. The evaluation is substantial and is supported by the Service Improvement and Development Team.

NEE has developed an IPCC model and good local relationships with stakeholders. It has commenced recruitment and will be recruiting the remaining staff in Q1 2021. It has good links with its local health, social care and VSCE partners and is developing new integrated working relationships and care pathways wrapped around PCNs.

BB CCG and MID Essex CCGs have commenced project work Q1 2021 based on the submitted model as part of the IPCC funding application. Implementation will be more complex in BB and Mid Essex as the mental health nurses working in the PCNs will be provided by other organisations. This will require joint working agreements and a Trusted Assessor model between EPUT as a treatment service and other organisations as assessment/triage services.

The benefits to PCN transformation are far reaching including much improved customer experience for patients e.g. less queuing, faster access along care pathways including testing the new 4 week standard. For local providers system interoperability and shared records are being piloted with EPUT delivering significant innovative solutions that will inform other areas of the UK. It will also have a significant impact on the future configuration of community mental health services as they are re-formed into an IPCC structure.

All PCN work is being overseen by a steering group in MSE and transformation Boards in NE and WE.

2021/22 Planning

MH IPCC
The fourth transformation programme, Community (Primary) Care is now more commonly referred to as Integrated Primary Community Care (IPCC) and is linked with the national drive to move towards a new mental health service configuration that does not recognise primary and secondary care terms or structures. Instead it refers to integrated community MH services set within a Primary Care Network (PCN) organisation. This organisation will increasingly operate with GPs and surgery staff, social care, mental health and voluntary staff working together as colleagues to support prevention, early intervention and timely joined up treatment and care.

This community mental health provision set within a PCN organisation will require significant local health, social care and VCS transformation which includes community mental health resources currently in secondary care. This will require a broader set of projects to realign existing care pathways with integrated place based PCN provision.

IPCC project work is planned for and defined by the 2021/2024 funding applications that have been developed and submitted to NHSE over the last few months.

Detailed programme portfolio plans are being developed to track implementation, recruitment and investment over the next year by operational managers, the Service Improvement and Development Team and local commissioners.

MH Complex Care/Rehabilitation
NHSE has asked local systems to speed up transformation plans and have committed to bring forward 2022/23 funding to support this, but where available funding is available.

Therefore another set of major transformation programmes of work to review, redesign and transform Complex Care/MH rehabilitation will take place over the next year. This includes weaving in the personality disorder and complex needs services described above. This work with include reform of the Care Programme Approach, a care planning, care co-ordination and risk management framework for those with complex health and social care needs. Thurrock started this work in March 2021. Other local systems will plan for this shortly.

I addition other funded transformation work will be taking place across Essex this year and next. This includes development of Eating Disorders services, EIP services, design and mobilise new ARMS services and continue and complete the implementation of the new Perinatal service that started 2020/21.

Detailed project planning and delivery forecasting with operational, finance, workforce/HR and projects leads are currently in progress with Essex proposals and associated funding being formally agreed 3rd June 2021.

4 Community Health Services Transformation

EPUT provides Community Health Services in two areas of Essex. South East Essex and West Essex.

A summary of transformation work is shown below, but it should be noted that SEE plans are likely to undergo significant change with the new MSE Joint Venture. EPUT, NELFT and Provide have signed an agreement to solidify the closer working relationship between our three organisations. The contractual joint venture provides the foundation for developing an integrated community health service for Mid and South Essex that combines the strengths of all three sovereign organisations.

The benefits of working in partnership include:
•Reduced variation for patients across community services
•Improved patient outcomes and experience
•Increased collaboration, partnership working and innovation for the clinical workforce
•Increased opportunities for agreeing best practice across the three organisations
•Ensuring community services are fit for the future and delivered closer to home

More detail about the impact on SEE services will be shared later in the year.

SEE Community Health Service Transformation Plans

A range of initiatives have been put in place to support the system by focusing and transforming key priority service areas during the Coronavirus outbreak across both Adult and Children's services.

Discharge to Assess (D2A)
In order to support people being discharged from hospital at pace, community services have developed a model for 'discharge to assess' services in partnership with local authorities, which will support the delivery of care to people in their own homes and reduce the need for individuals to be placed in a community bed. This will achieve better outcomes overall for patients. This included on 7th Dec 2020, opening our new 'Community Coordination Centre (CCC)' which streamlines access to our urgent/crisis services, consolidated under one number that incorporates our UCRT, Nursing and Specialist Nursing and Discharge to Assess services. The CCC will also accommodate our local authority partners to deliver collaborative, integrated working and improved patient outcomes.

Urgent Community Response Teams (UCRT)
Existing UCRT (SWIFT) has been strengthened to enhanced 'admission avoidance' requirement and deliver 2 hour crisis response in patients' homes. This saw the development and implementation on 30th April 2020 of a Single Point of Access for UCRT across the STP hosted by SEE Community Services in EPUT. This was a three month project funded via COVID monies until end of July and has now been approved for on-going funding by the STP. EPUT continue to lead the development and transformation of UCRT across the MSE HCP. The next phase of the project sees improved dashboard reporting, improved pathways with EEAST and 111 services and introduction of new technology.

Community Beds
In first spike of pandemic, Mountnessing Court and Cumberledge Intermediate Care Centre (CICC) were relocated to Brentwood Community Hospital. This was part of the MSE HCP decision to consolidate all community beds on two sites as part of the Covid-19 response. CICC was repatriated to Rochford Hospital early Oct 2020 and has been operating as sub-acute intermediate care facility managing COVID positive patients. Discussions are now underway to secure agreement for the optimum community bed configuration for post 1st April 2021 including decision on Mountnessing Court.

West Essex Community Health Service Transformation Plans

Out of Hospital Strategy
West Essex are implementing an out of hospital strategy/model programme which comprises four projects;

1. PCN Alignment of Community Teams (PACTS)
2. Care Coordination Centre (CCC)
3. Intermediate Care
4. Specialist Teams

These are integrated transformation projects working with our system partners, CCG, ECC, Acute Hospitals, St Clare's Hospice and PCNs.

PACTS **(**PCN Alignment of Community Teams)
The aim of this project is to establish an integrated West Essex integrated system partnership approach for Out of Hospital Care for 18+ residents in West Essex, this includes acute, EPUT community & mental health, ECC, hospice, GPs, ambulance, 111 services. Discussions are under way with each of the PCNs to support their agreement for a focussed approach within their PACTS.

CCC Care Coordination Centre
The aim is to implement an integrated (with system partners) Care Coordination Centre to receive, triage and onward refer all system referrals. Currently the referral form is being reviewed with the aim to use this electronically for all parties in order to facilitate this and an expert IT group has been set up to review the many clinical record systems currently used by different organisations.

Intermediate Care
The focus of the Intermediate Care project for the Out of Hospital Programme is to:

- Review rapid response and implement a 24 hour community response
- Re-designated community beds
- Support at home for patients as part of the Reablement agenda
- Develop and better interfacing with the Patient at Home Service and better integration with community teams and expansion of services
- Single system wide therapy team development

Specialist Teams
This is major transformation project involving a large number of specialist team. One of the first phases is the patient remote monitoring pilot The Community Respiratory team will be implementing the use of remote monitoring of vital statistics for COVID and moderate to low respiratory patients. Doccla, a company that specialises in virtual ward technology that support care at home and early discharge will supply and monitor readings into a dashboard which the community team will have access to, this will show if there are missing readings, readings within range or those that have exceed range. The aim is to roll this out w/c 29 March and is a six month pilot. Other phases will be designed and implemented later in the year.

5 Risks and Issues

The significant risk relates to recruitment in all three STPs/ICSs. Due to workforce challenges the Trust is examining options to improve recruitment but is also considering alterative staffing structures with commissioners to enable service initiatives to commence in 2021/22. This

includes working with VCS organisations to complement service delivery along-side EPUT services but also providing VCS training opportunities leading to future recruitment of staff. A major recruitment plan is in place and is showing signs of success but this will need to be monitored closely and regular monitoring and adjustment to plans. Preparedness plans are also being developed where required to predict any workforce shortfalls and re look at skill mix and other options for providing a safe and effective service, in the interim and long term.

Recruitment has remained the biggest risk to the transformation portfolio with a number of highlighted factors;

- EPUT borders East London where outer London weighting and fringe allowances are payable.
- Most professional groups have always been difficult to recruit to, with particular challenges with psychology and medical staff. National shortages of nursing staff is a long-term challenge.
- Support worker staff pools have also been heavily recruited to with increasing difficulty in recruiting to new initiatives, e.g. Mental Health Discharge Funding, even when bandings have been increased with no applications.
- Many of the transformational posts have required senior staff e.g. band 7 nurses in integrated primary care networks which are promotion opportunities for band 6 posts. These in turn are hard to recruit to. The local health economy across the three STPs will have drawn off the best of the band 5 nurses, either into band 5 posts or promotions to band 6.
- Neighbouring providers have the same extra funding and transformation plans. EPUT is directing competing with a shrinking pool of staff.

The Trust has continuously tried to mitigate the difficulties in recruitment including;

- Advertising campaigns including local airports, train stations
- Financial incentives, including staff referral incentives
- Support with moving to Essex
- Successful group sponsor licences from the Home Office for employing oversees professionals.
- International journal advertising campaigns.
- Skill mix reviews
- Strong and successful national representation to increase psychologist training places and EPUT successfully applied to be a main provider for psychologist apprentice training, the only one in the UK to be successful.

Despite the significant challenges, with the continuous effort put in, EPUT has overall successfully recruited with nearly 70% of MH positions being permanent with a further approximate 10% of positions filled with temporary staff, mostly bank staff.

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

6 Finance update

Due to the pandemic, there was inevitably slippage in the MHIS programme in 20/21, following discussion and agreement with CCG colleagues the slippage was incorporated in the MHIS planned programme for 21/22.

- Finance continue to support Operational and Work-Force colleagues in 21/22.
- Across the three systems (MSE/NE Essex/ West Essex), the Trust MHIS plan for 21/22 totals £20.9m; details of the 21/22 plan is recorded in the table below.

MHIS 2021_22	Pay	Pay	Non Pay	Total
Scheme	wte	£'000's	£'000's	£'000's
AAT (Mid Essex)	3.00	155		155
Acute Inpatients	7.00	135	33	168
Adult Community Mental Health Transformation Wave 2	5.00	358	146	504
ARM	1.50	51	10	61
ARMS (BB)	4.10	232	53	285
ARMS (SE)	9.10	100	27	127
Brentwood IPCC incl. older adults MH Transformation	9.00	170	35	206
Core 24 - Mid	8.88	596	102	698
Core 24 PAH	5.00	381	45	426
Crisis 24/7	69.34	4,132	777	4,910
Dementia (Brentwood & Basildon)	2.00	65	16	81
Dementia (Mid Essex)	3.00	81	23	104
Dementia (Southend)	2.00	71	17	88
Dementia (Thurrock)	1.00	21	5	25
Dementia Transformation	13.00	496	98	594
Eating Disorder services MSEP024 - £35k covers NE	2.50	243	41	283
EIP	6.20	262	54	315
EIP (Brentwood)	2.00	75	16	91
EIP (Thurrock)	2.00	53	12	65
EIP/ARM	4.50	194	34	228
FREED (MSE)	8.80	293	62	355
IAPT (SE)	6.20	72	17	90
IPCC INCL. Older Adults- South East - MSEP014	37.70	1,611	362	1,973
Liaison Services	6.21	420	63	483
Mental Health and Wellbeing Hub	7.86	230	74	304
MID Essex EIP MH Transformation	11.50	536	125	661
Mid Essex IPCC incl. older adults MH Transformation	10.00	253	58	311
MSE Trans 24/7 Wave 2	13.60	271	80	351
Perinatal MH Funding - LTP - 7.1% to 8.6%; 2020/21 - 2021/22	45.81	2,425	866	3,290
Perinatal MH Funding MSE - 65%, NE 18%, West 17%	13.40	725	163	888
Personality Disorder	3.10	177	70	247
Primary Care	7.00	467	74	540
Primary Care - South Thurrock	1.00	55	10	64
Primary Care Wave 1	6.00	352	134	487
Primary Care Wave 2	2.90	198	23	222
Psychosis Support - EIP	1.00	29	5	34
Recovery College and MH Wellbeing Hubs - MSELP002	1.00	52	12	64
SHIFT SECCG MH - MSEP026	2.00	95	26	120
Thurrock IPCC incl. older adults MH Transformation	22.40	742	167	908
Transformation Project Support	0.50	30	5	35
Trauma Alliance - MSELP003	1.10	70	14	84
Grand Total	369.20	16,974	3,953	20,927

7 Action Required

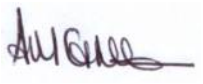
The Executive Operational Committee is asked to note the contents of this report,

Report prepared by:

Mark Travella
Associate Director Business
Development & Service Improvement

Russell Middleton
Head of Financial Management

On behalf of:



Alexandra Green
Executive Chief Operating Officer

		Agenda Item No: 11a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 May 2021**

Report Title:	CQC Compliance Update					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive					
Report Author(s):	Jane Cheeseman, Head of Compliance and Emergency Planning Amanda Webb, Senior Emergency Planning and Compliance Officer					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	July-August 2019 Action plan testing identified gaps of non-compliance
State which BAF risk(s) this report relates to	BAF45 - CQC Inspections and Learning BAF46 - CQC Fundamental Standards
Does this report mitigate the BAF risk(s)?	No
Are you recommending a new risk for the EPUT BAF?	No
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	N/A
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report		
This report provides an update on the activities undertaken within the Trust and information available to maintain compliance with CQC standards and requirements and to support the Trust's ambition of achieving an outstanding rating by 2022.	**Approval**	
	Discussion	✓
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Identify any further action that is required to be taken.

Summary of Key Issues

Meeting Registration Requirements

EPUT is fully registered with the CQC.

CQC Inspections

There has been 1 CQC inspections in this reporting period to the CAMHS services within St Aubyns and Poplar Adolescent Unit. The inspection is still underway and has so far involved site visits and information requests which are being progressed.

A review of the internal action plan, developed for the wider core service learning following the CQC unannounced inspection (October 2020), was undertaken at the last Inpatient (Adult and OP) Clinical Support Group on the 21st April 2021. The group agreed that the concerns raised have been addressed and therefore the Action plan has now been confirmed as closed and any remaining longer term actions have been added to group action log.

The Trust has responded to two information / data requests from the CQC.

a. Concerns were raised by a patient within Secure Services about leave during Covid-19, therefore procedures and policies were provided to the CQC upon request.
b. Data was requested following a complaint received by the CQC re an EPUT CAMHS unit. The request including incident trends, restraint numbers, seclusion numbers, duration of time spent in seclusion, safeguarding numbers, staffing rates/fill rates and further information regarding a specific self-harm incident.

Both responses were provided with the required information within the timeframes set by the CQC.

CQC Preparation

A project has been initiated to ensure appropriate preparation has been undertaken in the Trust for future CQC visits.

1. Support visits were undertaken to all inpatient areas. Upon review of the initial feedback provided by the Leads, each inpatient area had their own good / outstanding practice and initiatives in addition to their own challenges; however, there were some main themes identified across the Trust.
2. Self-Assessments are being undertaking by all inpatient areas
3. Learning from the support visits and self-assessments is being collated into a report for consideration
4. Staff engagement is underway with a number of reflective sessions held and future sessions planed
5. Staff resources are being updated. This has included issuing of new Quality Stars posters for each ward, issued of revised action cards and a new handbook and quality folder are in development.

Internal Compliance Regime

The Compliance Team has been focusing work on the following areas:

- Inpatient Clinical Support Group (managing learning)
- CAMHS Intensive Clinical Support Group (managing learning form the Longview Serious Incident)
- Action Plan Testing – CQC Well Led Inspection (July-August 2019)

The compliance team is now involved in a range of action plan testing including following CQC visits and PHSO action plans. Work is currently underway to look at developing one central learning plan that will focus on the testing findings and assurance of action embedding.

Relationship to Trust Strategic Objectives	
SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	✓
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	✓
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	✓

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	✓
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	

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

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

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	LRRG	Ligature Risk Reduction Group

Supporting Documents and/or Further Reading
Accompanying Report – CQC Compliance

Lead
Paul Scott **Chief Executive**

Agenda Item 11a
Board of Directors
26 May 2021

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CQC Compliance Update

1. Introduction

The purpose of this report is to provide an update and assurance on the key CQC related activities that are being undertaken within the Trust. The report also gives details of CQC guidance/updates that have been received since the previous full reporting in April 2021.

2. Meeting Registration Requirements

EPUT is fully registered with the CQC. No changes were required in this reporting period.

3. CQC Inspections

3.1. Unannounced CQC Inspection (St Aubyns May 2021)

The CQC completed an unannounced inspection on the 11th and 12th May 2021 following a serious incident resulting in the death of a Young Person. Since the visit the CQC have requested a large amount of information, including incident trends, restraint numbers, seclusion numbers, duration of time spent in seclusion, safeguarding numbers, staffing rates/fill rates and further information regarding a specific self-harm incident. A further visit was undertaken to Poplar Adolescent Unit on the 19th May 2021.

The inspection is still underway with the CQC making a series of further information requests and there is the potential to undertake further site visits if it is felt that there are any concerns or further information required at service-level.

An early indication of issues raised as a theme is in regards to staffing and use of bank and agency staff.

3.2. Unannounced CQC Inspection (Finchingfield October 2020)

The CQC completed an unannounced inspection on the 29th October focusing on Finchingfield Ward following a series of incidents that took place on the 23rd October. Following this inspection the CQC issued EPUT with a Warning Notice served under Section 29A of the Health and Social Care Act 2008 (issued on 27th November 2020). An action plan was developed to meet the Warning Notice areas of concern and this has been fully implemented and all areas have been compliance checked to ensure all actions have been addressed. The action plan has been closed and reported back to the CQC.

Following completion of the Finchingfield Action plan the Inpatient Clinical Support Group agreed to expand membership to include all adult MH inpatient services to ensure organisational learning from the inspection. An internal action plan was developed by the Inpatient Clinical Support Group to share and embed changes across adult MH inpatient services.

A review of the action plan developed for the wider core service was undertaken and it was agreed at the Clinical Support Meeting on the 21st April 2021, that the concerns raised have been addressed therefore the Action plan has now been confirmed as closed and any

remaining longer term actions have been added to group action log. Testing will be undertaken as part of compliance team action plan testing programme.

3.3. CQC Information Requests

The Trust has responded to two information / data requests from the CQC.

a. Concerns were raised by a patient within Secure Services about leave during Covid-19, therefore procedures and policies were provided to the CQC upon request.
b. Data was requested following a complaint received by the CQC re an EPUT CAMHS unit. The request including incident trends, restraint numbers, seclusion numbers, duration of time spent in seclusion, safeguarding numbers, staffing rates/fill rates and further information regarding a specific self-harm incident.

Both responses were provided with the required information within the timeframes set by the CQC

4. CQC Action Plan Testing

4.1 CQC Well Led Inspection (July-August 2019)

Compliance CQC action plan testing found gaps in embedded actions following the completion of CQC Action Plans. These have been previously reported to Executive Safety Oversight Group where it was agreed that the gaps found should be allocated to the appropriate Trust Committees to agree and take forward appropriate actions to ensure changes have been embedded.

The table below outlined gaps found and assurance on action being taken

Committee	Actions Monitoring	Progress
LRRG	M1.1 / M1.2 S1.1 / S1.2 Ligature and floor plans	M1.1 /M1.2 – actions complete S1.1 - underway S1.2 - action complete
HSSC	M6.1 Safety Alerts M12.1 Manager 3i sign off	M6.1 – action complete M12.1 - underway
CG&CQ	M7.1 Single Sex Accommodation / Sexual Safety	M7.1 - underway
Inpatient Quality & Safety Group	M9.1 Informing of rights M8.1 Observation & Engagement	M9 - underway M8.1 - underway

5. CQC Preparation

A project has been initiated to ensure appropriate preparation has been undertaken in the Trust for future CQC visits. There are 5 key components to the project plan which are outlined below:

5.1 Support Visits

Support visits were undertaken at all inpatient areas in preparation for any potential CQC visits. The visits were undertaken by members of the Compliance Team and members of the Corporate Nursing Team. The aim was to:

- Prepare wards/services and staff for potential unannounced CQC visits ensuring they have the tools to celebrate quality and safety initiatives and are empowered to be open about areas for further improvement
- Ensure that improvements directed by the CQC following inspections have been embedded
- Ensure that there is alignment with the EPUT Safety Strategy
- Assist wards with starting their self assessments

Initial feedback was shared with the Compliance Team by the support visit facilitator

5.2 Self Assessments

Ward self assessment tools have been developed in partnership with inpatient services to help wards in undertaking their own self assessment and reflection. The tools focus on helping identify areas for celebration and reflection on embedding of past learning. The tools should then be considered to ward meetings to think about any changes needed and completed tools shared with the Compliance Team.

5.3 Learning

Upon review of the initial feedback provided by the Leads, each inpatient area had their own good / outstanding practice & initiatives in addition to their own challenges; however, the main themes that were noted across the Trust are:

<u>Good & Outstanding practice</u>

- Teams were very welcoming
- Staff engagement with patients was positive and a caring and compassionate approach was demonstrated
- Areas felt that the communication / cascade process has improved with a larger oversight of Senior Management.
- A diverse, skilled and competent team who are able to step up and support each other, working together
- Sense of Team Pride
- Introduction of new technology to support contact with friends and family during the pandemic.

<u>Challenges</u>

- Concerns that quality sometimes gets compromised due to staffing and activity levels.
- Reduced physical contact with family members for the patients
- Refurbishment causing disruption to the ward which is causing distress to the patients
  - Non-therapeutic environment for the patients
  - Restricted access to rooms if workers in the area
  - When restricted, limited to areas that do not have enough furniture to seat all patients
- Environmental appearance on some wards appeared dull and not very inviting.
  - Following refurbishment – Evidence of poor craftsmanship
  - Following refurbishment - Wall items not all returned (fire maps, posters)
- Lack of ward storage. Offices and assisted bathrooms repeatedly reported as being used for storage.
- Lack of storage space for patient's belongings, small space, lacking containers for patient belongings.
- Recruitment & retention of staff, particularly qualified staff. Lack of staff available to backfill shifts.
- IPC Controls during Covid
  - Social Distancing – Room capacity following Covid Risk Assessment breached
  - Inappropriate mask wearing

  - Lack of signage identifying the measures that need to be taken, mainly in regards to room capacity
- Training / Supervision / Appraisal - The system was reported to be incorrect, and not reflecting appraisals completed by staff who have recently left the team or training that has been reported as completed.

Following the return of all the self-assessments, a full analysis will be undertaken utilising the questions and themes. The key findings and relevant actions will be reported and monitored through the Inpatient Clinical Support Group.

Work is also underway to identify the top learning points from SIs and past CQC inspections giving clear narrative of action taken to address the learning. This will be shared with all wards.

5.4 Staff Engagement

Staff engagement is underway with a number of reflective sessions held and future sessions planed. Attendance at sessions has been patchy and work is underway to join existing meetings to undertake engagement sessions.

5.5 Staff Resources

Staff resources are being updated. This has included issuing of new Quality Stars posters for each ward, issued of revised action cards and a new handbook and quality folder are in development.

6. Internal Compliance Regime

6.1. Clinical Support Groups

Adult and Older People Clinical Support Group

The Compliance Team continue to facilitate the established Inpatient Clinical Support Group with biweekly meetings and continuous checking and monitoring of the Action Log progress. Ongoing virtual and onsite visits are being undertaken to support the implementation of any outstanding actions.

CAMHS Intensive Clinical Support Group

The Compliance Team have facilitated the establishment of the CAMHS Intensive Clinical Support Group. At the initial meeting reflection was held on the Serious Incident on Longview. From this reflection a support plan has been developed and is being taken forward and ongoing investigation is underway following the SI processes from which further learning will be identified. The following key areas for learning have been identified so far:

1. Observation and Engagement: ensure observation levels are understood by all staff and time recorded accurately. There is an existing Obs and Engagement Working Group in place which CAMHS leads are linking into.
2. Oxehealth: ensuring use of Oxehealth is in line with SOP including having alert volume at an appropriate level. Wifi connectivity at the unit is poor and affects using of tablets for roaming Oxehealth monitoring.
3. Quality of Sheets: sheet easily torn. There is an existing project in place following concerned raised by LRRG at the quality of sheets and towels. CAMHS leads are linking into this work.

The Compliance Team have undertaken a number support visits to both Longview and Larkwood Wards with plans in place to also visit Poplar Unit as part of the intensive support

6.2 Action Plan Testing

The compliance team is now involved in a range of action plan testing including following CQC visits and PHSO actions plan. Work is currently underway to look at developing one central learning plan which will focus on the testing findings and assurance of action embedding.

7. Action Required

The Trust Board of Directors is asked to:

1. Note the contents of the report
2. Identify any further action that is required to be taken

Report Prepared by:

Amanda Webb
Senior Emergency Planning & Compliance Officer
and
Jane Cheeseman
Head of Compliance & Emergency Planning

On behalf of

Paul Scott
Chief Executive

Agenda Item No: 11b

SUMMARY REPORT	BOARD OF DIRECTORS PART 1	26 May 2021

Report Title:	**Safe Working of Junior Doctors Annual Report covering 1 April 2020 – 31 March 2021**					
Executive/Non-Executive Lead:	Dr M Karale – Executive Medical Director					
Report Author(s):	Dr P Sethi - Consultant Psychiatrist and Guardian of Safe Working Hours					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	N/A
State which BAF risk(s) this report relates to	N/A
Does this report mitigate the BAF risk(s)?	N/A
Are you recommending a new risk for the EPUT BAF?	N/A
If Yes describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register	
Describe what measures will you use to monitor mitigation of the risk	N/A

Purpose of the Report

This report provides the Board of Directors with:

- Assurance that Doctors in training are safely rostered and that their working hours are compliant with the Terms and Conditions of the Service.

Approval	
Discussion	
Information	X

Recommendations/Action Required

The Board of Directors is asked to note the findings of this report and to consider assurances provided by the Guardian of Safe Working Hours.

Summary of Key Issues

Doctors in Training Data:

Number of Doctors in training (total inclusive of GP and Foundation)	126
Number of Doctors in Psychiatry training on 2016 Terms and Conditions (average)	48
Total number of vacancies (average over reporting period)	29
Total vacancies covered by LAS and MTI (average over reporting period)	20

Annual data summary:

Trainees within the Trust:

Specialty	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average WTE)
Psychiatry	CT1-3	29	24	25	25	9.5
Psychiatry	ST4-6	18	23	23	25	14.5
Total		47	47	48	50	24

Trainees outside the Trust overseen by the LET guardian:

Specialty	**Grade**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total gaps (average WTE)**
GP trainees	ST1	16	18	18	19	0.25
Foundation	FY1	2	11	12	12	2.75
Foundation	FY2	12	13	13	13	2.25

Please refer to Appendix 5 for monthly breakdown of uncovered shifts

Agency Usage:

The Trust does not use agency workers and relies on the medical workforce to cover out of hours i.e. 5pm to 8:30am at internal locum rates. There are varied reasons for covering out of hours ranging from sickness, the additional out of hours that less-than full time trainees can't contractually cover and vacant posts. One of the main factors for an increase in shifts requiring cover was due to COVID absence.

The total number of shifts covered in reporting period:

Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/ Sickness/LTFT Cover/COVID	568	568	0	6445.5	6445.5
Total	568	568	0	6445.5	6445.5

Exception Reports:

A total of 10 exception reports were raised by trainees via the Allocate reporting system from 1 April 2020 to 31 March 2021.

Please refer to appendix 2 for details on Exception Reports.

Issues arising and actions taken to resolve:

1. Gaps in the rota are detailed in Appendix 1 with a monthly breakdown of vacancies. The gaps at CT level are filled with internal Doctors who are paid an internal locum rate. The gaps at ST level are unfilled; The Trust does not use agency locums. There are no particular reasons or patterns observed in these gaps, National recruitment seems to be the issue which has improved in the last quarter. One of the main factors for an increase in shifts requiring cover was due to COVID related absence.
   Action taken: Rolling Adverts on NHS jobs are in place, the Trust has recruited a number of MTI and LAS Doctors who are covering the gaps in the rota. GPs and FY2s are given an opportunity to express an interest to join the Bank to do On-Calls when they leave EPUT.
2. Junior Doctors expressed concerns over the lack of facilities in On Call rooms at the Linden Centre and Derwent Centre, some refurbishment work is also required at the Basildon Doctors room. A health and safety hazard concern was raised by Trainees for the Doctor's room at Linden Centre.
   Action taken: The Director of Estates is working closely with the Medical staff to address the issues regarding Doctors' rooms and On Call rooms. Some of the work has been completed successfully. There is still some outstanding work that needs to be addressed which Estates are aware. The health and safety issue has been addressed.
3. Junior Doctors expressed concerns on the lack of supervision and training opportunities at certain inpatient units where there is the lack of a substantive Consultant Post.
   Action taken: There have been some difficulties in recruiting permanent Consultant

posts at certain sites; appropriate clinical supervisors have been identified for these Doctors.

4. Junior Doctors have been asked to transport blood samples to the laboratory during their on call period.
   Action taken: The issue was escalated to Dr Karale. The matter has been addressed and resolved at most sites of the Trust.
5. Health Education England granted £30,000 to our Junior Doctors.
   Action taken: The money was spent (based on Junior Doctors' choice) on purchasing items for Junior Doctors room and On Call rooms. Some money has been kept aside for team building events which are on hold due to COVID.
6. A concern was raised by a Trainee at the Linden Centre regarding lack of on Call Doctors available between 9am-5pm which led to a lack of medical cover at a S136 suite.
   Action taken: Lack of medical cover at S136 suite at the Linden centre has been addressed. Doctors who are On Call are now based permanently at the Linden Centre, their outpatient clinics are blocked in advance, so that they do not have to travel out of site when on call.

Key issues from host organisations and actions taken:

There are no specific key issues within the Trust with regards to vacancy rates. There is a National recruitment issue. This has improved in the recent quarter and the number of gaps in the rota is less compared to last year.

In addition to issues already discussed as above, at the Junior Doctors Forum, Doctors have raised the following issue:

1. Access to laptops to work remotely/socially distanced during pandemic.
   Action taken: Laptops have been distributed to the Senior Doctors.

Summary

There are ongoing issues with vacancy rates resulting in rota gaps at Senior Trainee (ST) and Core Trainee (CT) level across the Trust. There are total gaps of 24 (average in the reporting period). The gaps are less compared to the previous year. The rota gaps at CT level are filled in by existing trainees who are paid NHS locum rates. The gaps at ST level are usually unfilled; The Trust employs LAS (Locum Appointed for Service) and MTI (Medical Training Initiative) Doctors who have filled in the gaps for the rota and service provision. EPUT has appointed Physician Associates who contribute to service provision. The Trust does not use Agency Locums. The Board to note that there are no specific issues within the Trust on these vacancy rates and there is a National issue in terms of recruitment. It is worth noting that the number of recruitments at CT and ST level in EPUT has improved over the last year, resulting in fewer gaps in the rota.

Facilities at the Doctors rooms and on call rooms have improved significantly.

There were 10 Exception Reports (Appendix 2) raised by the Junior Doctors between April 2019 and March 2020, all have been addressed.

The Junior Doctors Forum is held bi-monthly, all the issues addressed by the Doctors are escalated timely to the relevant managers/supervisors and the issues are addressed.

Junior Doctors continue to work relentlessly during the pandemic and were covering shifts related to COVID absence when needed.

Relationship to Trust Strategic Objectives

SO1: Continuously improve service user experiences and outcomes through the delivery of high quality, safe, and innovative services	X
SO2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts	X
SO3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve	X

Relationship to Trust Corporate Objectives	
CO1: To provide safe and high quality services during Covid19 Pandemic	X
CO2: To support each system in the delivery of all phases of the Covid19 Reset and Recovery Plans	X
CO3: Deliver our people agenda for 2020/21 with adjustments in line with the Covid19 response	X
CO4: To embed Covid19 changes into business as usual and update all Trust strategies and frameworks to reflect Covid19 Reset and Recovery and new NHSE/I Planning Guidance	X

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

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

Acronyms/Terms Used in the Report			
ST	Senior Trainee	S136	Section 136
CT	Core Trainee		
LAS	Locum Appointed for Service		
MTI	Medical Training Initiative		

Supporting Documents and/or Further Reading
Appendix 1: Monthly breakdown of uncovered shifts Appendix 2: Exception reports

Lead

Dr Milind Karale
Consultant Psychiatrist and Executive Medical Director

Appendix 1 Monthly Breakdown of Psychiatry Vacancies Apr 2020 to Mar 2021

NB Total gaps are all gaps that are not being covered by either an NHS or agency locum
Uncovered shifts are Mon to Fri 9am to 5pm as we cover CT1-3 overnight shifts via internal doctors and do not cover overnight shifts where there is a gap on the ST4-6 rota.

Specialty	Grade	Apr 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	43	2	80 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**6**	**240hrs**

Specialty	Grade	May 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	43	2	80 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**6**	**240hrs**

Specialty	Grade	Jun20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	43	2	80 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**6**	**240hrs**

Specialty	Grade	Jul 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	43	2	80 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**6**	**240hrs**

Specialty	Grade	Aug 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	5	200 hrs
Psychiatry	ST4-6	37	5	200 hrs
Total		**81**	**10**	**400 hrs**

Specialty	Grade	Sep 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	5	200 hrs
Psychiatry	ST4-6	37	5	200 hrs
Total		**81**	**10**	**400 hrs**

Specialty	Grade	Oct 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	4	160 hrs
Psychiatry	ST4-6	37	5	360 hrs
Total		**81**	**9**	**520 hrs**

Specialty	Grade	Nov 20	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	4	160 hrs
Psychiatry	ST4-6	37	5	200 hrs
Total		**81**	**9**	**360 hrs**

Specialty	Grade	Dec 20	Total gaps (average WTE)	Average no. of shifts uncovered (per

				week)
Psychiatry	CT1-3	44	4	160 hrs
Psychiatry	ST4-6	37	5	200 hrs
Total		**81**	**9**	**360 hrs**

Specialty	Grade	Jan 21	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	4	160 hrs
Psychiatry	ST4-6	37	5	200 hrs
Total		**81**	**9**	**360 hrs**

Specialty	Grade	Feb 21	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	1	40 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**5**	**200 hrs**

Specialty	Grade	Mar 21	Total gaps (average WTE)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	44	1	40 hrs
Psychiatry	ST4-6	37	4	160 hrs
Total		**81**	**5**	**200 hrs**

Appendix 2 Exception 1 April 2020 to 31March 2021

Quarter	Exception	Outcome
July to Sept	Trainee worked 1 and half hours overtime	Time off in lieu was granted
July to Sept	A trainee raised 3 Exception reports during her weekend on call, due to lack of rest and food facilities on site. This matter has been addressed, a temporary alternate room has been identified for on call doctors to rest at Linden Centre, microwave and a fridge is now available in the room. The original on call room at Linden Centre, Derwent Centre needs refurbishing,	The matter is now addressed.
July to Sept	Trainee worked 3 hours overtime	Time off in lieu was granted
July to Sept	A trainee worked 40 minutes overtime	Extra payment was granted
July to Sept	On call doctor worked 3 and a half hours overtime during weekend	Extra payment was made to the trainee
July to Sept	Specialty Registrar raised a concern; there were no on call doctors rostered between 9-5pm, this lead to lack of medical input when needed at Section 136 suite.	On call doctors are now available at all times on site at Linden centre, as their routine outpatient clinics on that day is blocked in advance, so they do not have to travel out of site.
Oct to Dec	Trainee raised an exception report after she was asked to transport blood samples from St Margaret's Hospital to Princess Alexandra Hospital during an on-call. This falls outside their job contract	Information has been shared with the operation staff and trainees appropriately advised.
Jan to March	Trainee raised a concern that due to lack of substantive consultant has affected his special interest sessions.	The DME has addressed the matter.