Essex Partnership University
NHS Foundation Trust

Meeting of the Board of Directors held in Public via Microsoft Teams
Wednesday 26 January at 10:00

Vision: Working to Improve Lives

PART ONE: MEETING HELD IN PUBLIC via Microsoft Teams

AGENDA

1	**APOLOGIES FOR ABSENCE**	SS	Verbal	Noting
2	**DECLARATIONS OF INTEREST**	SS	Verbal	Noting
3	**MINUTES OF THE PREVIOUS MEETING HELD ON:** 24 November 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	PS	Attached	Noting
7	**QUALITY AND OPERATIONAL PERFORMANCE**			
(a)	Quality & Performance Scorecard	PS	Attached	Noting
(b)	Patient-Led Assessments of the Care Environment (PLACE) 2021	TS	Attached	Noting
(c)	Approval of Charity Accounts 2020/21	TS	Attached	Approval
(d)	Update on Charitable Funds Annual Bidding Process	TS	Attached	Approval
8	**ASSURANCE, RISK AND SYSTEMS OF INTERNAL CONTROL**			
(a)	Board Assurance Framework 2021/22	PS	Attached	Approval
(b)	Standing Committees:			
	(i) Board Oversight Safety Group	AR-Q	Verbal	Noting
	(ii) Charitable Funds Committee	AS	Attached	Noting
	(iii) Finance & Performance Committee	LL	Attached	Noting
	(iv) People Equality & Culture Committee	ML	Attached	Noting
	(v) Quality Committee	RH	Attached	Noting
	(vi) Audit Committee	JW	Verbal	Noting
9	**RISK ASSURANCE REPORTS**			
(a)	(i) COVID-19 Assurance Report	PS	Attached	Noting

10	**STRATEGIC INITIATIVES**			
(a)	Safety First, Safety Always: 12 Month Update Report	NH	Attached	Noting
11	**REGULATION AND COMPLIANCE**			
12	**OTHER**			
(a)	Use of Corporate Seal	PS	Not Used	Approval
(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 30 March 2022 - at 10:00			
16	**DATE AND TIME OF FUTURE MEETINGS - subject to social distancing rules** Wednesday 25 May 2022 at 10.00am Wednesday 27 July 2022 at 10.00am Wednesday 28 September 2022 at 10.00am Wednesday 30 November 2022 at 10.00am			

Professor Sheila Salmon
Chair

Minutes of the Board of Directors Meeting held in Public
Held on Wednesday 24 November 2021
Held Virtually via MS Teams Video Conferencing

Attendees:

Prof Sheila Salmon (SS)	Chair
Paul Scott	Chief Executive
Prof Natalie Hammond (NH)	Executive Nurse
Sean Leahy (SL)	Executive Director of People and Culture
Nigel Leonard (NL)	Executive Director of Major Projects
Alex Green (AG)	Executive Chief Operating Officer
Janet Wood (JW)	Non-Executive Director
Alison Rose-Quirie (ARQ)	Non-Executive Director
Amanda Sherlock (AS)	Non-Executive Director
Manny Lewis (ML)	Non-Executive Director
Loy Lobo (LL)	Non-Executive Director
Rufus Helm	Non-Executive Director

In Attendance:

Angela Horley	PA to Chief Executive, Chair and NEDs (minutes)
James Day	Interim Trust Secretary
Chris Jennings	Assistant Trust Secretary
Gina Trimble	Trust Secretary Coordinator
Clare Sumner	Trust Secretary Administrator
Hilary Scot	Chief Pharmacist
John Jones	Lead Governor
Paula Grayson	Governor
Johnny Townson	Senior Business Support Manager
Tracy Reed	EOL Clinical Lead
Dr Gladvine Mundempilly	Clinical Director
Daniel Bayley	Head of Insight and Benefits Realisation, Oxehealth
Stephan Zentgraf	Account Manager, Oxehealth
Victoria Green	CQC
Charles Hanford	Interim Director of Estates Transformation
Yogeeta Mohur	Principal Freedom to Speak Up Guardian
Pippa Ecclestone	Deputy Lead Governor

SS welcomed Board members, Governors and members of the public joining this virtual meeting.

The meeting commenced at 10:00

128/21 APOLOGIES FOR ABSENCE

Apologies were received from Dr Milind Karale and Dr Mateen Jiwani (received during the meeting).

129/21 DECLARATIONS OF INTEREST

ML advised that he had recently been appointed to the Board of the Civil Aviation Authority from 01 October 2021 and had notified the Trust Secretary's Office accordingly. SS congratulated ML on this appointment and noted that there were no anticipated conflicts of interest.

SS also congratulated AS on her recent appointment to the Board of Southend Care Ltd as of 01 November 2021, again noting that there were no anticipated conflicts of interest. SS stated that these appointments demonstrated the rich and diverse experience of our Board members.

There were no further declarations of interest.

130/21 PRESENTATION: OXEVISION

AG advised that over the past year the Oxehealth safety monitoring system had been rolled out to inpatient MH wards across the Trust. This system is a remote patient monitoring tool designed to improve safety and quality of care on inpatient wards. AG introduced DB and SZ would provide an update on the early quantitative findings of the impact of the use of the system on four of our wards.

DB reported that four wards had been initially identified as pilot areas for the system – Ardleigh Ward, Chelmer Ward, Peter Bruff Unit and Hadleigh Unit. A before and after cohort study was completed for the wards which assessed self-harm and assault incidents and Bank and Agency spend related to 1:1 observations.

In terms of patient safety, the following was found:

- A 15% relative decrease in self-harm and assault incidents on the active wards compared to the control wards
- Self-harm decreased between 37% to 47% across the active wards in absolute terms or relative to control wards
- Ligatures decreased across the active wards between 9% and 85% in absolute terms or relative to control wards
- Harmful self-harm incidents and self-harm related A&E visits decreased 67% and 12% respectively
- Assaults decreased 4% in absolute terms across the active wards however results varied ward-to-ward between a 43% decrease to a 70% increase

And in terms of value for money:

- £516,679 annual cashable saving
- 417% positive cashable return on investment
- 43% reduction in Bank and Agency spend related to 1:1 observation spend across the four active wards

DB noted that the effects of Covid19 are likely to have impacted the data these results are based upon, despite attempts to mitigate its effect by managing evaluation periods.

SS thanked DB and SZ for sharing these encouraging results of the pilot project. ARQ agreed that these were indeed encouraging initial results and queried whether the financial impact in relation to a reduction of bank and agency usage is due to inpatient levels during the pandemic and whether there was any variance / impact.
Secondly, ARQ queried how the issue of consent from patients was dealt with, in particular what happens should a patient not consent to the use of this monitoring tool. DB advised that in terms of the financial impact, the study had normalised results against changes in occupied bed dates so this would be able to account for and not affect results of the study. In terms of consent, there is a robust process in place on admission to provide information to patients regarding the use of the monitoring tool. Patients are able to decline consent if they wish and there is a range of information on display around wards which explains the system as well as staff communicating what it is and how it is used. AG added that staff are not using the system to visually monitor patients but the system monitors the status of each bedroom and may, for example, alert staff to an issue which they would then respond accordingly. DB clarified that this was not a CCTV system. AG added that a

robust SOP was in place which was an important part of the patient welcome programme. Patients are shown where the monitoring systems are and posters are on display to advise how the system works. AG clarified that the Oxehealth system is part of a safety tool kit and not a standalone or replacement; therefore should a patient decline to consent to the use of the system, there are other mechanisms in place, and strong engagement remains in regard to observations and engagement.

NH noted that there are clearly good patient outcomes and patient safety measures and suggested that it is important to acknowledge digitalisation within the MH space and the need to keep a learning environment. Narrative from patients and staff also shows other benefits of the use of the Oxehealth system, for example, a better nights sleep as there is no interruption by staff to conduct observations. It is also noteworthy that the system can provide early warning signs in the deterioration of physical health which can prevent harm. Patients have reported feeling safer on the wards and staff have also reported a feeling of increased assurance with this additional tool in the safety toolkit.

RH acknowledged the very positive initial findings and the encouraging reduction in assaults recorded. RH queried whether statistical analysis had been applied to understand the significance. DB confirmed that overall the data that underpins the results was reliable, however further data would be required to show statistical significance. AG advised that the system had now been rolled out across the MH bed base and it was important to continue to learn to see what benefits it brings in a quality and safety space and so it is important to continue to explore where we can take this system.

RH queried whether staff and patient feedback in regards to the system had been sought. DB confirmed that this was the case and feedback indicated that patients felt safer and privacy and dignity had improved. RH suggested that there may be potential for 'false positive' incidents and queried the rate of this. SZ noted that alerts may be triggered for example should a patient be in the bathroom area for a period of time and upon exploration there are no concerns however this is an overall part of the monitoring and engagement of patients.

NL noted that the focus of the findings was around the decrease in assaults, however noted that there had also been a reduction seen in the use of restraint and prone restraint which was also positive. NL also commented that the system had been installed in other NHS trusts and queried how our early results compared. DB confirmed that initial findings were in line with those seen elsewhere; adding that some results seen were also seen in line with pre Covid findings.

PS noted that this had been a very important investment and good early data shows the positive impact of the system. We will continue to collect data which will be monitored via the ESOG / BSOG and Quality and Safety Committee to ensure continuous learning.

131/21 MINUTES OF PREVIOUS MEETINGS

The minutes of the meeting held 29 September were agreed as an accurate reflection of discussions held.

132/21 ACTION LOGS AND MATTERS ARISING

The action log was reviewed as follows:

- 035/21 a large amount of work had been undertaken in terms of a refreshed Board Assurance Framework as well as the undertaking of due diligence work during development sessions. PS confirmed that the refreshed framework would be presented to Part 2 of the Board of Directors today for discussion before submission to the public Board of Directors meeting in January 2022.

ARQ noted there were actions discussed previously that did not appear on the action log:

- An agreement had been made to invite representatives from the Vulnerable Adults Service working with homeless and refugees to share a presentation regarding this valuable service. SS advised that she had visited this service last week and had been extremely impressed with the range of support for these vulnerable cohorts of patients and remitted this action to the TSO for a future Board of Directors meeting.
- It had been agreed that TS would bring to a NED discussion group the Accountability Framework and RAG rating of Divisional performance. TS confirmed that he had been invited to attend the January 2022 NED discussion group to discuss early findings and development of data packs.

There were no other matters arising that were not on the action log or agenda.

The Board discussed and approved the Action Log.

ACTION:

1. **Vulnerable Adult Service to be invited to present at a future Board of Directors meeting. (TSO)**

133/21 CHAIRS REPORT INCLUDING GOVERNANCE UPDATE

The Chair presented a report providing the Board of Directors with a summary of key activities and an update of governance developments within the Trust.

SS was delighted to note that the EPUT mass vaccination centre programme had now delivered over 1 million vaccinations; SS extended congratulations to NL and team for this significant achievement

In partnership and accordance with CQC guidance, SS was pleased to report that Longview and Poplar CAMHS inpatient services had now reopened to new admissions under a phased process. The Trust will continue to proceed slowly and carefully and will engage fully with the CQC.

SS advised that she and the Non-Executive Directors were pleased to have recommenced visits to services across the Trust. SS also advised that RH had agreed and was keen to act as the Board Dementia champion to take a thematic view and ARQ had picked up on safety actions through the BSOG. AS thanked staff for welcoming NEDs during the service visits which provided a real opportunity to hear first-hand the experience of our staff, hearing what we can do to continue to support and acknowledging that Covid is not over. .

SL noted that there was a broader cultural piece and a real opportunity for reverse mentoring and broadening our mentoring programme as well as new ways into professional roles in the organisation through the apprenticeship programme. SS was also pleased to note that there was now an Apprenticeship Board established to steer and oversee this work.

The Board received and noted the Chair's Report.

134/21 CEO REPORT

PS presented the CEO report which provided a summary of key activities and information to be shared with the Board and stated that the performance report would also be discussed during this item.

ARQ noted that month 7 results summarised within the report noted that £3.5m efficiency had been delivered and queried how this had been achieved based on additional expenditure due to the Covid pandemic. TS responded that as a result of cost savings during the pandemic (i.e. travel expenditure etc.) we had been able to identify and deliver genuine savings and clarified that the efficiency had not been identified as a result of additional investment to respond to the pandemic.

SS acknowledged the sad passing of Sir David Amess MP and extended on behalf of the Board, sincere and heartfelt condolences to his family. SS continued that Sir David was deeply respected and it had been a pleasure for many to work alongside him and he would be deeply missed.

AG confirmed that a fifth Executive Safety Priority had been identified – Flow and Capacity; under which sat five work streams:

- Personality Disorders
- Community Flow
- Flow Processes
- Out of Area Placements
- Inpatient Modelling

AG provided assurance that these five areas had been brought together and linked from a safety point of view with executive oversight from AG and MK to bring together these key work streams. AG confirmed that the current position in terms of out of area placements represents the regional position. The Trust has also commissioned 11 block beds at the Priory. The OOA Plan identifies a trajectory to reach our zero ambition by March 2022 and we are confident that this will be achieved. NHSE recognise this challenge and have stretched the target until then. AG continued that we cannot look at this issue in a in silo and work is taking place with local authority and system colleagues regarding accommodation, admission avoidance and flow to the community as well as working on purposeful admissions. There is a lot of scrutiny expected as we move to the challenging winter period but this focus will help us to achieve safe occupancy levels. SS agreed that a cross system approach was key.

ARQ was assured regarding the out of area focus and the impact on the wider system which was far reaching; ARQ noted that the target for reduction and measured progress against the zero ambition was taking place at BSOG which provided further assurance that this is looked at closely.

In relation to suspension of staff, ARQ noted that it was agreed at the previous Board meeting that the length of time staff had been suspended for be included within future reports. RH observed that the average length of stay also impacted the need for staffing and celebrated and acknowledged the work that is happening internally and with system partners to unblock challenges. ML commented that the Finance and Performance Committee gives intensive scrutiny and are rigorously trying to understand blockages and system issues as well as potential solutions with recruitment and retention the underpinning issue.

PS commented that the Executive Team had identified flow as a priority which was being overseen by the ESOG and BSOG as well as ongoing discussions at other committees.

The Board received and noted the CEO's Report.

ACTION:

1. **Information regarding length of suspension to be included within CEO Brief / Performance Report. (SL)**

135/21 QUALITY AND PERFORMANCE SCORECARD

Discussed as part of the CEO Report agenda item.

The Board of Directors received and noted the report.

136/21	END OF LIFE ANNUAL REPORT 2020 - 2021

NH introduced Tracy Reed, EOL Clinical Lead and highlighted that the EPUT EOL services remain rated as 'outstanding' by the CQC; as well as the leadership of the team recognised by the community collaborative. The team has also received national acclaim and is pivotal in an advisory space into what EOL in MH looks like.

TR presented the updated EOL Annual Report paper and advised that a revised version had been submitted which included a patient story. JW thanked TR for this report which brings to life the powerful work being done. JW also appreciated the inclusion of a patient story and the positive results from evaluation forms and queried whether we are sharing this with the system. TR confirmed that we have a 57% response rate to evaluations which is higher than the national average. 96% are positive. Any issues raised are relating to fragmented services prior to being referred to the EPUT Team; meetings are ongoing with system partners to provide a collaborative approach and support learning.

AG reflected on the challenging past 18 monts and was pleased to see the patient story and the impact of the wider health and care MDT.

The Board of Directors received, welcomed and noted the contents of the report.

137/21	A FRAMEWORK OF QUALITY ASSURANCE FOR RESPONSIBLE OFFICERS AND REVALIDATION – ANNUAL BOARD REPORT

GM presented the report and advised that it was noteworthy that the appraisal take up rate had decreased.The reason for this was NHSE suspending the process for six months during the pandemic. GM continued that during this time, the majority of doctors within EPUT voluntarily went through with their appraisal process and therefore we are on trajectory to report a higher take up rate. In response to a query from RH, GM confirmed that for locums sourced via an agency, the agency is responsible for the appraisal process, however EPUT would request assurance that this process is complete.

The Board of Directors received and noted the contents of the report.

138/21	LEARNING FROM DEATHS MORTALITY REVIEW Q1 REPORT 2021/22

NH presented the report which provided information relating to deaths in scope for mortality review for Q1 2021/22. Within this period, there were 43 deaths which fell within scope for mortality review in accordance with the Trust's Mortality Review Policy. This is in line with quarters not impacted by Covid 19 in previous years. NH provided assurance that full exploration and scrutiny had taken place in line with the Trust's Mortality Review Policy.

The Board of Directors received and noted the contents of the report.

139/21	SAFEGUARDING ANNUAL REPORT

NH presented the report which provided the Board with an account of the safeguarding activities undertaken across services and with partners during the year 01 April 2020 to 31 March 2021. NH

advised that a revised version of the report had been circulated.This was as a result of minor typographical errors and did not affect the content of the report.

NH advised that the Quality and Safety Community had received and reviewed this report and had been humbled by the breadth and complexity of this agenda. NH continued that the report identified that there had been an increase in safeguarding activity, however this had been identified as a result of the pandemic.

LL commented that it may be useful to include some commentary or narrative to accompany graphs included within the report in future.

The Board of Directors received and noted the contents of the report and approved the report and publication.

140/21 HEALTH SAFETY AND SECURITY ANNUAL REPORT

PS presented the Health Safety and Security Annual Report advising that this report had been reviewed by the Quality and Safety Committee prior to submission to the Board of Directors. PS continued that a particular area of focus over the past year had been in regard to ligature risk reduction.

LL commented that similar to the previous report, it may be helpful to include commentary / narrative to accompany graphs within reports.

The Board of Directors received and noted the contents of the report.

141/21 PHARMACY AND MEDICINES OPTIMISATION ANNUAL REPORT 2020 - 2021

NH acknowledged the pharmacy team for their continued dedication and support during the pandemic, stating that it would be impossible to maintain patient safety across the organisation without the input of this team. NH also acknowledged HS's leadership during this unprecedented time. On behalf of the Board, SS echoed praise for the team and leadership. NL added that the team had been instrumental in the establishment of our mass vaccination centres with HS's reputation within the region second to none. HS thanked all for their acknowledgement and stated that it was important for those at the coal-face to receive this recognition.

ARQ stated that there had been significant ongoing challenges over the past 12 months and it was a credit to the team that business as usual had continued despite these challenges.

ARQ noted that with operational staff challenged with other priorities had there been a risk around the reduction in reporting of incidents. HS recognised the reduction of levels of reporting due to the pandemic.However medication errors had continued to be monitored and reviewed to identify trends and deal with them appropriate. AG commented that it was important to look at the difference between acknowledging and dealing with an incident and not reporting. AG also noted that the occupancy level had decreased which had been dictated by the Centre which would also factor into a decreased level of reporting. NH added that there were a number of confounding factors, including occupancy rate and services that were stopped during the pandemic, all of which were on the agenda at the monthly Medicines Management Committee. NH highlighted that in future, electronic prescribing would be key to safety.Reporting would be clearer and so in future, following adoption of this programme, increased monitoring will become available. SS agreed that the benefits of e-prescribing were strong throughout the report.

RH acknowledged the future implementation of e-prescribing and queried whether there may be anything that the Board could do to expedite this. HS confirmed that the project was underway (however had been paused during the summer) and was under review. It is hoped that during 2022/23 we will be in a position to roll this out – if not before.

ML referred to the increase in the cost of medications and noted that this had been a potential area to review as part of the CIP programme previously and queried whether procurement routes could be reviewed to ensure affordability. HS confirmed that there was no concern regarding procurement at this time, stating that a significant number of medications were obtained by national or regional contracts where best value is part of the contract. Where medications are purchased locally, the Trust aims to do so in a cost effective way however it is acknowledged that prices can fluctuate.

TS acknowledged the collective determination for an effective e-prescribing function and provided assurance that this will be resourced accordingly.

The Board of Directors received, noted and approved the contents of the report.

142/21 TRUST GREEN / SUSTAINABILITY PLAN

TS introduced and thanked Charles Hanford, Interim Director of Estates Transformation who had been instrumental in the development of the plan. TS continued that this plan was intended to be a clear statement of the direction of travel. The late central publication of a new sustainability directive will be attached as an appendix, and sets out the 'must do' actions for the Trust.

JW thanked all involved for pulling this plan together, stating that there had been a gap in the governance arrangements previously and appreciated the assessment tool to show where we are now, areas where we are ahead and in line with national average and stated that it was important to monitor and understand risks and barriers to achievement at the Finance and Performance Committee.

The Board of Directors approved the Plan and supported the approach to environmental sustainability within EPUT and the broader community.

143/21 FREEDOM TO SPEAK UP REPORT

SL extended thanks to Yogeeta Mohur, EPUT Principal Freedom to Speak Up Guardian for her continued positive engagement as part of this important agenda. LL noted the good level of engagement and progress. YM noted that the profile of the F2SU services continues to rise and those that have used the service have given excellent feedback. It is acknowledged that high performing organisations have a culture of speaking up and when staff area able to speak up, organisations are able to make better improvements for their staff. SL agreed that the highest performing areas are where managers are extremely engaged and understand the fatigue and emotional fatigue of their workforce and flex and adapt to meet their needs. SL continued that engagement is key and it is our responsibility to create conditions for our teams where engagement and freedom to speak up is a high priority.

LL agreed that culture is important and queried what has been learned specifically related to our culture at EPUT to prevent our best talent from burn-out and to learn from our processes so they become embedded. SL responded that as the organisation was about to reach its fifth year, the EPUT identify had now become grounded and we can build from there. A behaviours toolkit will drive positive behaviours and it is clear that we can see 'hope' in our staff. SL was confident that EPUT was now one strong organisation and as we continue to grow and embed expected behaviours we would get to a positive environment. ARQ noted that an Executive Team Priority

EPUT Culture of Learning would also introduce and integrate a positive impact on culture going forward.

The Board of Directors received, noted and approved the contents of the report.

144/21 STANDING COMMITTEES

SS noted that a review of NED chair of sub committees had taken place and to ensure the best use of skills and experience the following changes had been made:

- LL would now chair Finance and Performance Committee.
- ML would now chair the new People, Equality and Culture Committee (PECC).
- RH would now chair the Quality and Performance Committee

(i) Audit Committee
The Board received and noted the report and confirmed acceptance of assurance provided.

(ii) Board Safety Oversight Group
The Board received and noted the report and confirmed acceptance of assurance provided.

(iii) Finance and Performance Committee
The Board received and noted the report and confirmed acceptance of assurance provided.

(iv) Quality Committee
The Board received and noted the report and confirmed acceptance of assurance provided.

(v) People, Equality and Culture Committee including Terms of Reference Approval
The Board received and noted the report and confirmed acceptance of assurance provided. The Board approved the proposed Terms of Reference.

145/21 RISK ASSURANCE REPORTS

i) Covid 19 Assurance Report

PS presented the assurance report in relation to the actions taken in response to the Covid 19 pandemic. PS reflected that there had been significant work undertaken by all to respond to this pandemic but the Trust has also continued to deliver business as usual. PS acknowledged the continued work of the IPC team throughout the pandemic.

RH highlighted a typographical error in CRR 93/94. RH also queried whether there had been an impact following the directive for staff working within care homes being mandated to have received double vaccination. SL advised that minimal concern had been raised at this time, and we now focus on the vaccination of all NHS staff.

The Board of Directors:

1. **Noted the contents of the report.**
2. **Confirmed acceptance of assurance given in respect of actions identified to mitigate risks.**
3. **Noted the Covid 19 Gold risk register and summary mitigations**
4. **Did not request any further information or action.**

ii) Ligature Risk management Q2 Report

PS presented the quarterly report providing oversight of actions underway to mitigate the potential risk associated with ligature from a fixed point within the Trust's inpatient estate. PS confirmed that this remained an Executive priority focus with robust scrutiny via the ESOG. AG was pleased to report that the Trust saw the second month with a considerable reduction of incidents involving ligature from a fixed point; this has now brought the Trust in line with the national benchmark.

The Board of Directors received and noted the contents of the report.

146/21 STRATEGIC INITIATIVES

i) Safe Working of Junior Doctors Quarterly Report (Jul – Sept 2021)

GM confirmed that this report provided assurance that the Trust ensures doctor's contractual conditions are respected and advised there were no areas of concern to report.

The Board of Directors received and noted the contents of the report.

147/21 REGULATION AND COMPLIANCE

i) CQC Update

PS presented the CQC update which provided information on activities that are being undertaken within the Trust and information available to maintain compliance with CQC standards and requirements. PS advised that the recent main focus of work had been in regards to CAMHS and we continue to progress well with recruitment and were pleased to be able to reopen a second CAMHS inpatient unit with permission from the CQC.

The Board of Directors received and noted the contents of the report. The Board of Directors approved the CQC Action Plan to submit to the CQC as the final version.

148/21 USE OF CORPORATE SEAL

The corporate seal had not been used since the previous Board of Directors meeting.

149/21 CORRESPONDENCE CIRCULATED TO BOARD MEMBERS SINCE THE LAST MEETING

There were no items of correspondence circulated to the Board.

150/21 NEW RISKS IDENTIFIED THAT REQUIRE ADDING TO THE RISK REGISTER OR ANY ITEMS THAT NEED REMOVING

There were no new risks identified to be added to the Risk Register, nor any items that should be removed that were not discussed as part of the BAF discussions.

151/21 REFLECTION ON EQUALITIES AS A RESULT OF DECISIONS AND DISCUSSIONS

AG reflected that conversations held today regarding flow and long length of stay on wards as well as discussions regarding physical health demonstrate how hard we are working to bring parity to

physical and mental health. AG continued that discussions regarding a culture of learning and freedom to speak up also demonstrate work compassionate leadership.

152/21 CONFIRMATION THAT ALL BOARD MEMBERS REMAINED PRESENT DURING THE MEETING AND HEARD ALL DISCUSSION (SO REQUIRMENT)

It was noted that ML left at 12:09, however all other Board members had remained present during the meeting and heard all discussions.

153/21 ANY OTHER BUSINESS

There was no other business.

154/21 DATE AND TIME OF NEXT MEETING

SS thanked all for joining the meeting.

The next meeting of the Board of Directors is to be held on Wednesday 26 January 2022.

It was noted due to the ongoing pandemic, the meeting will again be held virtually via the MS Teams video conferencing facility.

154/21 QUESTION THE DIRECTORS SESSION

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

The meeting closed at 12:30.

Governor / Member / Public	Query	Response provided by the Trust
Judith Wooley	Oxehealth Savings: Are these actual, from staff currently deployed, or based on the establishment number of staff, assuming no vacancies or sickness?	Response from TS: These were actual and related to the reduced 1:1 observations carried out by our bank and temporary staff and aligned with the savings anticipated in the original business case.
Paul Walker	Oxehealth: results look very good especially regarding reductions in self harm & cost savings. The assault figures seem unexpected. Have patients expressed irritation because of these extra observations on them?	Response from NH: this is driven by patient profile and acuity. There is a lot that clinicians can do in terms of de-escalation, but sometimes this can be related to symptomology. Evidence shows greater irritation with closer observations and not permitting privacy and dignity so this irritation is expected to ease as we use more remote monitoring tools. Response from AG: early qualitative data shows a better quality of stay as patients are less disturbed with the use of remote monitoring tools, particularly during the night.
Paula Grayson	Performance Scorecard: Looking at the inadequate measure "patients not seen/contacted for 12 months", are we working on finding some innovative methods for enabling staff to contact them in some way if the issue is available time?	JW confirmed that a lot of work is being discussed at Finance and Performance and we are confident this will be de-escalated to a 'business as usual' as the number of patients not seen in 12 months reduces to become within the agreed KPI. JW added that there are escalation processes in place if the situation deteriorates. AG added that the solution has been clinically led where clinicians have helped to determine issues contributable to performance. We know that there are still some issues and we are addressing these.
Paula Grayson	At some future date, please can Governors have a second briefing showing the improvements to service activities for children transitioning to adult services and the positive assistance for Looked After Children?	AG confirmed that she would be happy to return and provide a further update.

Signed: …… Date: ……

In the Chair

John Jones	On patients not seen in last 12 months, I recall a major drive on this happened earlier this year but there seem to be a stubborn residue across all areas. I note a T&F final meeting on 16th November. What was the result? Clearly there is no benefit to patients of being on a list when no action /intervention takes place.	Response from Nigel Leonard: We met with the Execs from SNEE yesterday. The commissioners across our 3 systems have been working with us on the mental health investment standard and on a joint approach for MH services going forward. This plan has 49 actions. A significant proportion of new funding will increase capacity in primary care and with the alignment of secondary and primary care. In the future many patients on this list that our medics are holding in outpatients can be discharged and jointly managed in a community and primary care setting
John Jones	Are primary care aware of this and fully cooperating?	Response from Nigel Leonard: this is being worked through with the joint transformational teams CCG/EPUT
Paula Grayson	I assume that the positive, jointly agreed with service users', discharges are unlikely to take place before the ICBs are in place in April 2022?	Response from Nigel Leonard: this is being worked through with the joint transformational teams CCG/EPUT

Signed: …… Date: ……

ESSEX PARTNERSHIP UNIVERSITY NHS FT

Board of Directors Meeting
Action Log (following Part 1 meeting held on 24 November 2021)

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

Lead	Initials	Lead	Initials	Lead	Initials
Alex Green	AG	Nigel Leonard	NL	Amanda Sherlock	AS
Natalie Hammond	NH	Manny Lewis	ML	Trevor Smith	TS
Rufus Helm	RH	Loy Lobo	LL	Janet Wood	JW
Mateen Jiwani	MJ	Alison Rose-Quirie	ARQ	James Day	JD
Milind Karale	MK	Sheila Salmon	SS	Trust Secretary Office	TSO
Sean Leahy	SL	Paul Scott	PS		

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
November 132/21	Vulnerable Adult Service to be invited to present at a future Board of Directors Meeting.	TSO	~~January 2022~~ March 2022	**January 2022:** Item deferred due to moving to Board-Lite agenda in response to the current upsurge in the pandemic.	Open	
November 134/21	Inclusion of length of suspension to be included within CEO update / performance report.	SL	January 2022	**January 2022:** Length of suspensions added to the CEO report.	Closed	

Minutes Ref	Action	By Who	By When	Outcome	Status Comp/ Open	RAG rating
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~~ Sept 2021 Nov 2021 January 2022	**Update 28.07.2021:** BAF refresh unable to take place until Board of Directors have approved strategic objectives. Timescale for strategic objectives is presentation to TB in July 2021. Therefore BAF refresh will aim for September TB. Work is underway on refresh using draft objectives and taking into account learning from Amberwing sessions. **Update 29.09.2021** Strategic Priorities to be approved at 29th September Board and to be reflected in new strategic BAF to be presented in November. **Update 16.11.2021** BAF refresh paper submitted under part 2 with new proposed strategic risks. Once agreed, this will be reported to Part 1 Board going forward. **Update 18.11.2021** Presented to Part 2 and will now move to BAU with presentation at Part 1 in January 2022 **Update 23.11.2021** A large amount of work had been undertaken in terms of a refreshed Board Assurance Framework as well as giving due diligence during development sessions. PS confirmed that the refreshed framework would be presented to Part 2 of the Board of Directors today for discussion before submission to the public Board of Directors meeting in January 2022.	**Closed**	

				Update 10.01.22 Presented in Part 2 TB November. On agenda for Part 1 Jan 2022 so moved back to BAU with refreshed BAF		
March 040/21	Engagement Strategy to be reset and presented to the next Board of Directors meeting.	SL	~~May 2021~~ ~~July 2021~~ ~~November 2021~~ ~~January 2022~~ March 2022	Part of the HR review which will be completed in June 2021. **Update 28.07.2021**: There is a lot of work being undertaken following the HR review and therefore this action is deferred to November 2021. **January 2022:** Item deferred until March 2022 due to current upsurge in the Covid-19 pandemic.	Open	

		Agenda Item No: 5
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Chair's Report (Including Governance Update)**					
Executive/ Non-Executive Lead:	Professor Sheila Salmon, Chair of the Trust					
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 – *mandatory section*		
Summary of risks highlighted in this report	None	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 headlines 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:

- EPUT Child and Adolescent Mental Health Services (CAMHS)
- Board Lite Approach January 2022
- Service Visits
- Senior Director appointment

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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	CAMHS	Child and Adolescent Mental Health Services
NED	Non-Executive Director	CEO	Chief Executive Officer
NHSE	NHS England		

Supporting Documents and/or Further Reading
Main Report.

Lead
Professor Sheila Salmon **Chair of the Trust**

Agenda Item: 5
Board of Directors Part 1
26 January 2022

CHAIR'S REPORT (INCLUDING GOVERNANCE UPDATE)

1.0 PURPOSE OF REPORT

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust.

2.0 CHAIR'S REPORT

2.1 EPUT Child and Adolescent Mental Health Inpatient Services

I am delighted to report that all three of our Tier 4 CAMHS inpatient units are now open to new admissions. A robust daily risk assessment protocol is in place to ensure the safety of our services and work is ongoing to add more permanent staff members to our CAMHS wards. We have also recently successfully recruited a new CAMHS consultant within the last few weeks. Patient safety remains our highest priority. We continue to work closely with the CQC and our partners to lift our service standards to the highest level.

2.2 Board Lite Approach January 2022

Following updated NHSE guidance to NHS Trusts and Foundation Trusts, as a consequence of the pressures exerted by the Covid-19 variant Omicron, in order to ensure our Managers and Leaders are able to continue to respond to the ongoing pandemic as well as conduct 'business as usual', we have taken the decision to adopt a 'Board Lite' approach. Assurance is given that the Board of Directors continue to discharge their duty in ensuring the Trust meets all of its governance and regulatory obligations, continuing to provide safe and effective care for our service users.

All Board and sub-committee meetings are being conducted virtually until advised otherwise. The guidance is similarly applied to the Council of Governors and related meetings.

2.3 Service Visits

Due to the recent surge in Covid-19 cases across the country, the NEDs and I have not had the opportunity to undertake any in person service visits in the last few weeks. However, we are looking forward to resuming these as soon as it is deemed safe to do so, and arrangements are in progress to forward plan visits. In the mean-time virtual connection is happening where feasible.

2.4 Director Appointment – Senior Director of Corporate Governance

Following a robust recruitment process, I am pleased to announce that Denver Greenhalgh is joining EPUT in the overarching governance director role. Denver will oversee all aspects of Corporate Governance for the Trust as well as directing the Trust Secretary's Office. Denver commences in February. One of her first tasks will be to set in train arrangements for a "Well Led Review" which is due for completion in 2022.

I would like to take this opportunity to sincerely thank James Day for his able support and leadership of the Trust Secretariat whilst in post as our Interim Trust Secretary. We wish him well in his future endeavours.

3.0 LEGAL AND POLICY UPDATE

Items of interest identified for information:

3.1 Health and Care Bill: Report Stage.

Please see the first link below for a copy of the report. The second link is a copy of integration and innovation. **For Information: Link; Link**

3.2 The Latest Decision On Conditional Discharge And Deprivation Of Liberty.
Please see the first link below published on 26 November 2021 regarding patients with mental capacity who are subject to a conditional discharge in the community can lawfully remain under conditions that deprive them of their liberty and the second link is a copy of the guidance. The third link is a copy of new guidance on how to manage the restricted patient. **For Information: Link**; **Link; Link**

3.3 £5 Million Launched To Support Suicide Prevention Services.
Please see the link below for a copy of the press release dated 26 November 2021 outlining what groups and charities the money will assist. **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 of the Trust

		Agenda Item No: 6
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

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

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	N/A	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber-Attack	
Does this report mitigate the Strategic risk(s)?	N/A	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 a summary of key activities and information to be shared with the Board.	**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 Covid-19, Performance and Strategic Developments.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Main Report

Lead
Paul Scott **Chief Executive Officer**

Agenda Item: 6
Board of Directors Part 1
26 January 2022

CEO Report – January 2022

1.0 Introduction

I write this update, the first of 2022, with the Trust having successfully navigated through what has, arguably, been the most difficult winter period since the NHS was established. During later December and early January, when the Omicron wave was at its peak, we suffered unprecedented Covid outbreaks on our wards and staff sickness that reached c10% on average (higher in some locations). This put immense strain on those running the services. I am immensely proud, and full of admiration, of the response of all colleagues during this time. During a period of unprecedented and unrelenting pressures, people stepped up to ensure EPUT was able to maintain the delivery of all our services to the patients and communities we serve. Colleagues across mental health and community nursing services volunteered to work extra shifts, work in different locations, work over bank holidays and nights, and work in challenging conditions. You pulled together, and made huge sacrifices, for your patients and for each other. I cannot overstate my gratitude to you all – thank you.

The Trust continues to play a vital role in the roll out of the Covid-19 vaccination programme across Essex and Suffolk. You can read more detail around the programme later in this report, however, having now delivered over 1.2 million vaccinations across our mass vaccination centres, I want to thank, once again, our incredible vaccination teams and volunteers who have played such a vital role in protecting public health, allowing society to remain open, and allowing loved ones to safely see each other. The speed of mobilisation to massively increase our capacity, responding to enormous demand for booster jabs in the lead up to Christmas, was a testament to everyone involved.

Although we are yet to reach the end of the pandemic, I am hopeful that we have ridden the worst of the Omicron wave and we can start the year with some hope that we will be able to live our lives with more freedom. Covid-19 will undoubtedly pose continued challenges and surprises but we will remain focussed on making sure this year will be another year of progress for EPUT. We will focus on recovering from the impact of the pandemic and the continued expansion and transformation of our services.

We had to approach our work differently during the latest phase of the pandemic. Colleagues worked extra time, delayed training, delayed annual leave, worked in unfamiliar environments, and stretched their services in order to manage this last period safely. We will need to make sure we return to normal as quickly as possible, allow colleagues time and space to recover and reflect, put in place plans to recover training and annual leave deficits. I know that there is also a large section of the population that is waiting longer than anyone would like for access to healthcare – we have an important role to play in supporting the broader health and care system to reduce these waiting lists as quickly as possible.

There are also a range of incredibly exciting developments we hope will improve our services over the next few months. We will be focussed on transforming our services so that patients who need us have better access, better care and better outcomes. We will do this by continuing our expansion of Mental Health Services in the community, releasing more time to care for clinical colleagues on our wards, continuing to invest in new technology and bringing more staff to work on our wards. We will continue to build on the encouraging start to the delivery of our safety strategy, 'Safety First, Safety Always', (which you can read more about later in this report). We will also continue to build increasingly integrated services with our partners in health, social care and the voluntary sector.

I am delighted to welcome a new addition to our leadership team – Denver Greenhalgh who joins us next month as our Director of Corporate Governance. Denver brings a wealth of experience and delivery from the Acute Sector and has demonstrated that her values mean that she will contribute

hugely to our focus on improving the services we provide to patients, supporting colleagues to be the best they can and building greater integration of health and care services.

I want to take this opportunity to thank all colleagues across the entire EPUT family for the resilience, compassion and dedication they have shown to our patients, and each other, throughout a challenging winter period, and wish you all the very best for what I believe is going to be an exciting and transformational year for the Trust.

2.0 Key Issues

As we start a new year it is a good time to set out some of the high level plans we aim to progress in 2022/23 against our strategic objectives. I anticipate that these will form a core part of our annual plan that we will present to Board in the Spring:

2.1 We will deliver safe, high quality integrated care services.

Safety Strategy – "Safety First, Safety Always"

Despite the challenges of the last year we have remained relentlessly focussed on improving our safety and I am pleased that we are able to demonstrate some tangible improvements. We will build on this great start and look to expand the scope and scale of the safety strategy. Further detail on this is below and later on in the agenda for this meeting.

Continued Development of our Mental Health Services

By the time this financial year is complete we anticipate that we would have invested c£20m into expanding our Mental Health services in the community – this should mean there is more support for people in crisis and those needing support through primary care services. Our plans see a continued growth in the next financial year as well.

Virtual Wards Community Services

Working in partnership with Provide and North East London NHS Foundation Trust (NELFT) we are implementing virtual wards that mean people can be treated safely in their own home rather than have to go to hospital. This is enabled by our brilliant nursing teams, the latest technology and the oversight of medical colleagues from the hospital. This should have real benefits to patients who can receive the best care in their own homes as well as freeing up hospital capacity to treat patients who are waiting for surgery.

Clinical Leadership and Development of Care Units

We plan to restructure our services to form care units which will mean a better focus on local geographies, mean better integration as well as investing in clinical leadership. Together with the introduction of a structured accountability framework we will create a more balanced view of performance to incorporate safety and quality as well as finance and performance.

Children and Adolescent (CAMHS) Tier 4 Services

We needed to restrict access to our CAMHS wards over 2021, following a CQC visit, and due to the increasing demands on the service and a problem recruiting enough staff. I am really pleased that due to skilled and hard work from colleagues in the service all our wards are now open to admissions. We want to build on this work and embed these improvements as well as working to evolve the service to meet the changing needs of our patients.

2.2 We will enable each other to be the best that we can.

Nurse Recruitment

We are facing a national shortage of qualified nurses and we are working to secure a significant investment to attract nurses from overseas to work at EPUT. This should result in less reliance on temporary staff in our services and make us more resilient as we expand our services.

Increasing Time to Care

We know we can do more to help colleagues by reducing the administrative burden which will allow more time for our clinical staff to be with patients. We know that we have many opportunities to develop new roles to help the therapeutic recovery of patients and we know that new technologies are becoming available every day that will either improve safety or augment therapeutic care. We are planning to undertake a major piece of work to bring these together with the ambition to increase the number of permanent staff on our wards, release more time to care and improve outcomes for patients.

2.3 We will work together with our partners to make our services better.

Mid and South Essex Community Services Provider Collaborative

In 2021 we further cemented our collaborative arrangements with Provide and NELFT. We have established a shared ambition, created a shared platform for urgent care referrals and jointly implemented virtual wards. We plan to continue to develop our services to meet the needs of the population at local level working in increasing partnership with colleagues in Primary Care, Social Care and the acute sector.

East of England Specialist Services Collaborative

In July 2021 the six providers of specialist Mental Health services in the East of England formed the East of England Specialist Services Collaborative. This collaborative has responsibility for the commissioning budget as well as the provision of services. This will allow us to work with clinical leaders and patient representatives to modernise services in Eating Disorders, Forensics and CAMHS tier 4.

2.4 We will help our communities to thrive.

We know the impact of housing, education and employment on health outcomes. We will continue to develop our plans to have a positive impact beyond the delivery of healthcare services. Our sustainability strategy year 1 will be implemented; we will seek to use our role as an anchor institution by employing more people from local communities, and buying more locally. We will develop plans to increase the attractiveness of Essex as a place to work and to do business. We will form better partnerships with local enterprise, the voluntary sector and education. We have more to do to in this area and I am hopeful that 2022 will be the year when we start to finalise our plans in this area.

3.0 Performance and Operational Issues

Safety and Quality – Natalie Hammond, Executive Nurse

The Trust approved the patient safety strategy ‘Safety First, Safety Always’ in January 2021. The organisation’s principal strategy for safety drives our values, behaviours and actions. The annual report (agenda item 10(a)) demonstrates the progress made over the last twelve months. It sets out actions taken against the themes in the strategy, identified by staff and patients as key enablers, to performance outcomes and it demonstrates how these themes are driving improvements in patient

safety and quality outcomes across inpatient services. This strategy remains under continuous review as we revise our ambitions based on performance, learning and feedback from staff, patients, regulators, partners and other stakeholders.

The ESOG and BSOG continue to provide oversight and assurance of our safety strategy and delivery plans. The meeting continues to evolve and in the last report, we highlighted our fifth safety priority - Inpatient Flow. This priority relates to the reduction of inappropriate out of area placements through a holistic and systems-wide approach. Initial scoping is underway, with 6 work-stream themes.

- Out of Area Eliminations: out of area bed capacity and trajectory; clinical oversight of patient discharge and relocation; system response - CCGs, Local Authorities, and NHSEI.
- Inpatient Modelling: EPUT bed numbers, types, locations; optimal distribution of capacity; Mental Health Emergency Department.
- Optimal Patient Pathways: Inpatient Protocol for Personality Disorders, Community Personality Disorder pathway / Complex Needs pathways; overarching pathway.
- Purposeful Admissions: gatekeeping, assurance, process systems, and alternatives to admission; Safer Care bundle principals; Red to Green NHS methodology; earliest safe discharge.
- Community Flow: alternatives to admission; community care opportunities; community resources and capacity.
- Processes: Sit Reps; Safe Care; Smart Tool; OPEL.

Following the decision to pause the electronic-prescribing (EPMA) project in September 2021, we have undertaken a wholesale review of the project to ensure that when it restarts it is setup for success and we can be confident of delivery success. We have engaged with other Trusts to understand their experiences of delivery of EPMA and we have had a number of workshop sessions with EMIS who are the supplier of our EPMA solution. The business case is refreshed and due for presentation to the Executive Team in February and Board in March for approval.

Finance – Trevor Smith, Executive Chief Finance and Resource Officer

Finances 2021/22 (YTD, M9):

The Trust is reporting a surplus of £86k with a break-even forecast outturn.

The Capital annual plan remains £14.4m, YTD spend £6.8m (47% delivery compared to 31% for same period last year).

Cash balances (£85.0m) remain sufficient for trading activities.

Other key activities include:

- National and Local Planning 2022/23.
- M9 Annual Accounts and Agreement of Balances.
- Year-end Planning.
- International Financial Reporting Standard Submission (IFRS 16) re leases and licences.
- Review and update of Efficiency planning and delivery process.
- Establishment Reviews and restructures.
- External Audit tender.

Operations – Alex Green, Executive Chief Operating Officer

During December we focused on the development and implementation of our surge plan to ensure robust mitigations were in place in response to the risks presented by increasing numbers of COVID-19 cases and the Level 4 incident status. Our plan has enabled us to maintain service delivery and avoid any cessation of services. We have strengthened our urgent care responses across community

health services and mental health, supporting people in their own homes and playing a critical role in local system's resilience.

Despite pandemic related challenges, our operational performance has remained relatively stable. A decline in CPA reviews across our 3 system areas, attributable to staff sickness and caseload prioritisation, contributed to an increase in areas of inadequate performance. Areas requiring improvement fell from 11 in November to 7 during December.

Our adult mental health inpatient and PICU occupancy levels reduced below the respective national performance target, although it should be noted that outbreak related bed closures will have had an impact. Our average length of stay for both areas increased slightly, continuing to fall outside of the national target. Our delayed patient transfers reduced slightly to 5.7% and we have been undertaking work with our system partners to ensure timely visibility and escalation of delays, together with enhancing our own discharge co-ordination functions. A focused programme of work on flow has continued during this period and is expected to deliver sustained improvements and I am pleased to report that we remain on track with our trajectory to meet the zero ambition for adult mental health Out of Area placements by the revised end of March target date.

Major Projects – Nigel Leonard, Executive Director of Major Projects

Covid-19 Vaccination Programme Update

The Trust has continued to play a major role in the roll out of the COVID-19 vaccination programme across Essex and Suffolk, with the large-scale vaccination centres operated by EPUT having now delivered well in excess of 1.2 million vaccinations.

In December, we responded immediately to the national challenge advised on 12th December to accelerate the booster programme in response to the rising risk presented by the Omicron variant. Additional capacity was put in place very quickly across all our vaccination centres to ensure all those wanting to bring forward their booster dose were able to do so. To supplement this we also arranged a "Big Weekend" event at Chelmsford Race Course on 18th and 19th December during which we vaccinated over 3,600 people, attracting national and local media coverage thereby attracting more to attend. In one week alone, immediately after the Prime Minister's announcement in December, we delivered over 58,000 vaccinations across our centres. We opened two additional centres just before Christmas to provide additional capacity over the Christmas period and into the New Year. One of these, Chelmsford County Hall, is remaining open for the foreseeable future.

Whilst the activity in our centres has predominantly been for the booster programme, we have also been offering 1st and 2nd doses throughout the period to those eligible to ensure the evergreen offer of vaccination.

We have experienced a decline in the numbers of people attending our vaccination centres since the start of the New Year and are working with our system partners to look at innovative ways we can increase vaccination opportunities for those people who have yet to take up the offer of vaccination. We continue to urge those who have not yet taken up the offer to come forward.

Our School Age Immunisation Service has continued to deliver vaccination sessions in schools across Essex and Bedfordshire, Milton Keynes and Luton for 12 – 15 year olds. To supplement these in-school sessions, the service has delivered a number of pop up sessions in venues across the counties and all our vaccination centres have also been offering dedicated sessions for 12 – 15 year olds to be vaccinated.

Planning is now well underway to ensure that all our front line staff will be fully vaccinated by the NHS deadline of 1 April 2022.

The achievements of this programme continue to be phenomenal through extremely challenging times – I really cannot express my thanks strongly enough to all those involved – our staff, volunteers and our partner organisations, without whom none of this would have been possible.

People and Culture – Sean Leahy, Executive Director of People and Culture

Recruitment and Retention Highlights

Vacancy rate – In November the Trust vacancy rate rose slightly to 10.3%, however this does remain within the target of <12%. Just two directorates are outside this target in November: Finance & Resources, and Operations.

Turnover rate – Turnover has seen no significant change from 10.2% in October to 10.7% in November. Higher turnover rates are being witnessed within the Central Budgets & Efficiency, and Mass Vaccination directorates.

Starters and Leavers

There were 82 new starters in November. 10 of these new starters were registered nurses. The majority of staff employed to assist with the Mass Vaccination Programme are recruited as bank staff and therefore will not be counted towards this indicator.

During the month of December, the Trust had a total of 60 permanent 'new starters'. This is split between external starts of 26 and internal promotions of 34 this signifies an external workforce growth of 57% this month with 43% of vacancies being used for internal development of staff.

The Trust has also reported 14 new staff bank workers joined EPUT.

Monthly bank joiners are as below:

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
37	38	46	35	52	40	21	22	2	9	31	14

The Trust also had a total of 52 permanent voluntary leavers during the period.

Profession	New Starters	Percentage	Leavers	Percentage
Add Prof Scientific and Technic	5	8%	3	6%
Additional Clinical Services	32	54%	16	30%
Administrative and Clerical	9	15%	12	23%
Allied Health Professionals	5	8%	2	4%
Estates & Ancillary	1	2%	4	8%
Nursing and Midwifery Registered	8	13%	15	29%

Time to Hire

	End to End
October 2021	71.7 days
November 2021	52.3 days
December 2021	56.6 days

For the month of December time to hire was 56.6 days. This is measured from the date the vacancy is sent to advert up to the date the new staff member has all checks clear.

Changes in process and team communication have led to there only being a slight increase between November and December. For this reporting period we have faced re-deployment of recruitment staff to the Mass Vaccination Team, in addition to the festive leave period and COVID related sickness.

Retention Plan

EPUT have been working closely with MSE partners via the ICS to create a workable retention strategy during the pandemic crises. A target was set in August 2021 "To reduce EPUTs Turnover rates to 9% by August 2022", which was seen to be achievable with the suggested targets put in place. It was agreed that the 'Primary Action's' would be to: 1. Assess High Turnover areas, 2.Improve Career pathways, 3. Targeted support and development opportunities and 4. Improve Recruitment. Each of these primary actions also had secondary targets aligned to them. In December HR held its first 'Retention Strategy task and finish group' inviting the Trust's key stakeholders to take part and contribute in relevant actions. The task and finish group will hopefully meet bi-monthly to monitor its success and review the turnover rates.

Recruitment Programmes

- **International Recruitment (IR) –** IR is a vital component of support for enabling us to meet the needs of our population and services. In October and November 2021 EPUT, in collaboration with MSE, successfully recruited ten international nurses from India and has approved funding to recruit 50 nurses before the end of March 2022. There is now a business case that further seeks approval for EPUT to expand the project by recruiting, appointing and successfully training 135 nurses between April and December 2022.
- **HCSW –** Objective to reduce Healthcare Support Worker vacancies to as close to 0 by 31st March 2022 (As of December 2021 current vacancies stand at 205wte). Project being delivered in collaboration with MSE.

Sickness Management

- In October (last available Trust performance report) the sickness absence rate rose slightly to 6% (above the Trust target of 5% but below the mental health benchmark of 6%) this is a continuing increasing trend, reasons attributed to this are increases in Gastrointestinal and cold/cough/flu reported symptoms. In October Covid accounted for 8% of all sickness absence Long-term sickness remains consistent at 3.7% and is within the Trust target.
- In December the UK declared a Covid Pandemic wave caused by new Variant Omicron – This new variant has had a dramatic impact on staffing absence throughout December and January with its peak being the 5th January where 312 staff were absent due to covid (isolation and covid sickness) accounting for 5.2% of the workforce and total staff sickness absence increased to 7.6%.
- Since the 5th January sickness level have started to decline as at 16th January current total sickness absence (general and covid) is 4.5% (269 staffs) and covid absence (Isolation and sickness) absence 2.5% (151 staff) of the workforce

Employee Relations Highlights

- 13 Formal disciplinary cases (4 is in relation to temporary worker)
- 4 Suspensions (1 temporary worker precluded)
- 4 Grievances (2 temporary Workers)
- 6 Dignity at work complaints (Bullying and harassment) – (2 temporary workers)
- 2 Appeals
- 2 Employment Tribunals
- 7 formal capability

In relation to the length of suspension, these are as follows:

Current suspensions / preclusions are between 21 weeks and 2 weeks in duration and relate to allegations of harassment, patient safety or safeguarding concerns.

Employee Relations activities within disciplinary, suspensions, grievances and appeals have significantly decreased since previous reported this is due to a targeted work on resolving grievance processes and change in processes for managing temporary worker concerns which has reduced timescales in case completion. Decrease by 24 cases (disciplinary, grievances, dignity at work and appeals) and decrease of 7 for suspensions.

Covid vaccination as a condition of employment programme

On 6 January 2022, the Government made new legislation, approved by Parliament, which amended the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"). This extends the scope of mandatory vaccination requirements for staff beyond registered care homes to health and wider social care settings in England

The vaccination as a condition of deployment (VCOD) requirements include front-line workers, as well as non-clinical workers not directly involved in patient care but who may have face to face contact with patients, including ancillary staff such as porters, cleaners or receptionists.

Fully vaccinated in this sense means 2 covid vaccinations (booster is not included in the regulations) or medical exemption

A programme of work has been in place to validate the vaccination/exemption status of all Trust workers including the Trusts temporary workforce. To date we have 497 workers whose vaccination/exemption status we have been unable to validate. (250 substantive staff (4.2% of substantive workforce) and 247 temporary workers). Further work is ongoing to validate these staff over the next 2 weeks. The national guidance for stage 2 of the programme was released on the 14th January, which sets out the formal process to be enacted if a worker who falls into scope of the regulations remains unvaccinated by the 1st April. The trust will now be working through the implementation of this guidance

Mandatory Training

There has been a temporary halt to face to face mandatory training courses, till January 21st, to assist with the extraordinary staffing pressures that the Trust is experiencing at the moment. E-learning courses are unaffected and are being phased back to pre-Covid update periods.

The overall compliance for December was 89%, a decrease of 1% from November. Compliance for the Pre-COVID update frequencies remains at 85%. The DNA rate for December was 12.5%, with only 55% uptake of places during the month
Fire Safety compliance remains the same at 81%, Basic Life Support (84%). TASI has decreased by 1% to 86%. Safeguarding Level 3 remains below 90%, Children 85% and Adults 87%. Grab Bag, Moving & Handling and Medicines Management all remain compliant. Information Governance remains under the threshold at 88%, CareFall has increased from 68% to 70% and Transfusion Process has fallen from 61% to 30%. The tutor for Transfusion Process has left the trust and we are searching for alternative providers.

The figures show that even before the halt to delivery of classes, mandatory training was struggling to reach compliance especially for the subjects requiring face to face classes. A recovery plan has been created and will be discussed at the command meetings. It does involve putting on additional classes but also includes suggestions for prioritising groups of staff so that we minimise any risk.

Student Placements

Placement capacity is stretched so the exploration of innovative placements continues. The Trust is working in partnership with the HEIs to explore placements in the Private and Voluntary sectors. As many of these settings do not employ registered clinicians, careful consideration has to be given to the competencies that can be acquired in these settings, and supervision/ assessment

arrangements. EPUT is hiring nurses on Bank to help provide long-arm assessment of students placed in these settings.

ARU has decided to remove all students from placement for the next two weeks. Whilst this does reduce the pressure on clinical learning environments it will require careful consideration of how these placement hours can be made up.

Other Issues

- The first meeting of the Apprenticeship Board has taken place.
- The new apprenticeship learner management system will be installed in January. This follows a recommendation from a previous Ofsted visit.
- The first cohorts of STORM (suicide prevention) staff have attended the train the trainer course
- The RISE leadership programme has commenced for BAME staff. There is a temporary halt put on delivery and rescheduling of workshops to relieve staffing pressures over January.
- An update has been given to HEE regarding the current spend of CPD funds. All staff have been requested to complete study leave applications or release unspent funds.
- Talks have commenced with Essex University regarding accreditation of the Level 5 Associate Practitioner Foundation Degree which will be required for the new Level 5 standard.

Employee Experience

Equality, Diversity and Inclusion update:

Following the Equality and Inclusion function being re-integrated as part of the Staff Engagement Directorate, there have been no changes to the projects undertaken. The WRES and WDES have both been updated for Q1 (September – December 2021). The first version of the Employee Trans and Non-Binary Employee Policy and Procedure, in collaboration with the Staff LGBTQ+ Network, has been drafted and is still currently with the Employee Relations team awaiting approval. The ED&I Team has also supported Disability and Mental Health Network for Disability History Month in November, with live events (as well as other training sessions provided) being shared with our Mid and South Essex partners.

Other key activities:

- We are currently still in the process of creating a dashboard to better capture data we as a Trust do not already have access to for marginalised and minority groups – working with Mid and South Essex Data Analyst to build on the dashboard they have already created.
- We supported the development of the NHS East of England Anti-Racism Strategy, with our Equality Advisor volunteering to record this presentation for use across Mid and South Essex.
- The General Workforce report for 2020 – 2021 is on track for completion in March 2022, with the 2021 – 2022 GWR being developed after April 2022.
- We are reviewing our existing ED&I training offer to our Staff Engagement Champions and our workforce in line with new branding guidelines and to ensure these are provided in conjunction with the Workforce, Development and Training function of the Trust.
- We will also be reviewing the effectiveness of the Networks across the Trust and ensuring there is greater alignment with the equality champions.

Staff Engagement and Wellbeing

Our staff engagement and wellbeing activity is centred on building and driving the strategy to listen, connect and positively impact our employee's overall experience. We strive to create various mechanisms for staff to provide feedback and share their views and these include the Annual Staff

Survey, Quarterly Pulse Surveys, our network of engagement champions, CEO live brief sessions and localised culture reviews and deep dives.

The 2021 Annual Staff survey closed on 26 November 2021 and our final response rate was 47% this was the same response rate in 2020. The results of the survey are expected by March 2022 and the team will work on disseminating these with a clear focus on taking action.

The new National Quarterly Pulse Survey was launched on 4 January and is due to close on 31 January 2022. Our internal campaign has launched to encourage participation and increase employee interaction. The pulse survey will be open to colleagues in the first month of every quarter as we enable our staff to share their views and provide them with a variety of mechanisms and opportunities to do so.

Other key activity:

- Planning is underway to review and better align our engagement and equality champion networks with a clearer purpose, expectations and sponsorship. Importantly, the network will be streamlined with the overall employee experience function and aligned with other internal networks.
- Delivery of service specific culture review report with recommendations for action.
- Health and Wellbeing phased handover to new Health and Wellbeing Director.
- Review of current staff recognition with a view to establish a full reward and recognition strategy for our staff.
- Health and wellbeing support continues: working with Here for You, Long- Covid support, Menopause support group, burn out sessions, mindfulness, wellness plans linked to appraisals, updated work-life balance guidance and bespoke individual and team level support.
- New Year New You campaign launched internally to support and promote education of mental health and wellbeing.
- Delivering of staff benefits and salary sacrifice schemes including cycle to work scheme, childcare vouchers including childcare vouchers for Mid Essex CCG, and Staff Covid Thank you Lottery.

Communications

The priority for the team has been to support the Trust with communications around the response to the level 4 incident, alongside the mass vaccination activity:

- Daily attendance at both silver and gold command meetings to capture follow up communications including updating guidance on intranet
- Communications plan developed to align to the 3 phases of mitigations and surge planning
- Regular updates from CEO and ET to all staff – including weekly all staff briefings

Mass vaccinations**:**

- Internal and external communications to support the max vaccination programme
- PR and Social campaign to drive take up of the vaccine - proactive sell in of media opportunities including broadcast media – Sky, BBC

The team have also been carrying on with “business as usual” communications:

- Working with stakeholders on key internal projects
- Managing proactive PR
- Handling reactive media enquires
- Updating intranet, producing Wednesday Weekly, regular all staff emails, ticker and staff briefings
- Forward planning via a newly established communications planning and editorial process.

EPUT Rebrand

- With a new rebrand of EPUT imminent, the team are working to create packs of collateral to go to each ward/site we have with rebranded posters, leaflets etc to ensure everyone is aligned with the new branding
- Working internally with each team to ensure the values, vision etc along with the new brand is incorporated into the look and feel of each piece of work

- Creating video content for wards to help promote them on our social channels and new website

Vaccination programme

- Since the need for the mass vaccination programme, the team have predominantly been working on getting our vaccination centres out onto our social media channels.
- We are currently working on a localised campaign for SNEE to promote their vaccination centres using various channels including more localised radio ads, organic social media posts along with boosted and paid for social posts, potential door drop within the local area, using TikTok to promote vaccinations to 12-15 year olds and continuous updates of the website.

		Agenda Item No: 7a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

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:	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.	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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		
This report provides the Board of Directors • 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 9 (December 2021).

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

Six inadequate indicators (variance against target/ambition) have been identified at the end of December 2021 and are summarised in the Summary of Inadequate Quality and Performance Indicators Scorecard.

- CPA Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology
- Sickness Absence

There are two inadequate indicators which are an Oversight Framework indicator for December 2021.

- Out of Area Placements
- Sickness Absence

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

There are no inadequate indicators within the CQC scorecard. As at the end of 10th January 2022, 62 (94%) individual actions have been reported as complete, 4 (6%) individual actions are in progress and are not yet due for completion and 0 individual actions are overdue.

Within the Finance scorecard one item has been RAG rated inadequate for December;

- Temporary Staffing

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: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Paul Scott **Chief Executive Officer**

NHS
Essex Partnership University
NHS Foundation Trust

Trust Board of Directors
EPUT Integrated Quality and Performance Score Cards
December 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.

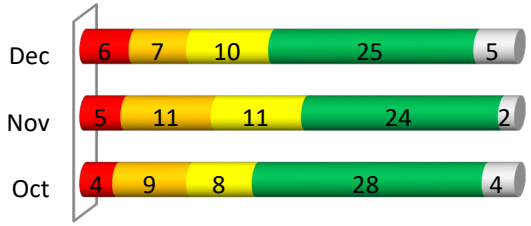
How is data presented?

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)ower values	Special Cause of improving nature of lower pressure due to (H)igher or (L)ower 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 which are at variance as a whole 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 with National or Commissioner targets. These have been highlighted to Finance & Performance Committee.

SECTION 1 - Performance Summary

Summary of Quality and Performance Indicators

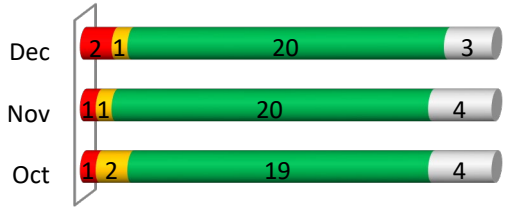


December Inadequate Performance

- CPA Reviews
- Inpatient MH Capacity Adult & PICU
- Out of Area Placements
- Patients not seen, inc Patients with No Consultant Review within 12 months
- Psychology
- Sickness Absence

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

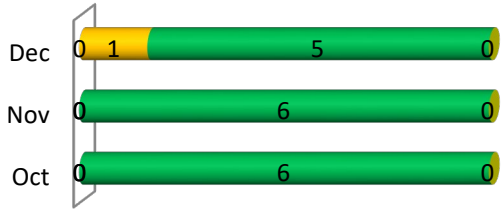
Summary of Oversight Framework Indicators



December Inadequate Performance

- Out of Area Placements
- Sickness Absence

Summary of Safer Staffing Indicators



One risk identified within the Safer Staffing section:

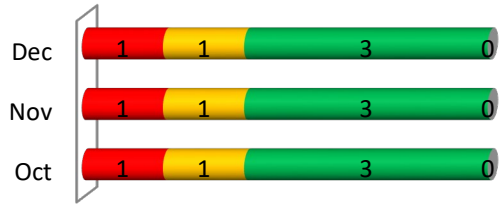
- Ward Fill Rates below 90%

Summary of CQC Indicators

The CQC completed an unannounced inspection of the CAMHS services in May/June 2021.
The CQC has rated our CAMHS service as 'inadequate'. The final report has identified 22 areas for improvement (13 Must Do, 9 Should Do). The Trust has developed an enhanced action plan to address the concerns raised; this will require approval prior to submission to the CQC.

As at the end of 10th January 2022, 62 (94%) individual actions have been reported as complete, 4 (6%) individual actions are in progress and are not yet due for completion and 0 individual actions are overdue.

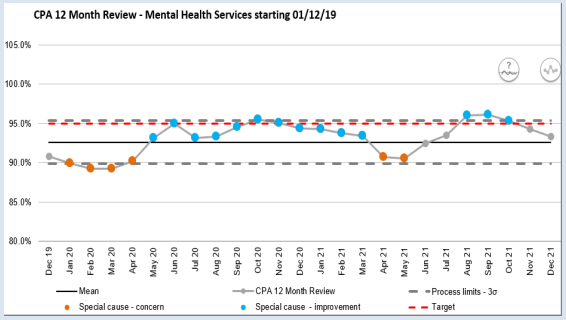
Finance Summary

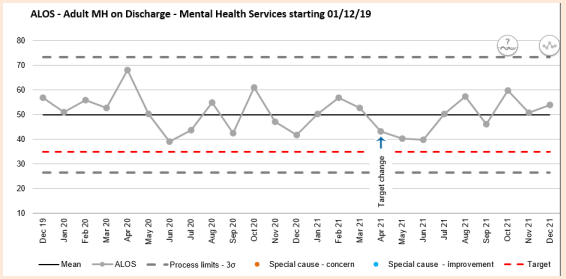


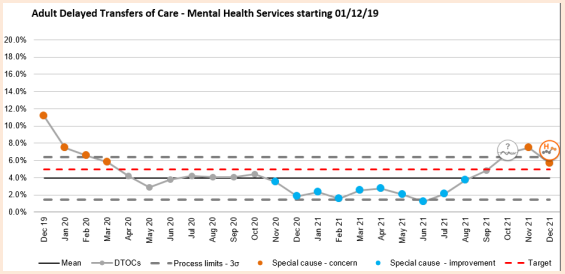
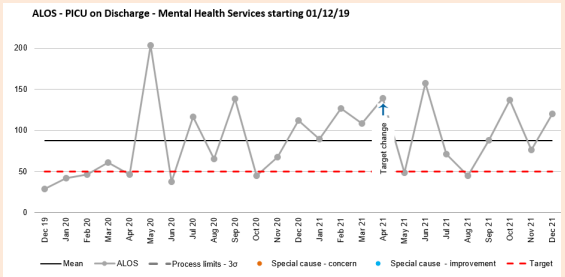
December Inadequate Performance

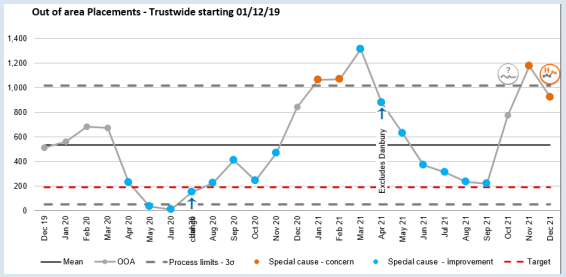
- Temporary Staffing

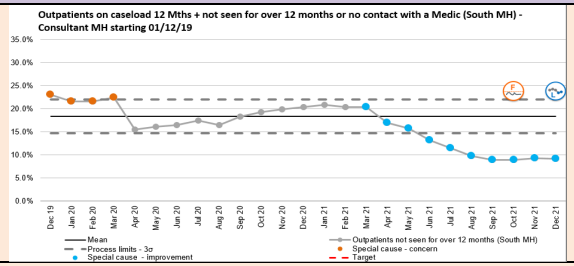
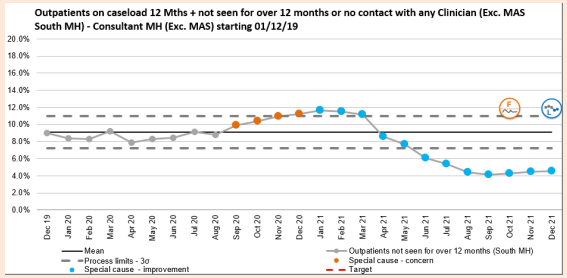
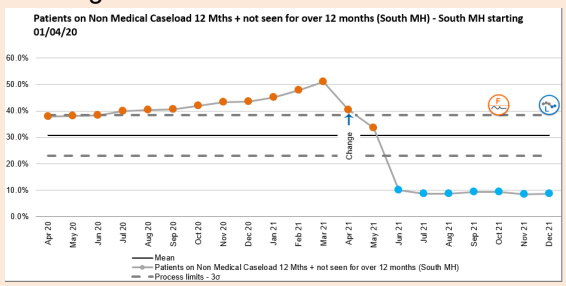
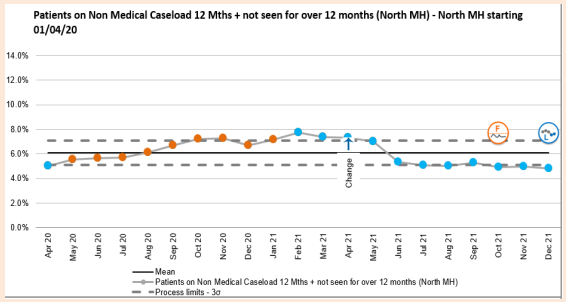
SECTION 2 - Summary of Inadequate Quality and Performance Indicators Scorecard

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.3 CPA Review Committee: Quality Indicator: National Data Quality RAG: **Amber**	**Inadequate** CPA Reviews has been highlighted as inadequate, in December overall performance remains below target to 93.3%. Both North East & West, and Mid & South STP's are breaching target, whilst Specialist and Trust wide services are achieving target. This performance aligns with the increased peak in COVID and the staffing impact from this. This will be reviewed again in March. The Productivity Team investigate all breaches and continue sending clinicians a report of reviews that are becoming overdue in advance to enable the review to be booked and completed before they become overdue. As well as this, teams monitor their CPA review target on a weekly basis and Flow & Capacity Leads work with clinicians to manage their caseload requirements, this is helping to keep caseloads down, despite increases in referrals, and ensure reviews are captured early. Deep dives are also being scheduled for teams where there has been a significant drop in compliance. CPA reviews are part of monthly supervision standing agenda and monthly Team Business meetings. The operational clinical managers continue to work with all services to support compliance. All Commissioners have noted performance.						
	People on CPA will have a formal CPA review within 12 months **Target 95%**	93.3%	●	Above Target = Good 	●	There were 11 Teams in the South, one Team in Mid, three Teams in NE, three Teams in West and one Trust Wide Team below target.	

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.9 Inpatient Capacity Adult & PICU MH Committee: Quality Indicator: Local Data Quality RAG: TBC	**Inadequate** With the closure and opening of beds on a daily basis due to COVID outbreaks it is increasingly challenging to acquire accurate bed occupancy information. Work is being undertaken by the Director of Nursing and Infection prevention and control to report this data correctly. Average length of stay continues to be addressed by the Purposeful Admissions Steering Group, and sub work streams include delayed transfers of care, and the inpatient pathway. Further time is still required to complete this work due to the Level 4 COVID incident status. **ALoS;** The adult average length of stay on discharge has increased slightly in December, and it continues failing to achieve stays that are in-line with or shorter than the NHS benchmark. The Adult rate is currently at 54 days against a target of <35 days. There were 107 discharges in December (33 of whom were long stays (60+ days)). PICU has also increased and remains outside target in December with an average of 120.3 days, against a benchmark of <50. There were 8 discharged in December (4 of whom were a long stays (60+ days)). **Occupancy:** Adult bed occupancy has reduced to 92% in December which brings performance within the target of <93.4%. Due to COVID pressures there have been a significant amount of wards closed to admissions, as well as beds closed for social distancing. PICU bed occupancy remains within target at 70% against a benchmark of <88%. **Delayed Transfers of Care;** Work has been undertaken to increase the reporting of delays on to the patient systems, however there are known factors contributing to delays which in turn increases average length of stay. In December 5.7% of clients are a delayed transfer of care, which is a positive reduction on November's position. Using the discharge/seasonal pressures funding, the North discharge team have been able to successfully expand the team with registered clinicians, which has had a positive impact on delays across the North wards. A focus on early identification of potential barriers to discharge, working to support care coordinators with resolution, and system escalation as required has allowed for team to attend to DTOC avoidance rather than just a focus on complex delays. The South team have recently had funding from discharge/seasonal pressures money agreed to replicate the North enhanced discharge team and are beginning the process of recruitment. The current resource in South is focused on the resolution of complex delays.						
	2.9.2 Adult Mental Health ALOS on discharge less than NHS benchmark **Target: <35** (Adult Acute Benchmark 2020 35)	54 days	●	Below Target = Good  	●	Consistently failing target 107 discharges in December (33 of whom were long stays (60+ days)). Adult Acute 2020 benchmark EPUT result was 31, against a National mean of 35.	TBC

Effective Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
	2.9.3 % Adult Mental Health Delayed Transfers of Care below national benchmark **Target: 5%** (Adult Acute 2020 Benchmark 5%)	5.7%	●	Below Target = Good 	●	Adult Acute 2020 benchmark EPUT result was 8%, against a National mean of 5%.	N/A
	2.9.5 PICU Mental Health ALOS on discharge less than NHS benchmark **Target: <50** (PICU 2020 Benchmark 50)	120.3 days	●	Below Target = Good 	●	Eight discharged in December (four of whom were long stays (60+ days)). PICU 2020 benchmark EPUT result was 48, against a National mean of 50.	

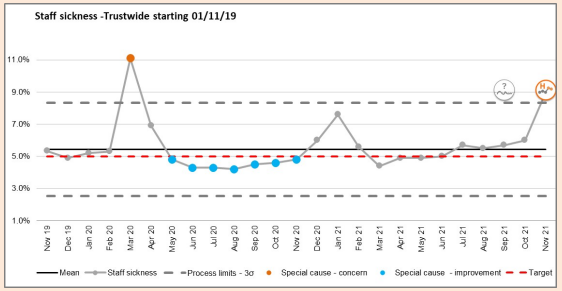
Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M9 Perf**	**RAG**	**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
4.5 Out of Area Placements Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	**Inadequate** December has seen a reduction in out of area bed days, 923 (excluding Danbury). The Trust has worked closely with NHS England on this and they are aware of the challenges presented to the Trust in recent months. An increase in mental health presentations to A&E and further ward closures due to COVID outbreaks has affected this indicator. Positive steps have been taken with more oversight now available on the placements to the Priory and work remains ongoing to continue to reduce the number of OOA placements. Confirmation was received from NHSE/I that from October, the target has changed to 25 per month, with a view to reduce to 0 by March 2022. It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract. Four new clients were placed OOA in December, and following the repatriation of 22, there were 25 remaining OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA**	923 Days	●	Below Target = Good 	●	Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward.	Mar 2022
4.9 Patients Not Seen / no contact for over 12 months Committee: Quality Indicator: Local Data Quality RAG: **Blue**	**Inadequate** Improving trends have been witnessed in recent months across all medical and non-medical indicators. Work remains ongoing to continue this improvement. The 0% target for this indicator requires review. Following discussion at the October Data Quality meeting, it was agreed that the Aspergers & Care Home Liaison teams would be excluded from the non-medical indicators, this change has been made effective from April 21 and has further improved the performance. Those teams excluded will continue to be monitored through the DQ group. Performance on this indicator continues to be monitored through the Outpatient dashboard, and the Data Quality Task & Finish group.						
	4.9.1 Patients with no consultant review within 12 months **Target 0%**	9.2% (357 / 3,871 clients)	●	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	

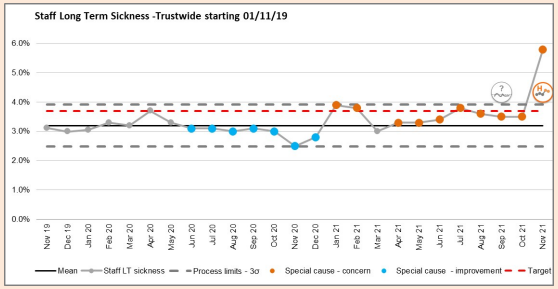
Responsive Indicators							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						12 months + as at the end of the reporting period. (inc. telephone contacts / inpatients and contacts with any consultant)	
	4.9.2 Patients on Consultant Caseload South Essex not seen / no contact by any clinician for over 12 months **Target 0%**	4.5% (171 / 3,761 clients)	●	On Target = Good 	N/A	As above but excludes MAS Medic Caseload and includes any contact with another HCP.	
	4.9.3 Patients on non-medical South Essex caseload not seen / no contact by any clinician for over 12 months **Target 0%**	8.7% (277 / 3,188 clients)	●	On Target = Good 	N/A	The constructs for non-medical caseloads have been updated to include telephone contacts (Mobius Only), contact by other clinician and current inpatients effective 1st June 2021. Following discussion at the October Q&P Pre-meet, it was agreed that the Aspergers & Care Home Liaison teams would be excluded from this report; this change was made effective November 21 and backdated to April 21. 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.	
	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%**	4.8% (235 / 4,851 clients)	●	On Target = Good 	N/A		

4.10 Psychology  Committee: Quality Indicator: Local Data Quality RAG: **Blue**	4.10 Clients waiting on a Psychology waiting list	Significant work and improvements are being made across the Adult Community Psychological Service in South with continued scrutiny being invested to best utilize available resource. The service prioritises a front end loading of engagement in the form of first provision through a Psychological Awareness Programme (PAP) This leads to an accessible formulation focused assessment that can support the development of a clinically informed treatment and safety plan. This results in people accepted initially being seen in a responsive timeframe. The PAP set-up also supports wider MDT engagement, a robust risk management response and ensures that people are sitting in a clinical pathway confirmed as being appropriate to meet their needs, and fast-tracks treatment in groups. It also prevents DNA's and provides service users with informed choice regarding treatment. It also assists in ensuring that service users are ready for active psychological intervention. South East Essex has focused on clearing those waiting for PAPS in the past 2 months, resulting in wait times reducing to 2 weeks across all areas. This has equated to 4 PAPs running between Nov-Dec. Assessments/formulation sessions are scheduled for Dec-Jan for participants. The service has also prioritised running 2 STEPPS groups between the end of 2021 and into 2022. This has cleared those waiting for STEPPS groups in the complex needs pathway. DBT provision continues to be loaded in the Southend area, with 20 people waiting for a screening. This is 4 less than Nov and wait times have reduced from 10 to 8 months. Step 4 has been commissioned in SEE and recruitment underway with some posts filled. This will mobilize approximately 20% of people waiting on the individual WL to the new service provision, resulting in significant impact on further reducing wait times. Risk review calls continue to be undertaken for those waiting every 3 months. Within South West; waits are reducing with step 4 being introduced and some patients being stepped across in all localities across the South West. The service is close to being fully recruited to all the additional posts commissioned, which will make a significant difference to how quickly those patients who remain with psychology will be picked up from the wait list. Four Clinical Associates in Psychology (CAP) started in December who will gradually pick up a case load, as well as other qualified staff starting in the early new year. The service anticipates that the waits will reduce over the next 6-9 months and access to psychology in South West will be much speedier once the wait list is worked through and we are fully resourced, as commissioned. Risk calls are being made to those waiting (not on CPA) and to ensure any additional needs have a care plan and are documented. Wait times are as follows (December 2021): • Basildon: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 67 waiting. Across all interventions, the longest waiter is 31 months and this is for specialist individual intervention on the complex needs pathway. The longest wait for individual therapy on the ACP pathway is 27 months. • Brentwood: STEPPS/DBT assessment currently has the highest number of clients awaiting intervention with 25 waiting. Across all interventions, the longest waiter is 30 months and this again for specialist individual intervention again on the complex needs pathway. The longest wait on the ACP pathway for individual therapy is 23 months. • Thurrock: Individual psychology currently has the highest number of clients awaiting intervention with 26 waiting. Across all interventions, the longest waiter is 31 months and this is for specialist individual intervention on the complex needs pathway. The longest wait on the ACP pathway for individual therapy is 27 months.

		• Southend: Individual psychology currently has the highest number of clients awaiting intervention with 69 waiting. Across all interventions, the longest waiter is 26 months and this is for individual therapy. • Castle Point: Individual psychology currently has the highest number of clients awaiting intervention with 13 waiting. Across all interventions, the longest waiter is 10 months and this is for individual therapy. • Rochford/Rayleigh: Individual psychology currently has the highest number of clients awaiting intervention with 30 waiting. Across all interventions, the longest waiter is 12 months and this is for individual therapy.

<table>
<tr><th colspan="7">Well-Led Indicators</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M9
Perf</th><th>RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td rowspan="3">5.3 Sickness Absence

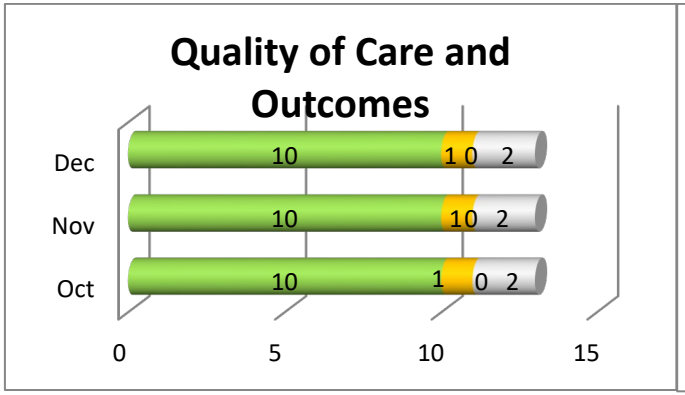
Committee: FPC
Indicator: Oversight Framework
Data Quality RAG: Blue</td><td colspan="6">Inadequate
In November sickness absence rose to 9%, from 6% in October. Increases were expected with the current COVID level 4 incident status and the staffing pressures as a result. Long term sickness absence also rose in November to 5.8%, from 3.5% in October.
The latest National data covers August 2021 and EPUT reported in line with the England average of 5.1% at 5.2%.
Sickness absence is reported in arrears to allow for all entries in to Healthroster. The draft positions for December currently show higher rates than those witnessed in November.</td></tr>
<tr><td>5.3.1 Sickness Absence consistent with MH Benchmark 6%
EPUT Target <5.0%</td><td>9.0%</td><td>●</td><td>Below Target = Good
 
</td><td>●</td><td rowspan="2">The sickness figures are reported in arrears to allow for all entries on Health Roster.
National data August 2021: The overall sickness absence rate for England was 5.1%. This is the same as in July 2021 (5.1%) and higher than August 2020 (3.9%). EPUT reported in line with the England average at 5.2%.</td><td></td></tr>
<tr><td>5.3.2 Long Term Sickness Absence below 3.7%

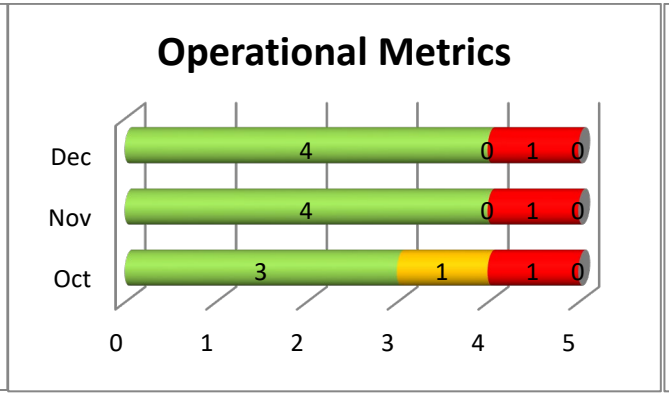
Target 3.7%</td><td>5.8%</td><td>●</td><td>Below Target = Good
 
</td><td>N/A</td><td></td></tr>
</table>

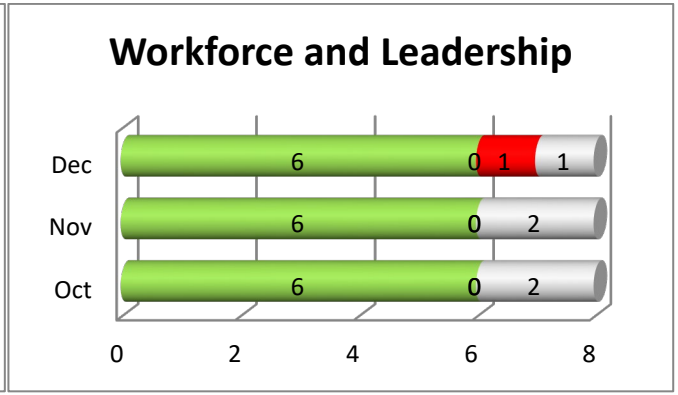
SECTION 3 – Oversight Framework

Click here to return to 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.





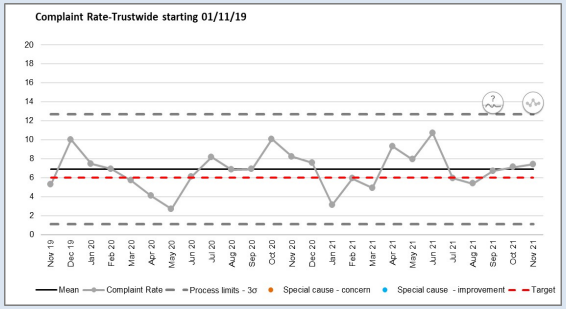


Inadequate

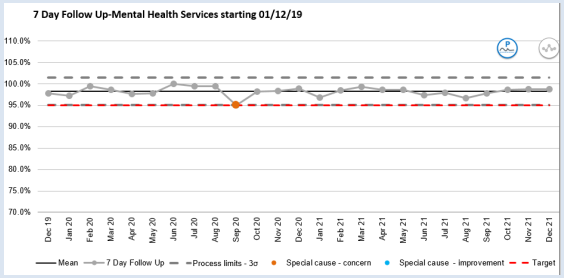
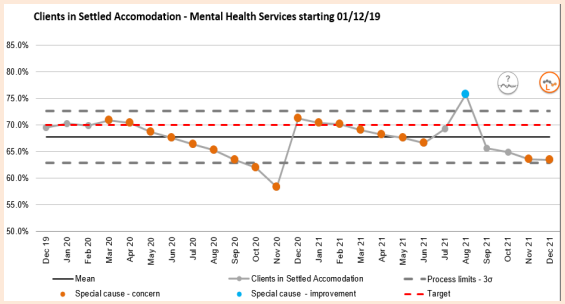
- Out of area placements
- Sickness Absence

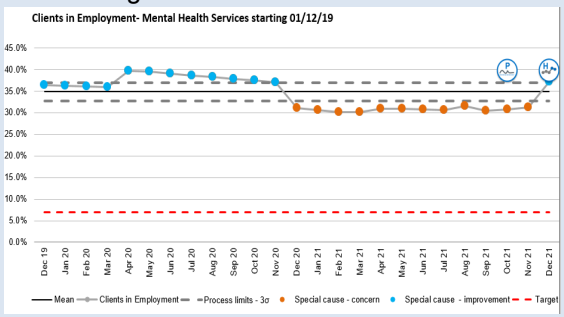
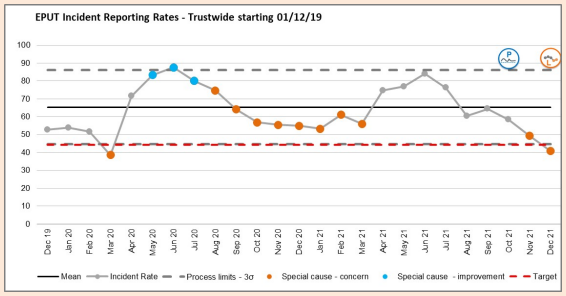
Requires Improvement

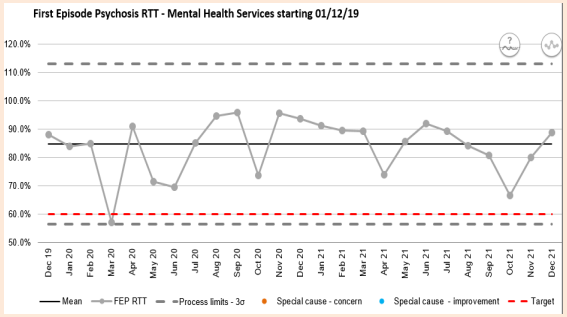
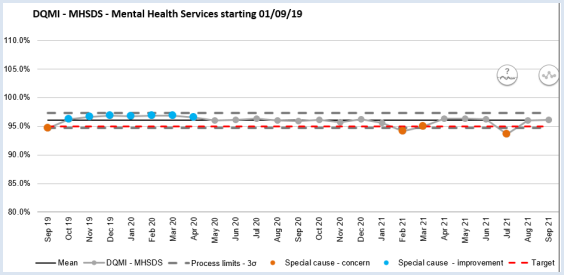
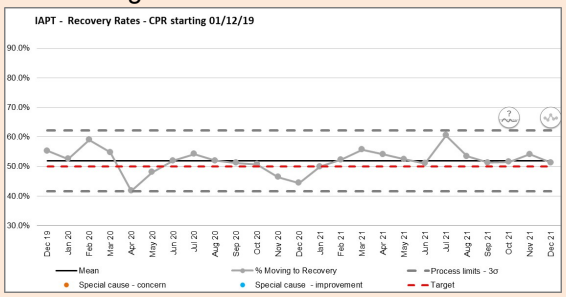
- Incident Reporting Rates

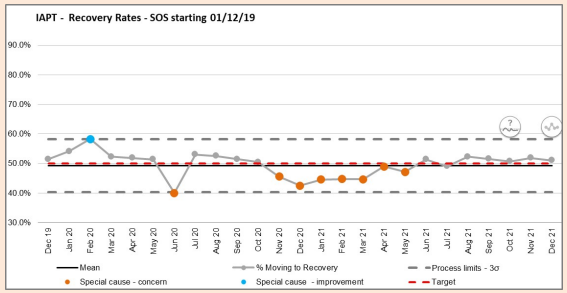
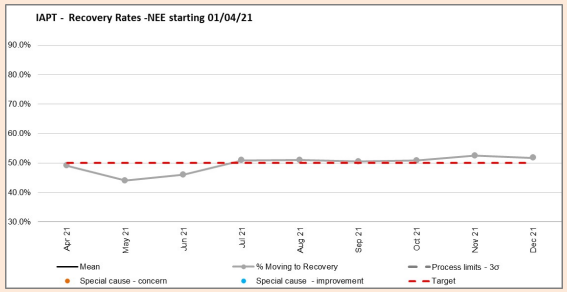
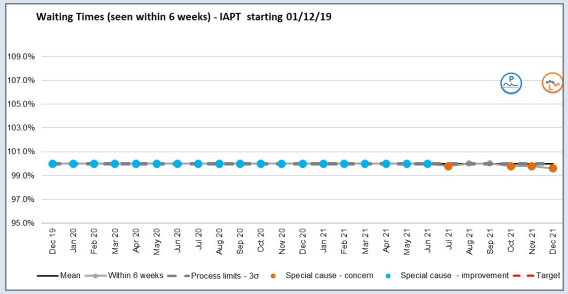
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.1.1 CQC Rating Committee: FPC Data Quality RAG: **Green**	Achieve a rating of Good or better	Good	●	A restriction has been imposed onto the registration for the CAMHS service. Following improvements made and assurances provided to the CQC it has been agreed that Poplar Unit and Longview Ward can take admissions with no more than 2 per week and from the 4th January 2022, Larkwood Ward can take admissions up to a maximum of 1 patient per week, without seeking permission from the Commission.			
4.1.1 Complaint Rate Committee: FPC Indicator: Oversight Committee Data Quality RAG: **Green**	4.1.1 Complaint Rate **OF Target TBC** Locally defined target rate of 6 each month		●	Below Target = Good 	●	Awaiting update	N/A
5.6 Staff FFT Committee: FPC Data Quality RAG: **Green**	5.6.1 Staff FFT recommend the Trust as place to work **Target 63%**	The Staff FFT has been replaced with the National Quarterly Pulse Survey. This launched on the 4th January and will close on the 31st January. Results will be provided once published.					
	5.6.2 Staff FFT recommend the Trust as a place to receive treatment **Target 74%**						

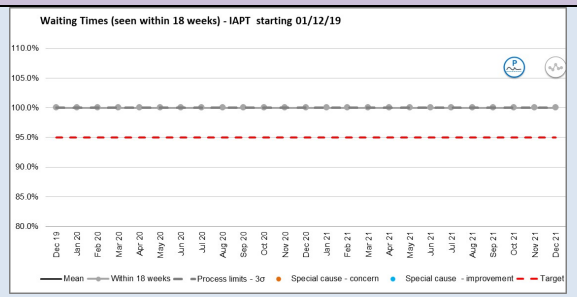
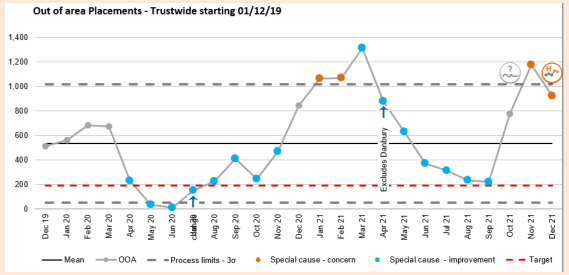
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
1.1 Never Event Committee: Quality Indicator: OF Data Quality RAG: **Blue**	0 Never Events **2019/20 Outturn 0**	0	●	Year to Date 0	●		N/A
1.6 Safety 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 MH Patient Survey Committee: Quality Indicator: Oversight Framework 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.					N/A
3.3 Patient FFT	3.3.1 Patient FFT MH response in line with benchmark	83%	●	Low response numbers.	●	12 total responses for MH 10 Very Good/Good	

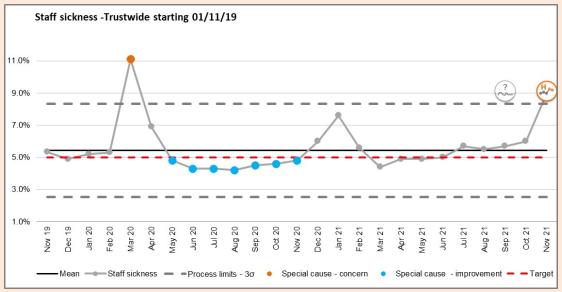
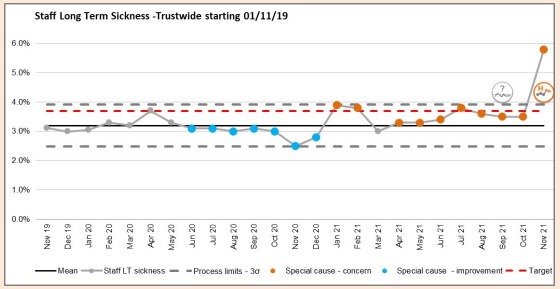
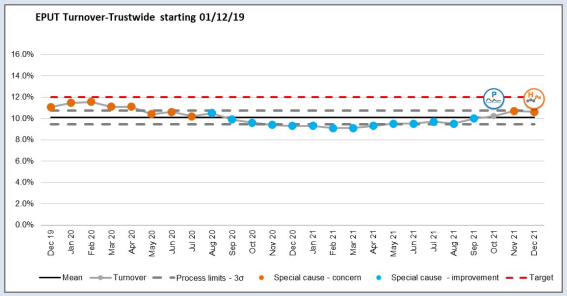
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
 Committee: Quality Data Quality RAG: **Green**	Target = 88% (Adult Acute 2020 Benchmark 88%)			The roll out of I Want Great Care has now been rescheduled to 23rd January 2022 due to the renewed COVID pressures.		Adult Acute 2020 benchmark EPUT result was 88%, against a National mean of 88%.	
	3.3.2 Patient FFT CHS response in line with benchmark Target = 96%	86%				7 total responses for CHS 6 Very Good/Good	
2.8.1 Mental Health Discharge Follow up  Committee: Quality Data Quality RAG: **Blue**	2.8.1 Mental Health Inpatients will be followed up within 7 days of discharge **Target 95%** **Benchmark 98%** (Adult Acute 2020 Benchmark 98%)	98.7%		Above Target = Good 		Discharge follow ups form part of EPUT's "10 ways to improve safety" initiative. Adult Acute 2020 benchmark EPUT result was 92%, against a National mean of 98%.	
2.4 MH Patients in Settled Accommodation  Committee: Quality Indicator: Oversight Framework Data Quality RAG **Green**	We will support patients to live in settled accommodation **Target 70% (locally set)**	63.5%		Above Target = Good 		December performance : Paris 58.4% Mobius 79.1% Performance for Paris is being investigated Additional operational work continues to help improve performance going forward.	N/A

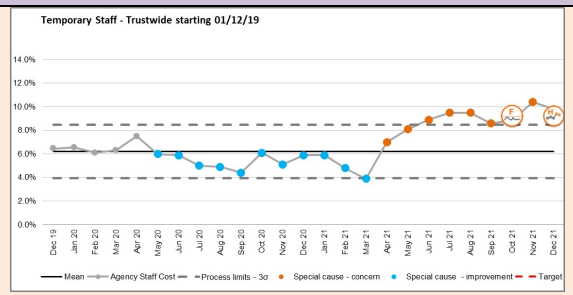
Quality of Care and Outcomes							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
2.5 MH Patients in Employment Committee: Quality Indicator: Oversight Framework Data Quality RAG: **Green**	We will support patients into employment **Target 7% (locally set)**	37.1%	●	Above Target = Good 	●	December performance : Paris 43.1% Mobius 18.5% Assurance indicates consistently passing target.	N/A
1.8 Patient Safety Incidents Reporting Committee: Quality Data Quality RAG: **Amber**	Incident Rates will be in line with national benchmark **>44.33** **MH Benchmark**	40.8	●	Above Target = Good 	●	MH is just below target for December, with the EPUT total at 40.8 which is the lowest YTD. **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 2020.**	
1.15 Admissions to Adult Facilities of under 16's Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Green**	0 admissions to adult facilities of patients under 16	0	●	Zero admissions in December One year to date.	N/A		N/A

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
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%**	88.9%	●	Above Target = Good 	●	December performance represents: 24 / 27 patients.	N/A
2.2.1 Data Quality Maturity Index Committee: FPC Data Quality RAG: **Green**	2.2.1 Data Quality Maturity Index (MHSDS Score – Oversight Framework) **Target 95%**	96.1%	●	Above target = good 	●	Latest published figures are for September 2021	
2.16.4/5/6 IAPT Recovery Rates Committee: FPC Indicator: National	2.16.4 IAPT % Moving to Recovery CPR **Target 50%**	51.3%	●	Above Target = Good 	●	Decrease in performance from the November figure, still meets target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Data Quality RAG: **Green**	2.16.5 IAPT % Moving to Recovery SOS **Target 50%**	51.1%	●	Above Target = Good 	●	Little change from the November figure; is still meeting target.	
	2.16.6 IAPT % Moving to Recovery NEE **Target 50%**	51.7%	●	Above Target = Good 	●	Slight decrease from the November figure; is still meeting target.	
2.16.7/8 IAPT Waiting Times ● Committee: FPC Data Quality RAG: **Green**	Improving Access to Psychological Therapies (IAPT)/talking therapies waiting time to begin treatment: **75% within 6 weeks**	CPR & SOS 99.6%	●	Above Target = Good 	●	Consistently above target.	N/A
		NEE 91.5%	●	Above Target = Good	●	Consistently above target.	
2.16.9/10 IAPT Waiting Times	Improving Access to Psychological Therapies (IAPT)/talking	CPR & SOS 100%	●	Above Target = Good	●	Consistently above target.	

Operational Metrics							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
 Committee: FPC Data Quality RAG: **Green**	therapies waiting time to begin treatment: **95% within 18 weeks**					
		NEE 100%		Above Target = Good		Consistently above target.	
4.5 Out of Area Placements  Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Amber**	December has seen a reduction in out of area bed days, 923 (excluding Danbury). The Trust has worked closely with NHS England on this and they are aware of the challenges presented to the Trust in recent months. An increase in mental health presentations to A&E and further ward closures due to COVID outbreaks has affected this indicator. Positive steps have been taken with more oversight now available on the placements to the Priory and work remains ongoing to continue to reduce the number of OOA placements. Confirmation was received from NHSE/I that from October, the target has changed to 25 per month, with a view to reduce to 0 by March 2022. It should be noted that as of December 2020 the Trust purchased 18 beds from the Priory, Danbury ward. These beds were counted in our figures however; the Trust has received confirmation from NHSE who have provisionally agreed these can be reported as appropriate OOA placements. These have been excluded from the OOA data backdated to April 2021; however, we are currently awaiting confirmation that we can reflect this change back to the start of the contract. Four new clients were placed OOA in December, and following the repatriation of 22, there were 25 remaining OOA at the end of the month.						
	Reduction in Out of Area Placements **Target: Reduction to achieve 0 OOA**	923 Days		Below Target = Good 		Reducing Out of Area Placements forms part of EPUT's "10 ways to improve safety" initiative. Data excludes patients placed on Danbury Ward.	Mar 2022

Workforce and Leadership							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
5.3.1 Staff Sickness Committee: FPC Indicator: Oversight Framework Data Quality RAG: **Blue**	5.3.1 Sickness Absence consistent with MH Benchmark 6% **EPUT Target <5.0%**	9.0%	●	Below Target = Good 		The sickness figures are reported in arrears to allow for all entries on Health Roster. National data August 2021: The overall sickness absence rate for England was 5.1%. This is the same as in July 2021 (5.1%) and higher than August 2020 (3.9%). EPUT reported in line with the England average at 5.2%.	
	5.3.2 Long Term Sickness Absence below 3.7% **Target 3.7%**	5.8%	●	Below Target = Good 	N/A		
5.2.2 Turnover Committee: FPC Data Quality RAG: **Green**	5.2.2 Staff Turnover (Benchmark 2020 MH 12% / 2017/18 CHS 12.1%) **OF Target TBC** **Target <12%**	10.6%	●	Below Target = Good 	●	Special Cause of concerning nature of higher pressure due to higher values. Reducing Turnover forms part of EPUT's "10 ways to improve safety" initiative.	N/A
5.7.3 Temporary Staffing (Agency)	5.7.3 Proportion of temporary Staff (Provider Return)	9.8%	●	Below Target = Good	N/A		

<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th colspan="2">Position M9</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><th></th><th></th><th>Perf</th><th>RAG</th><th></th><th></th><th></th><th></th></tr>
<tr><td>Committee: FPC
Indicator: Oversight Framework Indicator
Data Quality RAG: Green</td><td>No Oversight Framework Target</td><td></td><td></td><td> 
</td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">5.5 Staff Survey
Committee: FPC
Data Quality RAG: Green</td><td>5.5.1 Outcome of CQC NHS staff survey</td><td colspan="5" rowspan="2">The 2021 Staff Survey has now closed. Results of the survey will be published in March 2022.

<u>Information from the 2020 Staff Survey</u>
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.

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

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

Teamwork Average of:
• % agreeing that their team has a set of shared objectives</td><td></td></tr>
<tr><td>5.5.2 Support & Compassion, Team Work and Inclusion</td><td></td></tr>
</table>

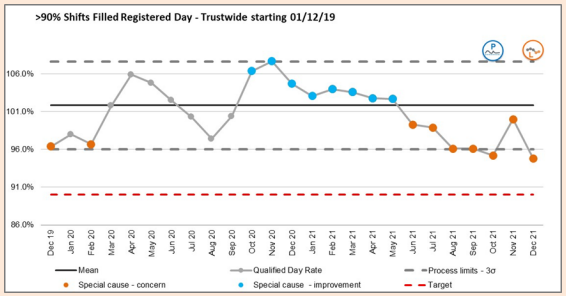
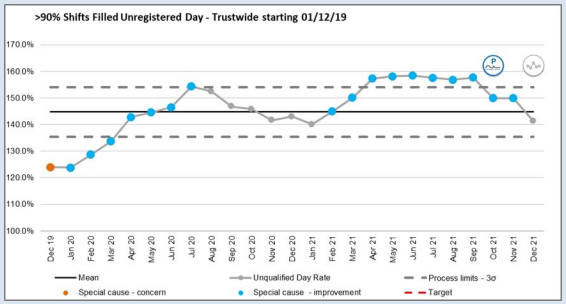
<table>
<tr><th colspan="7">Workforce and Leadership</th></tr>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position M9
Perf | RAG</th><th>Trend</th><th>Nat RAG</th><th>Narrative</th><th>Recovery Date</th></tr>
<tr><td></td><td></td><td colspan="5">
• % agreeing that their team often meets to discuss the team's effectiveness
<table>
<tr><th>Staff Survey 2020</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q4h The Team I work in has a set of shared objectives</td><td>75.4%</td><td>74.6%</td><td>Better than average</td><td>●</td></tr>
<tr><td>Q4i The Team I work in often meets to discuss the team's effectiveness</td><td>68.5%</td><td>69.8%</td><td>Below Average</td><td>●</td></tr>
</table>
Trusts in lowest third across the sector will represent a concern

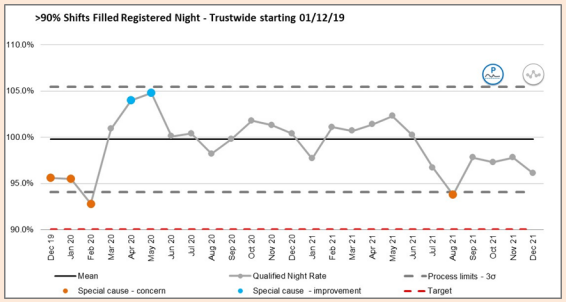
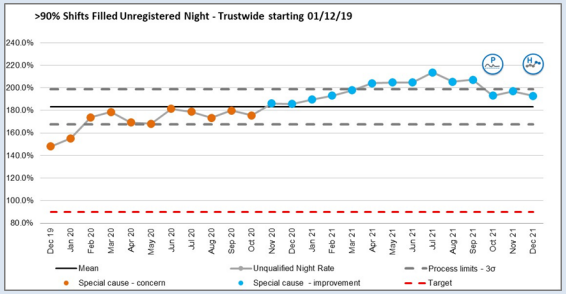
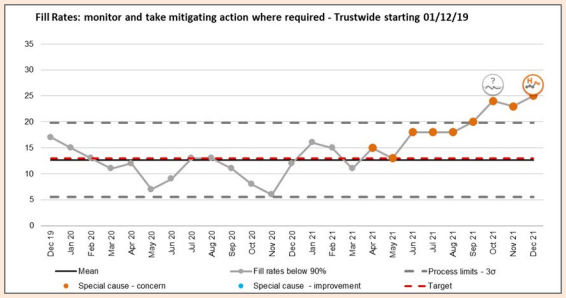
Inclusion (1) Average of
• % staff believing the trust provides equal opportunities for career progression or promotion
• % experiencing discrimination from their manager/team leader or other colleagues in the last 12 months

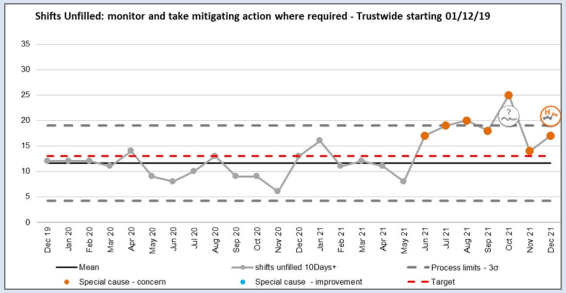
<table>
<tr><th>Staff Survey 2020</th><th>EPUT</th><th>Average</th><th>Comments</th><th></th></tr>
<tr><td>Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age</td><td>84.7%</td><td>86.6%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

SECTION 4 – Safer Staffing Summary

Click here to return to summary page

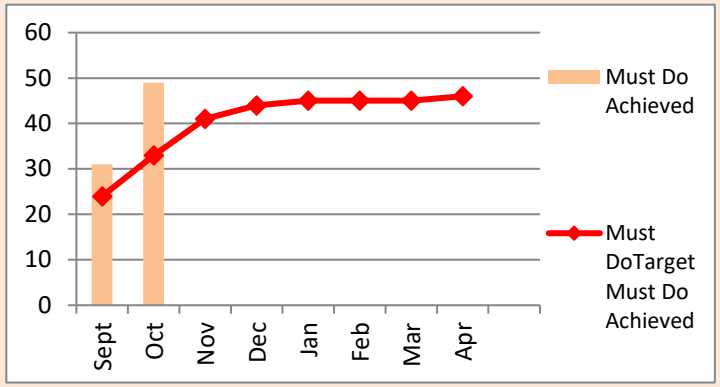
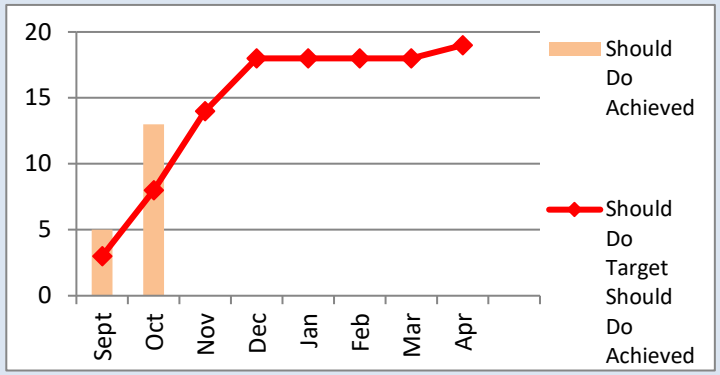
Safer Staffing							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Please note that the below indicators do not include apprentices or aspiring nurses who are awaiting their pin and who are currently working on the wards.							
Day Qualified Staff 	We will achieve >90% of expected day time shifts filled.	94.8%		Trend above target = good 		The following wards were below target in December: Older: Ruby, Beech(Rochford), Henneage, Kitwood Nursing Home: Rawreth Court, Clifton Lodge Specialist: Fuji, Edward House,Forest, Dune, Rainbow, Larkwood Adult: Willow, Galleywood, Gosfield Adult – Assessment: Peter Bruff, Basildon MHAU	N/A
Day Un-Qualified Staff 	We will achieve >90% of expected day time shifts filled.	141.3%		Trend above target = good 		The following wards were below target in December: Specialist: Causeway, Aurora, LD: Woodlea Clinic Nursing Home: Rawreth Court CHS: Avocet Older: Roding	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
Night Qualified Staff	We will achieve >90% of expected night time shifts filled	96.1%	●	Trend above target = good 	●	The following wards were below target in December: Adult – Assessment: Peter Bruff CAMHS: Larkwood, Longview Nursing Home: Rawreth, Clifton Older: Beech, - Rochford, Tower. Henneage Specialist: Causeway, Fuji, Edward House	N/A
Night Un-Qualified Staff	We will achieve >90% of expected night time shifts filled	192.8%	●	Trend above target = good 	●	The following wards were below target in December: Older: Roding	N/A
Fill Rate	We will monitor fill rates and take mitigating action where required	25	●	Below Target = Good 	●	The following wards had fill rates of <90% in December: Adult:, Gosfield, Willow, Gosfield Adult-Assessment: Peter Bruff, Basildon MHAU Older Adult: Beech – Rochford, Henneage, Kitwood, Ruby, Roding & Tower Nursing Homes: Clifton Lodge & Rawreth Court Specialist: Alpine, Aurora, Causeway, Dune, Edward House, Fuji, Rainbow, Woodlea Clinic	N/A

Safer Staffing							
RAG	**Ambition / Indicator**	**Position M9**		**Trend**	**Nat RAG**	**Narrative**	**Recovery Date**
		Perf	**RAG**				
						CAMHS: Larkwood, Longview CHS: Avocet, Poplar,	
Shifts Unfilled	We will monitor fill rates and take mitigating action where required	17	●	Below Target = Good 	●	The following wards had more than 10 days without shifts filled in December: Adult: Ardleigh, Gosfield Adult-Assessment: Peter Bruff, Basildon MHAU CAMHS: Larkwood Older Adult: Beech-Rochford, Henneage, Tower Nursing Homes: Rawreth Court, Clifton CHS: Poplar Specialist: Causeway, Dune, Edward House, Fuji, Rainbow & Woodlea Clinic	N/A

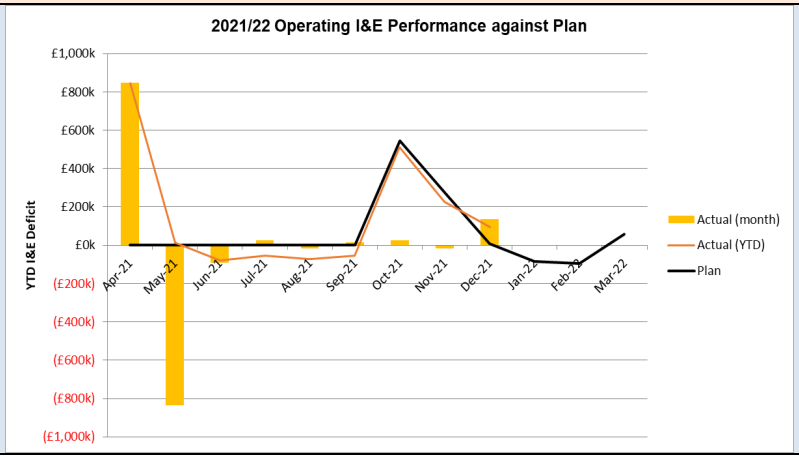
SECTION 5 – CQC

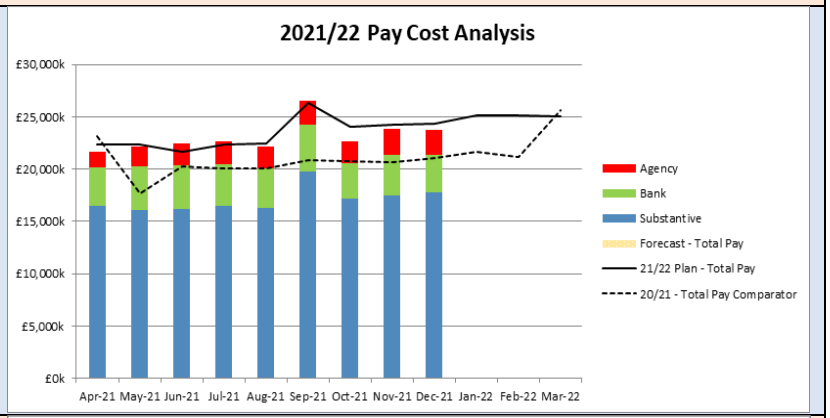
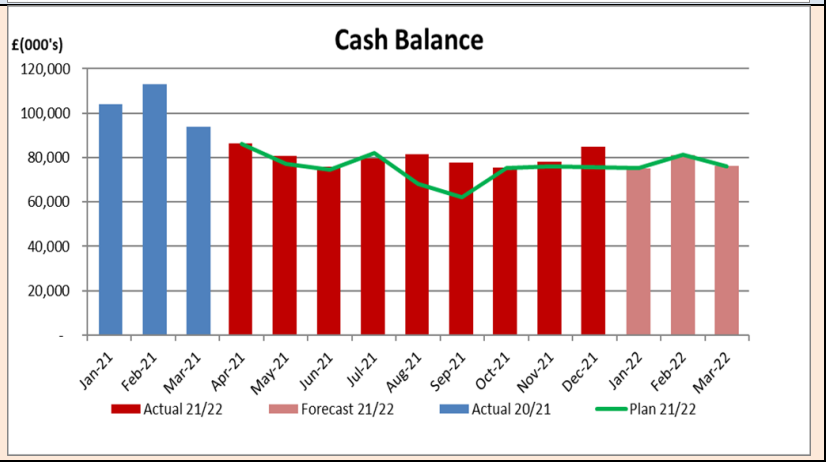
Click here to return to summary page

RAG	Ambition / Indicator	Position M9	Trend (above target = good)	Narrative
CQC Must do Actions	There will be 0 CQC Must Do actions past timescale	At the end of December 0 actions were past timescale	Achieve target = good performance 	0 CQC Must Do actions are past timescale at the end of December 2021
CQC Should do Actions	There will be 0 CQC Should Do actions past timescale	At the end of December 0 action were past timescale	Achieve target = good performance 	0 CQC Should Do actions are past timescale at the end of December 2021

SECTION 6 - Finance

Click here to return to summary page

<table>
<tr><th>RAG</th><th>Ambition / Indicator</th><th>Position</th><th>Trend</th></tr>
<tr><td>Capital Expenditure</td><td>Maximising Capital Resources</td><td>The Trust has incurred capital expenditure of £6.8m against the £14.4m programme. The Trust Capital group is meeting with greater frequency to approve schemes and monitor the programme and sub groups have also been established to monitor spend to ensure delivery of the 2021/22 plan. Work continues on the prioritisation of 2022/23 and future years plans continue.</td><td>
Capital
<table>
<tr><th></th><th>Annual Plan £000</th><th colspan="3">Year to Date</th></tr>
<tr><th></th><th></th><th>Plan £000</th><th>Actual £000</th><th>Variance £000</th></tr>
<tr><td>ICT (including ePrescribing)</td><td>2,428</td><td>1,476</td><td>805</td><td>671</td></tr>
<tr><td>MEMS / Other equipment</td><td>200</td><td>100</td><td>26</td><td>74</td></tr>
<tr><td>Safety & Ligature</td><td>1,942</td><td>796</td><td>1,588</td><td>(792)</td></tr>
<tr><td>Backlog Maintenance</td><td>2,349</td><td>1,147</td><td>952</td><td>195</td></tr>
<tr><td>Health & Safety</td><td>1,000</td><td>643</td><td>311</td><td>332</td></tr>
<tr><td>Strategic Schemes:</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dormitory Project</td><td>2,159</td><td>1,222</td><td>284</td><td>938</td></tr>
<tr><td>Other</td><td>1,085</td><td>834</td><td>475</td><td>358</td></tr>
<tr><td>Charge against Capital Allocation</td><td>11,163</td><td>6,217</td><td>4,442</td><td>1,775</td></tr>
<tr><td>DHSC Dormitory Project</td><td>3,080</td><td>3,080</td><td>2,309</td><td>771</td></tr>
<tr><td>PFI Residual Interest</td><td>109</td><td>82</td><td>82</td><td>0</td></tr>
<tr><td>Net CDEL</td><td>14,352</td><td>9,379</td><td>6,833</td><td>2,546</td></tr>
</table>
</td></tr>
<tr><td>Trust I&E 2020/21</td><td>Operating Income and Expenditure</td><td>The year to date position is a £86k surplus; in-month positive variance £0.4m and YTD £0.1m favourable, mainly attributable to unplanned income.</td><td> 
</td></tr>
</table>

RAG	Ambition / Indicator	Position	Trend
Efficiency Programmes	Planned improvement in productivity and efficiency	In order to deliver the annual financial plan which incorporates the H2 impact, the Trust will need to deliver £9.8m of efficiencies during the year. The plan requirement in H1 is £3.5m and H2 target is now £6.3m. YTD reported position is £6.2m (of which £3.4m is recurrent). There remains an urgent focus to develop recurrent efficiency programmes before the financial year 22/23.	
Temporary Staffing	Level of Temporary Staffing Costs	The Trust continues to focus efforts in converting bank staff to substantive positions to enable consistency of care. The cost in M9 remains consistent with M8. Overall temporary staffing costs for the month of £6m. The Trust has developed a number of recruitment initiative including international.	
Cash Balance	Positive Cash Balance	Cash balance as at end of M9 was £85.0m being above plan by £9.1m. Receipts are higher than planned and include unplanned non-recurrent income for the Provider Collaborative and from NHS England.	

	Efficiencies	YTD Plan	YTD Delivery	YTD Variance
	£m	£m	£m	£m
H1	3.5	3.5	2.1	1.4
H2	6.3	3.1	4.1	(1.0)
EPUT Total	9.8	6.6	6.2	0.4

END

		Agenda Item No: 7b
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Patient Led Assessment of the Care Environment (PLACE) 2021**					
Executive/ Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Lee Williams, Strategy Lead					
Report discussed previously at:	Council of Governors – 8 December 2021					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report		
Summary of risks highlighted in this report	Patient Safety, Patient Care	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 Director with the 2021/2022 PLACE-Lite inspection results.	**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 sets out arrange of remedial actions and pathways to rectification (i.e. immediate action or inclusion into a rolling programme of works)
- The proposed changes to the development of the process

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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			
PLACE	Patient-Led Assessments of the Care Environment		

Supporting Documents and/or Further Reading
PLACE Report

Lead

Trevor Smith
Executive Chief Finance Officer

NHS
Essex Partnership University
NHS Foundation Trust

Patient-Led Assessments of the Care Environment (PLACE)

EPUT 2021

Contents

Essex Partnership University
NHS Foundation Trust

Introduction

Essex Partnership University
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- The PLACE programme was introduced in April 2013 to replace the Patient Environment Action Team (PEAT) assessments, which ran from 2000-2012.

- The PLACE collection underwent a national review, which started in 2018 and concluded in summer 2019. The question set has been significantly refined and revised, and guidance documents have been updated. The review ensured that the collection remains relevant and delivers its aims.

- The annual PLACE programme was suspended in 2020 due to the operational difficulties and associated risks brought about by Covid-19. PLACE Lite remained open for healthcare organisations to undertake assessments if they chose to do so. The same arrangement now applies to PLACE in 2021.

- PLACE Lite was instigated in September 2021

Key Findings

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- The PLACE collection was substantially reviewed and refined in 2019. 2019 scores therefore establish a new baseline
- EPUT substantially improved in both Privacy and Dignity & Wellbeing. We also saw smaller improvements in Food & Hydration and Dementia Friendly
- We fell slightly in Cleanliness, Condition, Appearance & Maintenance and Disability & Access

	PLACE-Lite 2021/2022 Average Score	PLACE 2019/20 Average Score	Change	National Average 2019/20	Change
Cleanliness	97.04%	99.50%	-2.46	98.6%	-1.56
Food & Hydration	93.74%	90.46%	+3.28	92.2%	+1.54
Privacy, Dignity & Wellbeing	90.90%	84.89%	+6.01	86.1%	+4.8
Condition, Appearance & Maintenance	95.73%	97.6%	-1.87	96.4%	-0.67
Dementia Friendly	97.12%	95.09%	+2.03	80.7%	+16.42
Disability & Access	89.68%	90.40%	-0.72	82.5%	+7.18

Scoring

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NHS Foundation Trust

- On the day(s) of assessment, the teams visit the various areas of the hospital and unit (e.g. wards, communal areas) filling out the relevant scorecards (paper or digital) based on observed conditions.

- Marks awarded for each question count towards one or more domains. Domain totals are then calculated on EFM and expressed as a percentage of the maximum marks available for each domain for each organisation and site.

- National averages are calculated using the following formula, to take into account the variation in hospital size (and that not all areas are assessed in larger sites):

$$\frac{\text{The sum of [Each site's score (points) multiplied by the number of beds in that site]}}{\text{The total number of beds in all assessed sites}}$$

Locations and numbers

NHS
Essex Partnership University
NHS Foundation Trust

The following locations took place in the 2021 Place Lite Assessment

439 Ipswich Road
Chelmer ward
Stort ward
Clifton Lodge (Carehome)
Brockfield House
St.Margarets Hospital
Robin pinto
Woodlea
Basildon MH Unit
The Lakes
Broomfield **Hospital**
Rochford Hospital
Christopher Unit
Rawreth Court (Care Home)
Kingswood
Mary St. Aubyn's
Landermere
Thurrock Hospital
Byron Court (heath Close)

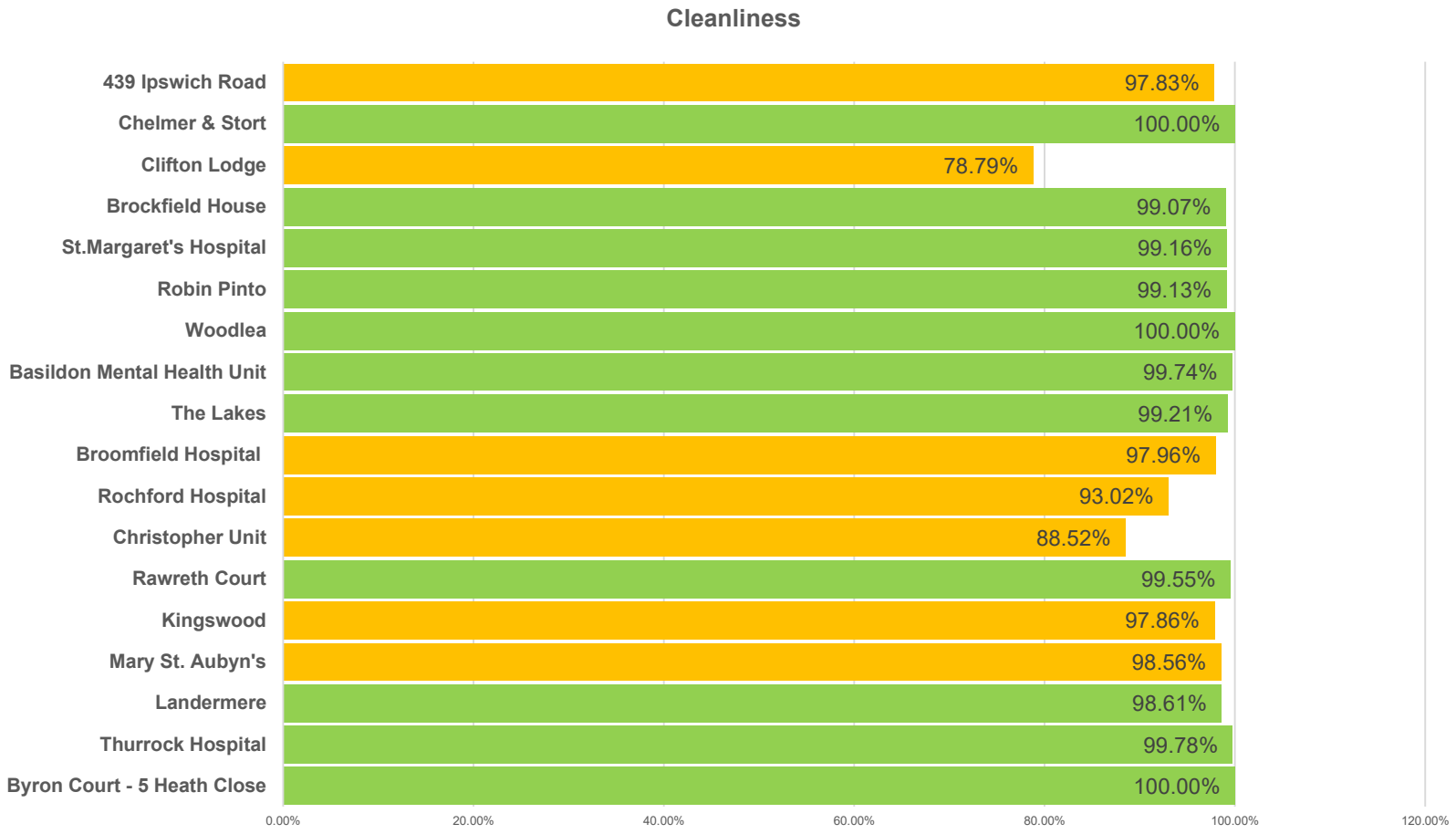
Assessment teams visited and assessed:

- 760 Beds
- 44 Wards
- 18 inpatient units

Cleanliness

Essex Partnership University
NHS Foundation Trust

97.04% (*1.57% below National Average 2019/20, 2.46% below EPUT 2019/20 99.50%*)



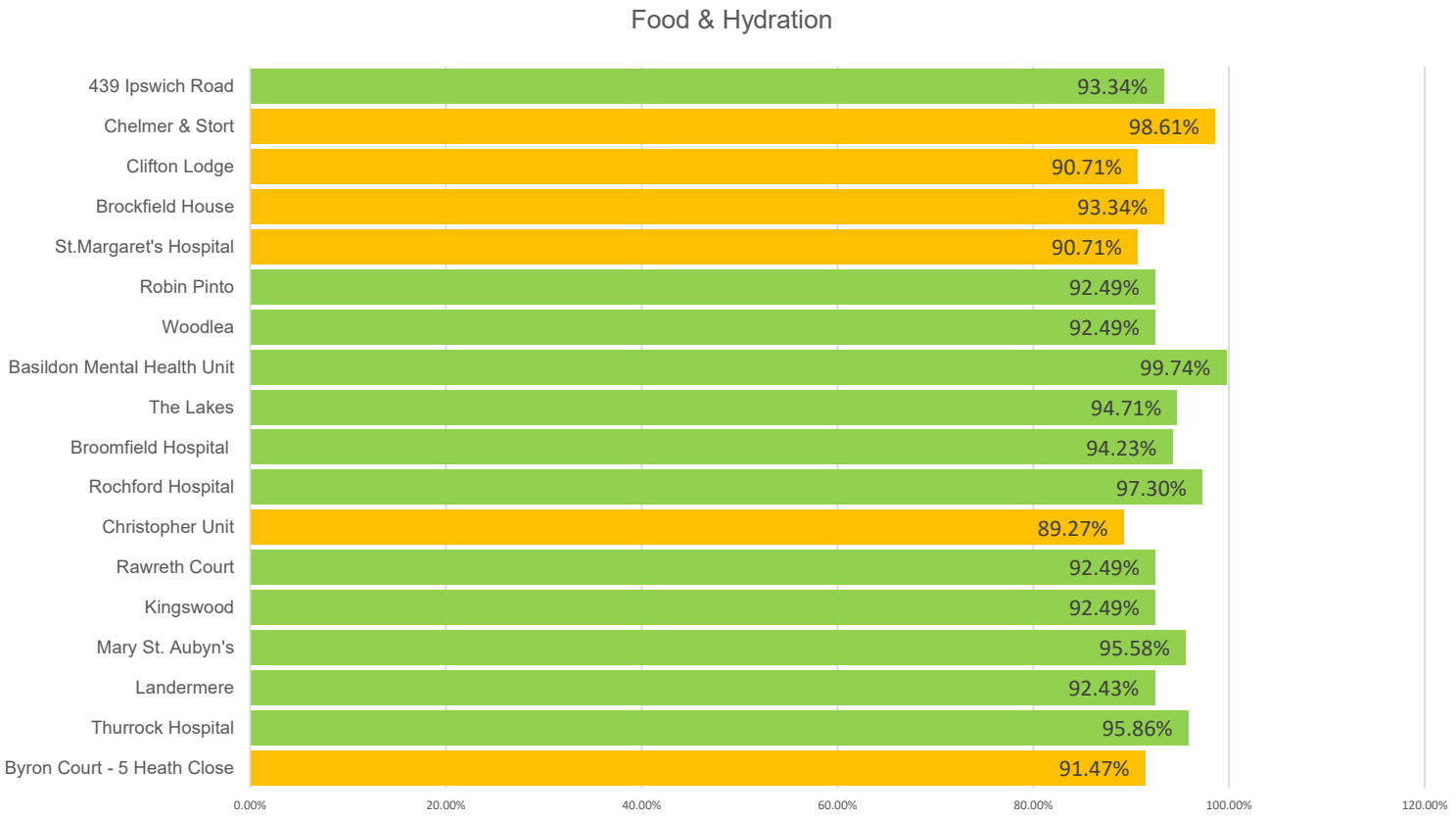
Cleanliness

- Continued monitoring through regular weekly and monthly auditing.
- Cleaning audit scores submitted to Trust Quality Groups and Infection Control for monitoring by the CCG's.
- The department is currently exploring options to improve the process, by moving away from paper based audits to digital audits where data is captured on an intuitive platform, and live reporting is enabled.
- For areas of non-compliance, the Department is investing in additional professional training that will be cascaded throughout the department to ensure full understanding of healthcare cleanliness standards.
- The Estates and Facilities Team are reviewing the new national cleaning standards to ensure that the Trust is compliant, with any additional requirements are in situ before March 2022.

Food & Hydration

Essex Partnership University
NHS Foundation Trust

93.74% (*1.54% above National Average 2019/20, 3.28% above EPUT 2019/20 90.46%*)



Food & Hydration

- New catering contractors (Raynors Food, Tillery Valley, Brakes Bros and Kent Diaries) appointed August 2021.

- Good feedback has been received regarding:
  (i) the variety of menus
  (ii) and quality of the food provided

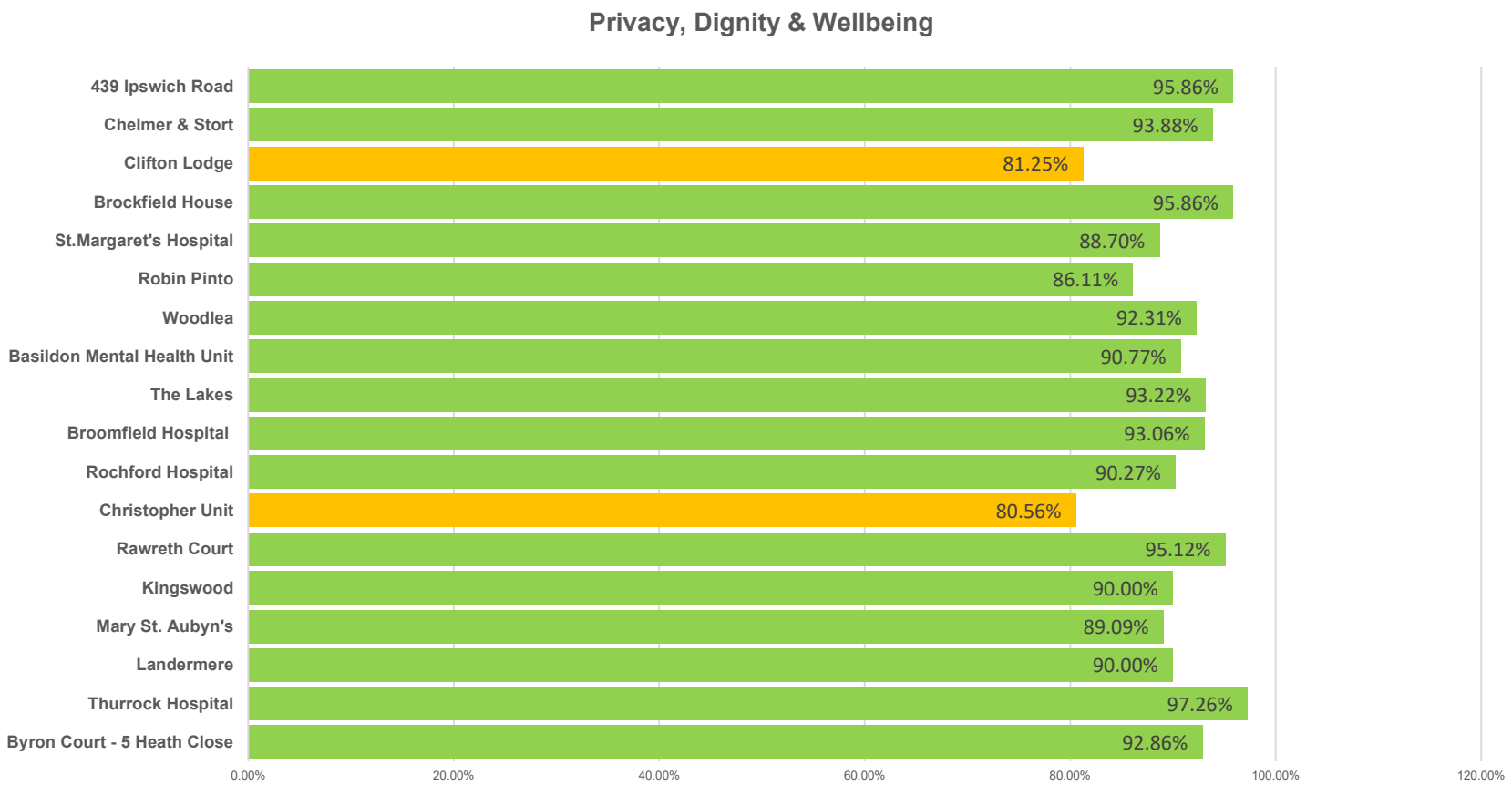
- Brexit & Covid recently impacted on the supply chain causing menu restrictions
- Temporary measures implemented to mitigate and counteract issues
- Contingency measures have been reviewed in light of the difficulties.

NB: Food and hydration are measured against personal preference and is challenging to substantiate the results.

Privacy, Dignity & Wellbeing

NHS
Essex Partnership University
NHS Foundation Trust

90.90% (*4.8% above national average 2019/20, 6.01% above EPUT 2019/20 84.89%)*



Privacy, Dignity & Wellbeing

- The trust improved on the national average and our own previous scores due to several key undertakings:

- The Trust has invested a substantial amount of money (over £3 million) to remove dormitory accommodation at Basildon Mental Health Unit.

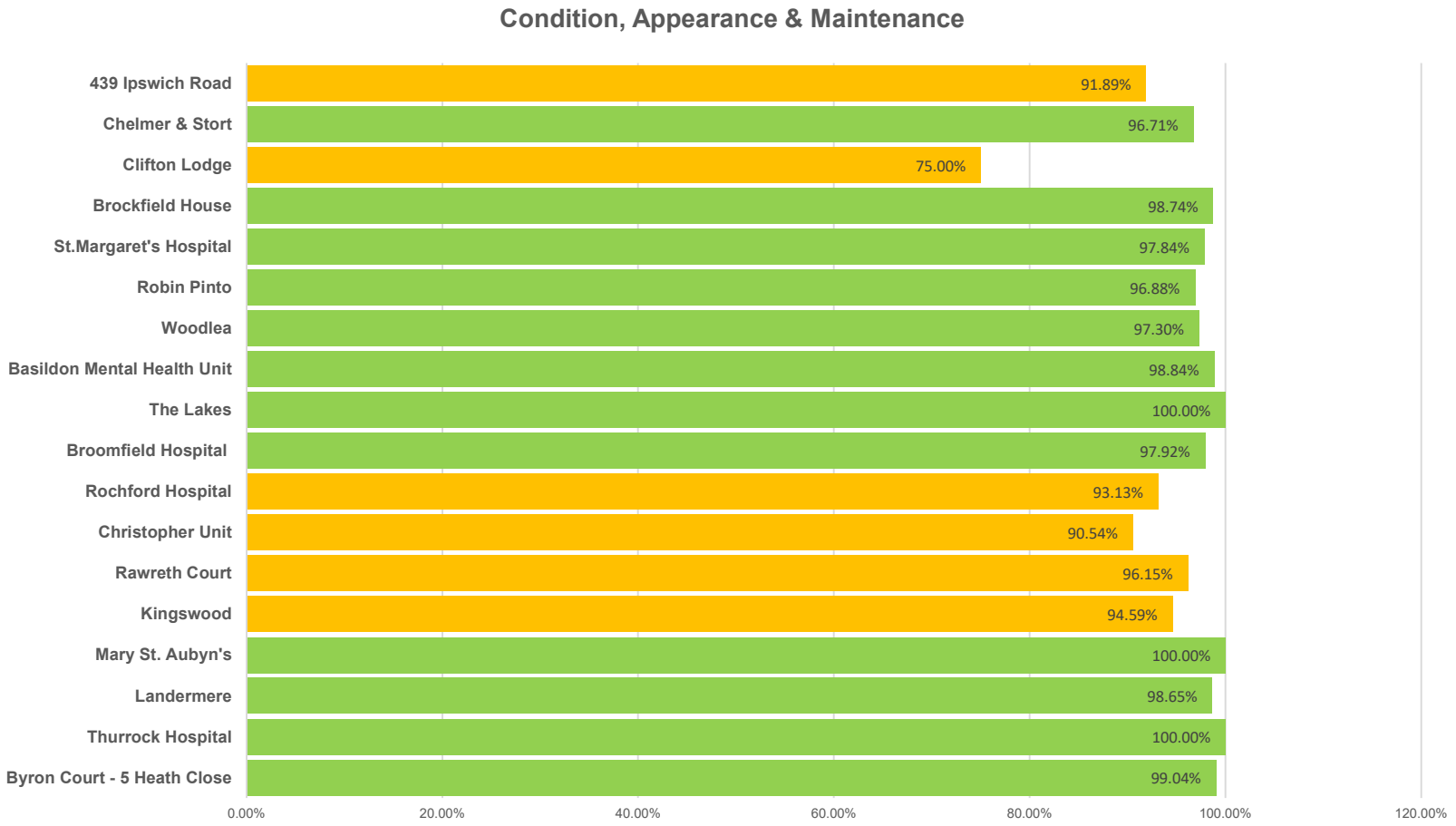
- This led to Basildon Mental Health Unit notable increasing its score by 8.04% (Cherrydown and Kelvedon wards)

- The training and development team have also improved training and access to all which has almost certainly had an effect on the improved score.

Condition, Appearance & Maintenance

Essex Partnership University NHS Foundation Trust

95.73% *(EPUT 0.67% below national average, 2019/20, 1.43% below EPUT 2019/20 97.16%)*



Condition, Appearance & Maintenance

- The Trust has an overarching theme around tired and weary décor such as :
    I. Walls
    II. Painting
    III. Lime scale on bathroom furniture.

- A draft 5 year capital and revenue improvement plan is in production that will address these issues

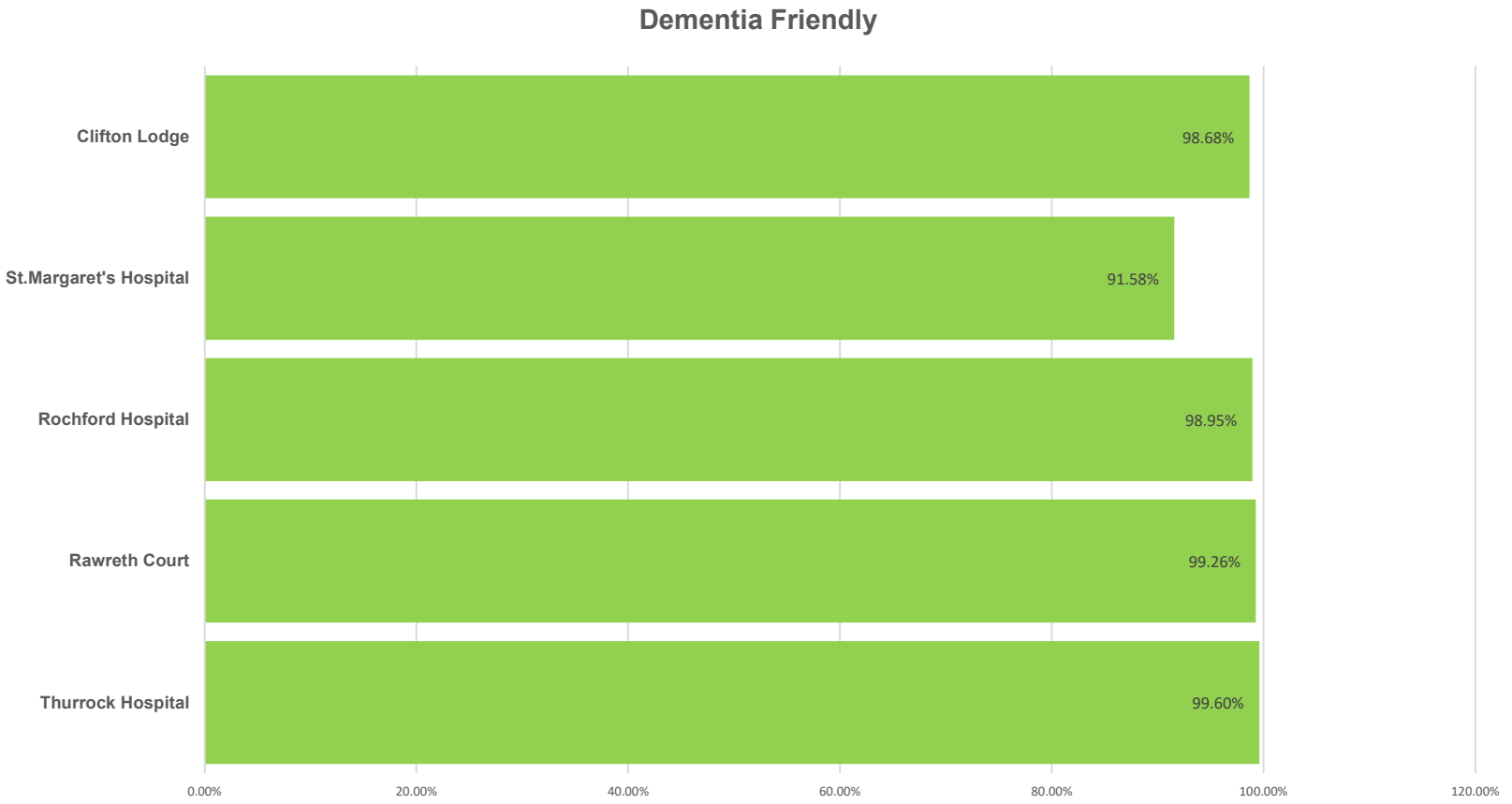
- The plan will seek Executive support in January 2022 as part of planning for 2022/23 – 2027/28

- Clinical, technical and patient input will be included within the plan.

Dementia Friendly

Essex Partnership University
NHS Foundation Trust

97.12% *(EPUT 16.42% above national average, 2019/20, 2.03% above EPUT 2019/20 95.09%)*



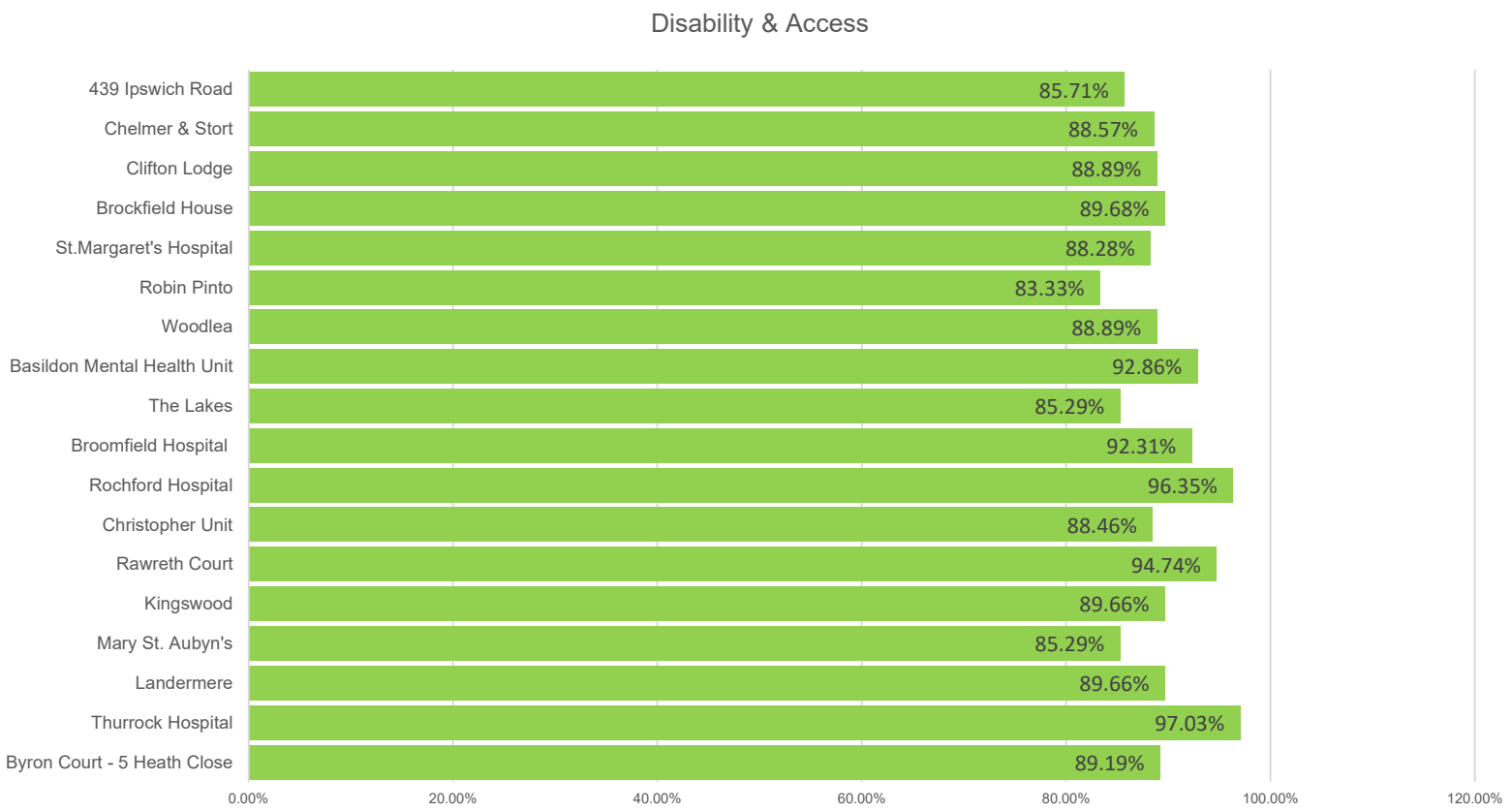
Dementia Friendly

- EPUT performed extremely well for Dementia Friendly
- To put this into perspective, against the 2019/20 scores EPUT would be ranked in the top 15 in the country for how Dementia Friendly our wards are.
- We will be taking this away and sharing our feedback with our system partners, ultimately sharing best practice to improve the experience of patients across Essex

Disability & Access

Essex Partnership University
NHS Foundation Trust

89.68% (*7.18% above national average 2019/20, 0.72% below EPUT 2019/20 90.40%)*



Disability & Access

- While we still maintain a strong position against the national average we did drop slightly in our previous score

- The Trust has included within its 5 year plan, both strategic and operational actions in support of accessibility.

- Signage and access are key action points in the 22/23 plan.

- While major works around disability & access have not been completed due to resources being dedicated to patient safety, we have still improved on:
- Signage
- Furniture
- Lighting
- Colour paints
- Phone loops

NHS
Essex Partnership University
NHS Foundation Trust

Disability & Access Capital Planning

SITE NAME / BUILDING	SPECIFIC ACTIVITY OR AREA	TENURE (OWNED/OCCUPIED /LEASED)	DELIVER IN-YEAR	PROJECT DESCRIPTION	AREAS / REGIONS	BUILDING PROJECTED REMAINING LIFE	RISK RANKING	Projected Budget Cost
ALL SAINTS HOUSE	DISABLED	OWNED / OCCUPIED	**5**	NO PASSENGER LIFT ACCESS TO 1ST & 2ND FLRS. FOR DISABLED PEOPLE.RECOMMENDATION - WHEN FUTURE REFURBS / NEW BUILD PROJECTS OCCUR PROVIDE PROVISION FOR DIASBALED PEOPLE TO IMPROVE / UPGRADE ACCESS IN ACCORDANCE WITH BEST PRACTICE GUIDANCE.	NORTH	20	Moderate	**£50,000**
C. & E. CENTRE	DISABLED	OWNED / OCCUPIED	**1**	DISABLED PROVISIONS IN GENERAL IS DEEMED POOR THROUGHOUT. RECOMMENDATION - UNDERTAKE AN EQUALITY ACT SURVEY AND ASCERTAIN WHAT IS REQUIRED.	NORTH	20	Significant	**£1,000**
KINGSWOOD CENTRE	DISABLED	OWNED / OCCUPIED	**2**	NO PROVISION HAS BEEN MADE FOR DISABLED ACCESS TO THE FIRST FLOOR. RECOMMENDATION - CONSIDER EQUALITY ACT REQUIREMENTS.- SURVEY AND DESIGN CHANGE .	NORTH	20	Low	**£8,000**
EPUT - TRUST WIDE	SIGNAGE	OWNED / OCCUPIED	**1**	WAYFINDING	ALL	35	MODERATE	**£15,000**
THE LAKES BUNGALOW	DISABLED	OWNED / OCCUPIED	**1**	DISABLED PERSOS PROVISION IS GENERALLY POOR THROUGHOUT. RECOMMENDATION - UNDERTAKE AN EQUALITY ACT SURVEY & IMPLEMENT THE FINDINGS.	NORTH	20	Moderate	**£1,500**

Overall Conclusions, Observations and Recommendations for 2022/23

- EPUT performed strongly against the national average and improved on many areas compared to last year
- A particular highlight being our ranking for Dementia Care. A score that places us in the top 15 healthcare providers in the country for Dementia Care
- While scores were good across many areas there still seems to be a lack of a coherent plan and strategy for improving PLACE scores in the future
- In addition there is a requirement to raise the profile of the PLACE process, align and triangulate with data available from other quality review processes and provide additional monitoring to help embed awareness of the impact of a good care environment for patient safety and experience.

What worked well

Essex Partnership University
NHS Foundation Trust

- Staff engagement: it was felt that staff were accommodating and friendly to the Assessing Team.

- Open to ideas and suggestions: In areas where it was felt that improvements could be made, the Assessing Team felt that opinions, ideas and suggestions was valued. Assessors had the opportunity to complete multiple site visits, this allows individual assessors to compare site standards and share ideas and recommendation based on other site practices.

- Responsive to the current climate (COVID-19): Comments reflect the responsiveness and site preparation for visitors and staff to the current COVID-19 pandemic.

What can be improved

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NHS Foundation Trust

- Timings: Assessors found the there was not enough time to complete a thorough and detailed assessment. The assessment asked that paperwork is completed at point of access, but individuals would like to reflect on their experience.

- Planning and communication: It was felt that preparation for the assessment was confusing. Estates and Facilities will review the process with the Patient Safety Team to simply the appointment of assessors, and circulate easy to read documentation prior to each visit. Training sessions to be established.

Recommendations

Essex Partnership University
NHS Foundation Trust

1. A review of oversight and engagement to take place in Jan 2022
2. PLACE awareness slide pack to be developed that can be shared in both clinical and non-clinical forums.
3. PLACE awareness training to be provided to department leads, Matrons and Heads of Nursing in order to increase awareness of the requirements of PLACE audits.
4. Review of the quality of local training and preparation for assessors as this is fundamental to the success of PLACE as assures good assessors and demonstrates that we value our volunteers and intend to take their views seriously.
5. For all new build projects the Dementia and Disability-specific PLACE criteria will be considered at the early planning stages.
6. Explore a model for undertaking additional PLACE-lite audits to provide additional monitoring and embed awareness of the impacts of a good care environment for patient safety and experience.
7. Explore opportunities for peer auditing with partner organisations.

Annex 1

Regional comparison of results

Average site score by region

Essex Partnership University
NHS Foundation Trust

Regional Average Cleanliness scores 2019

	2019
England	**98.6%**
East of England Commissioning Region	98.9%
London Commissioning Region	98.5%
Midlands Commisioning Region	98.6%
North East and Yorkshire Commisioning Region	98.8%
North West Commissioning Region	98.9%
South East Commissioning Region	98.4%
South West Commissioning Region	97.9%

Source: NHS Digital

Regional Average Food and Hydration scores 2019

	2019
England	**92.2%**
East of England Commissioning Region	91.0%
London Commissioning Region	91.8%
Midlands Commisioning Region	92.1%
North East and Yorkshire Commisioning Region	93.2%
North West Commissioning Region	92.6%
South East Commissioning Region	91.6%
South West Commissioning Region	92.4%

Source: NHS Digital

Averages are means and are weighted for bed numbers, and do not include sites with no beds.
See page 10 on Scoring for more detail

Regional Average Organisational Food scores 2019

	2019
England	**91.9%**
East of England Commissioning Region	91.8%
London Commissioning Region	93.2%
Midlands Commisioning Region	92.6%
North East and Yorkshire Commisioning Region	92.1%
North West Commissioning Region	91.5%
South East Commissioning Region	91.3%
South West Commissioning Region	89.6%

Source: NHS Digital

Regional Average Ward Food scores 2019

	2019
England	**92.6%**
East of England Commissioning Region	91.4%
London Commissioning Region	91.7%
Midlands Commisioning Region	92.5%
North East and Yorkshire Commisioning Region	93.9%
North West Commissioning Region	93.2%
South East Commissioning Region	91.9%
South West Commissioning Region	93.7%

Source: NHS Digital

Regional Average Privacy, Dignity and Wellbeing scores 2019

	2019
England	**86.1%**
East of England Commissioning Region	83.5%
London Commissioning Region	86.7%
Midlands Commisioning Region	85.9%
North East and Yorkshire Commisioning Region	87.8%
North West Commissioning Region	88.0%
South East Commissioning Region	84.2%
South West Commissioning Region	84.6%

Source: NHS Digital

Regional Average Condition, Appearance and Maintenance scores 2019

	2019
England	**96.4%**
East of England Commissioning Region	96.7%
London Commissioning Region	96.3%
Midlands Commisioning Region	95.9%
North East and Yorkshire Commisioning Region	97.5%
North West Commissioning Region	96.9%
South East Commissioning Region	95.8%
South West Commissioning Region	95.7%

Source: NHS Digital

Regional Average Dementia scores 2019

	2019
England	**80.7%**
East of England Commissioning Region	78.9%
London Commissioning Region	81.9%
Midlands Commisioning Region	78.8%
North East and Yorkshire Commisioning Region	81.2%
North West Commissioning Region	83.3%
South East Commissioning Region	79.9%
South West Commissioning Region	80.1%

Source: NHS Digital

Regional Average Disability scores 2019

	2019
England	**82.5%**
East of England Commissioning Region	80.4%
London Commissioning Region	83.5%
Midlands Commisioning Region	81.8%
North East and Yorkshire Commisioning Region	82.9%
North West Commissioning Region	84.6%
South East Commissioning Region	82.0%
South West Commissioning Region	80.9%

Source: NHS Digital

Further information

Essex Partnership University
NHS Foundation Trust

- The PLACE programme was introduced in April 2013 to replace the Patient Environment Action Team (PEAT) assessments, which ran from 2000-2012.

- The PLACE collection underwent a national review, which started in 2018 and concluded in summer 2019. The question set has been significantly refined and revised, and guidance documents have been updated. The review ensured that the collection remains relevant and delivers its aims.

- PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:
  - Putting patients first;
  - Active feedback from the public, patients and staff;
  - Adhering to basics of quality care;
  - Ensuring services are provided in a clean and safe environment that is fit for purpose.

- PLACE encourages the involvement of patients, the public, and both national and local organisations that have an interest in healthcare in assessing providers.

PLACE – **P**atient **L**ed **A**ssessments of the **C**are **E**nvironment

Essex Partnership University
NHS Foundation Trust

- The Patient-Led Assessments of the Care Environment (PLACE) are an annual assessment of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia.
- The PLACE assessment tool provides a framework for assessing quality against common guidelines and standards. The environment is assessed using a number of question forms depending on the services provided by the facility. These can be viewed here: http://content.digital.nhs.uk/PLACE
- Questions score towards one or more non-clinical domains: Cleanliness; Food/Hydration; Privacy, Dignity and Wellbeing; Condition, Appearance and Maintenance; Dementia; and Disability.
- A total score as a percentage is produced for each domain at site and organisation level, as well as a national and a regional result.

PLACE domains

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- PLACE assesses a number of non-clinical aspects of the healthcare premises identified as important by patients and the public, known as domains:
  - Cleanliness
  - Food and hydration
  - Privacy, dignity and wellbeing
  - Condition, appearance and maintenance
  - Dementia: how well the needs of patients with dementia are met
  - Disability: how well the needs of patients with a disability are met

- The criteria for each represent good practice as identified by professional organisations whose members are responsible for the delivery of these services
  e.g. the Healthcare Estates Facilities Managers Association, the Association of Healthcare Cleaning Professionals and the Hospital Caterers Association. Dementia domain criteria draw heavily on the work of The Kings Fund and Stirling University.

- **As the changes following the review have been extensive, it is important to note that 2019 scores establish a new baseline and are not comparable to those achieved in previous assessments.**

Timescales

Essex Partnership University
NHS Foundation Trust

- The annual PLACE programme continues to be suspended in 2021 due to the operational difficulties and associated risks brought about by Covid-19. PLACE Lite remained open for healthcare organisations to undertake assessments if they chose to do so
- It is for organisations to decide how and when they organise and undertake their PLACE Lite assessment(s). The frequencies vary, some organisations prefer monthly assessments, some quarterly, every six months or once a year. For EPUT these assessments took place in September 2021

		Agenda Item No: 7c
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Final Charity Accounts 2020/21**					
Executive/ Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts					
Report discussed previously at:	Audit Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report		
Summary of risks highlighted in this report	No risks identified	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	n/a	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 the final Charity Annual Report and Accounts for 2020/21 to the Board of Directors for approval.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Approve the final Charity Annual Report and Accounts for 2020/21
3 Approve the signing of the Letter of Representation on behalf of the Trust
4 Request any further information or action.

Summary of Key Issues

The auditors work around the 2020/21 Charity Annual Report and Accounts is now completed and a final copy is attached at appendix 1. These have been reviewed in both draft and final form by the Audit Committee and are now recommended for approval by the Board.

Due to the value of the Charities gross income during the year, a full audit was not required and as such, the Trust's external auditors completed an independent examination in line with the 2011 Charities Act. This did not identify any changes to be made to the overall value of the charity but one unadjusted item relating to investment income not accrued for within the accounts totalling £1.9k has been detailed within their report.

In addition to approving the accounts, the Board are also asked to consider and approve the Letter of Representation (appendix 2) for signing on behalf of the Board by the Executive Chief Finance Officer and Chair of the Audit Committee.

Following approval by the Board, the external auditors will issue their opinion and the accounts will be submitted to the Charity Commission by the deadline of 31 January 2022.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	
3: We empower	

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**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading
Appendix 1 - Final Charity Annual Report and Accounts 2020/21 Appendix 2 – Letter of Representation

Lead

Trevor Smith
Executive Chief Finance Officer

Essex Partnership University NHS

NHS Foundation Trust Charities

Annual Report and Accounts 2020-21

ANNUAL REPORT AND ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2021

CHARITY INFORMATION

Name:	Essex Partnership University NHS Foundation Trust Charities
Trustees:	The Board of Directors of Essex Partnership University NHS Foundation Trust
Charity Number:	1053793
Charity Offices:	Essex Partnership University NHS Foundation Trust Head Office The Lodge Lodge Approach Runwell Wickford Essex SS11 7XX
Independent Examiners:	Ernst & Young LLP 400 Capability Green Luton LU1 3LU United Kingdom
Bankers:	Lloyds Banking Group 34 High Street Grays Essex RM17 6LX
Investment Brokers:	BlackRock Investment Manager (UK) Ltd 33 King William Street London EC4R 9AS M&G Securities Limited Laurence Pountney Hill London EC4 0HH CCLA Investment Management 80 Cheapside London EC2V 6DZ

REPORT OF THE TRUSTEES FOR THE YEAR ENDED 31 MARCH 2021

1. INTRODUCTION

The Essex Partnership University NHS Foundation Trust Charities (referred to as the Charity for the purpose of this document) was renamed from the legacy organisation's name (South Essex Partnership University NHS Foundation Trust Charity) on 1st April 2018, as a result of the merger of the former North Essex Partnership University NHS Foundation Trust and the South Essex Partnership University NHS Foundation Trust and their associated Charities.

The purpose of this report is to inform users of the accounts on the structure, policy and objectives, and governance arrangements of the Charity. The report also covers funding arrangements and a high level financial review for the year.

2. GOING CONCERN

These accounts have been prepared on the basis that the Charity is a going concern. This means that the assets and liabilities of the Charity reflect the ongoing nature of the Charity's activity.

3. SCOPE

The objective of the Charity is that the funds are made available to benefit the patients and staff of the Essex Partnership University NHS Foundation Trust (The Trust), or for any other NHS organisations on behalf of whom the Trust administers funds.

The Charity is sub-divided into a number of linked funds, each of which has a specific purpose and this determines the type of expenditure that can be incurred. Each linked fund is further broken down into smaller funds which are assigned an individual fund number. Each fund has a designated fund manager who is responsible for approving expenditure against the fund, monitoring fund levels and co-ordinating fund raising activities where appropriate in accordance with the scheme of delegation.

4. OBJECTIVES AND STRATEGY

The objective of the Charity during the current and future years is to support the needs of patients and staff of the Trust, in improving standards of care and facilities, within the scope of provision included above.

In seeking to achieve the Charity's objective, the Charity actively encourages donations and organises fund raising events.

5. FUNDS

Unrestricted funds are those which are not subject to any specific restriction, but can be used in accordance with the general purpose of the Charity, to improve standards of care and facilities for patients and staff within the scope of the Charity.

Restricted funds are funds which are subject to specific restrictions, over and above the general purpose of the Charity.

6. STRUCTURE AND GOVERNANCE

The charitable trust, which is an umbrella Charity, is an unincorporated body, with each separate restricted and unrestricted fund within the charitable trust being governed by its own model declaration of trust. The model declaration of trust sets out the specific or general purpose of the fund by way of its objects. This structure enables donations received into the restricted funds to be used for the purpose intended by the donors and those donations given for general purposes to be controlled.

The Charitable Funds Committee has delegated authority from the Board of Directors to approve applications for funds up to £10,000 in accordance with agreed criteria and the Charity's objects. This Committee is overseen and monitored by the Board of Directors. The Corporate Trustee for the Charity is the Essex Partnership University NHS Foundation Trust, with responsibility for the management of the Charity undertaken by the Board of Directors. Any provision for training and induction of Trustees is therefore covered under the ongoing requirement of the Board of Directors.

7. RESERVE POLICY

During 2020/21, fund managers have again been encouraged by the Trustees to use the funds available to them. The Trustees aim to ensure the value of the overall fund is maximised in line with the Investment Policy and will ensure that the capital value of endowment funds are maintained in perpetuity. The funds will continue to be used to improve the standards of care and facilities provided to patients and staff.

8. INVESTMENT POLICY

The Charity has an investment policy which aims to achieve a split of funds between investment in the unit trust and deposit style investments. This is maintained in order to meet the spending plans of the organisation. This also provides detail around the Charity's corporate, social and ethical responsibilities in terms of where investments are made.

Funds are currently invested with the following investment managers:

BlackRock Investment Management
M&G Securities Ltd
CCLA Investment Management

The Committee is responsible for reviewing and updating this Investment Policy on a regular basis.

9. RISK STATEMENT

The risk to the Charity is that equity investments may be adversely affected by a material fall in stock market values. The Committee will continue to monitor risks at its meetings, and obtain professional advice where appropriate with respect to its investments.

10. FUNDING

Income is received from direct contributions from the public, in addition to income from dividends and interest receivable. In addition, funds are generated from fund raising activities. During 2020/21, the Trust was also fortunate to have received grants from NHS Charities Together totalling £172,100.

Each fund receives a proportion of dividends and interest received from the investments in accordance with the average fund value during the year. This basis of apportionment is also applied to capital losses/gains, administration expenses and the management fees of the investment managers. The Committee consider this apportionment equitable.

The investments are made in accordance with the Trustee Act of 2000. The investment advisers have been instructed to exclude any direct investment in the tobacco industry, as this is considered inappropriate for an NHS Charity.

The Charity also follows the 2017 Money Laundering, Terrorist Financing and Transfer of Funds Regulations which came into force on 26 June 2017 (superseding the 2007 Regulations). These regulations aim to ensure that there are robust arrangements in place to ensure incoming resources, especially cash donations, are not the proceeds of crime.

11. FINANCIAL REPORT FOR THE YEAR

The attached accounts give full details of the income and expenditure for the year and the value of the assets and liabilities at the year end. The information below is given to supplement these formal accounts.

The value of the Charitable Funds as at 31 March 2021 was £1,038,000 (2019/20: £876,000). The net movement in value is an increase of £162,000 (2019/20: -£134,000) and which was attributable to;

1. Unrealised gain on investment which amounted to £184,000 (2019/20: -£164,000)
2. Total expenditure of £259,000 (2019/20: £179,000)
3. Total income of £237,000 (2019/20: £209,000)

The direct charitable expenditure is charged to the accounts on an accrual basis, and was in line with the objectives of the Charity. The total expenditure for the year of £259,000 can be further analysed as follows,

- Expenditure on patient welfare of £127,000 – this includes an additional palliative care support service, cycling sessions, music therapy, games and leisure activities and improvements to outside areas.
- Expenditure on staff welfare of £100,000 – this includes courses and books, support health and fitness, equipments and hot meal during Covid-19 pandemic.
- Expenditure on fundraising activities £1,000.
- Expenditure on support costs of £31,000.

The General Charitable Fund does not directly employ any staff; however a governance (support) cost to cover staff time was made by Essex Partnership University NHS Foundation Trust. Governance costs are charged across the funds based on the proportion of funds held, and are considered each year by the Charitable Funds Committee.

12. OPEN ARTS PROJECT

Open Arts is a charitable community arts and mental health service managed by the Trust, which helps to improve and maintain mental health and wellbeing. Open Arts is not funded by the NHS but operates completely on external funding, donations and fundraising by participants, volunteers and local businesses.

What a year it has been! As the world continued to live in a global pandemic, the Open Arts service continued to adapt its delivery, the health and wellbeing of participants and volunteers has always been at the forefront. Open Arts provides structure, which for many is also a safety net. Knowing that activities and weekly contact continues to be a regular weekly occurrence, has been a lifeline to many of our participants, and continues to help them to manage their mental health. Where many clubs, appointments and sessions closed, Open Arts continued delivering:
500 Client 'In the Open Arts' sessions/Zoom
139 Volunteer Studio/Course & Community Engagement hours /Sessions
1690 Estimated People Attending Community Engagement Activities
60 participants and volunteers received regular weekly contact from Open Arts

"… let's not forget a very important part, the one who holds it all together, who remains cheerful and supportive with constant empathy and energy... you! Thank you Jo (and all your staff and volunteers). Open Arts would not be the same without you x"

"I am honoured to be, and love being, a volunteer at Open Arts... Also thank you for being the great person that you are Jo - you work tirelessly keeping Open Arts running as well as caring for our welfare collectively, and supporting/listening to us individually. I will never be able to thank you enough for the way you and Open Arts have changed my life so much for the better! - Lorraine"

As a result of Open Arts participation, substantial benefits have been reported, including improved mental health, increased social activity, greater confidence and self-esteem, reduced use of mental health services and increased take up of wider community based opportunities.

A heartfelt thank you to the Open Arts team; our artists and volunteers, friends, members and participants. For the funding and support received from Fowler, Smith & Jones Trust, the Co-op and EPUT.

If you can help support Open Arts or would like information on how you can, please contact Epunft.open.arts@nhs.net or call Jo Keay, Open Arts manager, on 07580 982462

You can donate online via CAF www.cafonline.org search for **Essex Partnership NHS Foundation Trust Charities or 1053793.** Please make sure you type **For Open Arts** in the message box. Thank you.

A summary of the income streams and resources expended relating to Open Art is detailed below;

Statement of Financial Activities	
	2020/21
Incoming resources from;	**£**
Various donation	2,377
Investment income	930
Gain from investment valuation	4,786
Total income	**8,093**
Resources expended on	
Charitable fund activities	(8,147)
Administration and other cost	(808)
Total expenditure	**(8,955)**
Net income/(expenditure) for the year	**(862)**
Fund balance at the beginning of the year	21,092
Fund balance at the end of the year	**20,230**

13. **THE TRUSTEES**

The Trustees for the "The General Charitable Fund" for the year ended 31 March 2021 are as follows:

Professor Sheila Salmon	-	Trustee
Sally Morris	-	Trustee (until 30/09/2020)
Paul Scott	-	Trustee (from 01/10/2020)
Andy Brogan	-	Trustee (until 23/10/2020)
Alex Green	-	Trustee (from 24/10/2020)
Mark Madden	-	Financial Trustee (until 30/09/2020)
Trevor Smith	-	Financial Trustee (from 01/10/2020)
Dr Milind Karale	-	Trustee
Nigel Leonard	-	Trustee
Professor Natalie Hammond	-	Trustee
Sean Leahy	-	Trustee
Janet Wood	-	Trustee
Alison Davis	-	Trustee
Amanda Sherlock	-	Trustee
Nigel Turner	-	Trustee (until 30/09/2020)
Manny Lewis	-	Trustee
Dr Rufus Helm	-	Trustee
Dr Alison Rose-Quirie	-	Trustee
Dr Mateen Jiwani	-	Trustee (from 18/01/2021)
Loy Lobo	-	Trustee (from 31/03/2021)

All appointments to the Board of Directors of the Essex Partnership University NHS Foundation Trust Board are also the appointed Trustees of the Essex Partnership NHS Foundation Trust General Charitable Fund. Non-Executive Directors are normally appointed for a fixed term of three years.

14. **ADMINISTRATION ARRANGEMENTS**

The Trust holds monthly Board of Directors meetings, which include an update from the Charitable Funds Committee at least twice a year. The day-to-day management of the restricted funds has been delegated to Fund Managers who have delegated authority to approve expenditure of up to £5,000 or the balance of fund (whichever is lower).

The Board of Directors has delegated the management of the unrestricted funds to the Chief Executive of the Foundation Trust.

The Board of Directors has retained approval of expenditure commitments of a recurring nature and approval of expenditure over £10,000, with the Charitable Funds Committee approving expenditure of above £5,000 and up to £10,000.

15. **INDEPENDENT EXAMINERS**

NHS Funds held on Trust are subject to the 2011 Charities Act, which superseded the 2006 Charities Act and states that all Charities with a gross income of more than £25,000 are required to have some form of external scrutiny of their accounts. In addition, if the Charity has gross income in excess of £1 million in the period of account, or if its gross income exceeds £250,000 and the aggregate value of assets (before deduction of liabilities) exceeds £3.26 million, then the accounts will be subject to a full audit.

For the year ended 31 March 2021 the Charities income was below the £1 million threshold and as such the annual report and accounts will not therefore be subject to a full audit. However, due to the Charities having income in excess of the £25,000 threshold, they will instead be subject to an independent examination as required by the Charities Act 2011.

16. ACKNOWLEDGEMENTS

The Trustees acknowledge the generous contributions and donations made by the public, as well as the time and commitment of staff.

17. APPROVAL

This report was approved by the Trustees and signed on their behalf.

Professor Sheila Salmon
Chair

Date:

Statement of Trustees' Responsibilities

The Trustees are responsible for:

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 2011;
- establishing and monitoring a system of internal control; and
- establishing arrangements for the prevention and detection of fraud and corruption.

The Trustees are responsible for the preparation of financial statements in accordance with the Charities Statement of Recommended Practice (FRS 102) Accounting and Reporting by Charities for each financial year. The Charity Commission directs that these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with Charities SORP (FRS 102). In preparing these accounts the Trustees are required to:

- apply on a consistent basis, accounting policies laid down by applicable accounting standards;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.
- prepare the accounts on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation.

The Trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1 to 13 attached, have been compiled from and are in accordance with the financial records maintained by the Trustees.

By Order of the Trustees

Signed:

Chair …… Date:

Financial Trustee …… Date:

Independent examiner's report to the trustees of Essex Partnership University NHS Foundation Trust General Charitable Fund

To be inserted after signing by Board

FUNDS HELD ON TRUST ACCOUNTS 2020/21

The accounts of the funds held on Trust by Essex Partnership University NHS Foundation Trust

Foreword

These accounts have been prepared by the Trust under section 98(2) of the National Health Service Act 1977 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The Essex Partnership University NHS Foundation Trust is the corporate trustee of the funds held on trust under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990. The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.

The Essex Partnership NHS Foundation Trust Charitable Funds Held on Trust are registered with the Charity Commission. The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the aforementioned organisations.

If you require any further information regarding these accounts please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268_739666

Trevor Smith
Financial Trustee

Statement of Financial Activities for the Year ended 31 March 2021

	Note	Unrestricte Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds £000**	2019/20 Total Funds £000
Incoming Resources from:						
Donation, grant and legacies	2	198	2	-	200	140
Other trading activities	3	2	-	-	2	26
Investment income	4	15	20	-	35	43
Total income		**215**	**22**	**-**	**237**	**209**
Resources Expanded on:						
Charitable activities	5	(227)	(32)	-	(259)	(179)
Total expenditure		**(227)**	**(32)**	**-**	**(259)**	**(179)**
Net gain/(losses) on investments	6	79	105	-	184	(164)
Net income/(expenditure)		**67**	**95**	**-**	**162**	**(134)**
Transfers	12	-	-	-	-	-
Net movement in funds		**67**	**95**	**-**	**162**	**(134)**
Reconciliation of funds						
Total fund balance brought forward		336	512	28	876	1,010
Total fund balance carried forward		**403**	**607**	**28**	**1,038**	**876**

The statement of financial activities includes the income and expenditure account.
The notes are at pages 5 to 13 and form part of this document.

Balance Sheet as at 31 March 2021

	Note	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	**Total Funds 2020/21 £000**	***Total Funds 2019/20 £000***
Fixed Assets						
Investments	7	385	580	27	992	*808*
Total fixed assets		385	580	27	992	*808*
Current Assets						
Debtors	8	-	-	-	-	*1*
Short term investments & deposits	9	4	7	-	11	*11*
Cash at bank and in hand	10	19	27	1	47	*71*
		23	34	1	58	*83*
Current Liabilities						
Creditors: Amounts falling due within one year	11	(5)	(7)	-	(12)	*(15)*
Net current assets		18	27	1	46	*68*
Total assets less current liabilities		403	607	28	1,038	*876*
Creditors: Amounts falling due after more than one year		-	-	-	-	-
Provisions for liabilities and charges		-	-	-	-	-
Total Net Assets		403	607	28	1,038	*876*
The funds of the charity						
Total restricted funds	13	-	607	-	607	*512*
Total unrestricted funds	13	403	-	-	403	*336*
Total Endowment funds	13	-	-	28	28	*28*
Total charity funds		403	607	28	1,038	*876*

The notes are at pages 5 to 13 form part of this document.

Signed:

Date:

Statement of Cash Flow at 31 March 2020

	Note	2020/21 Total Funds £000	*2019/20 Total Funds £000*
Cash flows from operating activities			
Net cash provided by/(used in) operating activities	10.2	(59)	*1*
Cash inflow/(outflow) from other activities	12	-	-
		(59)	*1*
Cash flows from investing activities			
Dividends, interest from investments	4	35	*43*
Proceeds from sale of investments	7	-	-
Purchase of investments		-	-
Net cash provided by/(used in) investing activities		35	*43*
Cash flows from financing activities			
Repayment of borrowings		-	-
Cash flows from borrowings		-	-
Net cash provided by/(used in) financing activities		-	-
Change in cash and cash equivalents during the year		(24)	*44*
Cash and cash equivalents at the beginning of the year		71	*27*
Cash and cash equivalents at the end of the year		47	*71*

NOTES TO THE ACCOUNTS

1. Accounting Policies

1.1 Accounting Policies

The financial statements have been prepared under the historical cost convention and in accordance with the Statement of Recommended Practice issued in October 2019 - Accounting and Reporting by Charities (FRS 102), and with accounting standards and policies for the NHS approved by the Secretary of State.

There have been no changes to accounting policy for the 2020/21 financial year.

1.2 Incoming Resources

a) All incoming resources are included in full in the statement of financial activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the Charity's right becomes legally enforceable;
ii) certainty - when there is reasonable certainty that the incoming resource will be received;
iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability

b) Gifts in Kind

i) Assets given for distribution by the Charity are included in the Statement of Financial Activities only when distributed.
ii) Assets given for use by the Charity (e.g. property for its own occupation) are included in the Statement of Financial Activities as incoming resources when receivable.
iii) Gifts made in kind but on trust for conversion into cash and subsequent application by the Charity are included in the accounting period in which the gift is sold.

In all cases the amount at which gifts in kind are brought into account is either a reasonable estimate of their value to the Charity or the amount actually realised. The basis of the valuation is disclosed in the annual report.

c) Intangible Income

Intangible income (eg the provision of free accommodation) is included in the accounts with an equivalent amount in outgoing resources, if there is a financial cost borne by another party. The value placed on such income is the financial cost of the third party providing the resources.

1.3 Resources Expended

The Funds Held on Trust account is prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the accounts when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Resources expended are split into two main categories being the costs of generating funds and the actual costs of charitable activities. The costs of generating funds are the costs associated with generating income for the Funds Held on Trust. A grant is any payment which is made voluntarily to any institution or to an individual in order to further the Charity's objectives, without receiving goods or services in return.

The cost of activities in the furtherance of charitable activities is expenditure incurred on the provision of services or goods. Support costs are an integral and material part of the costs of activities in the furtherance of charitable activities and/or expenditure incurred in paying grants. Management and administrative expenditure includes direct and indirect costs (as distinct from directly pursuing charitable activities). Direct costs include those of external and internal audit and legal advice for trustees, the indirect costs include office and communication costs.

1.4 Tangible Fixed Assets and Donated Assets

The General Charitable Fund has no retained fixed assets or donated assets.

1.5 Investment Fixed Assets

Investment fixed assets are shown at market value.

Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividend.

Other investment fixed assets are included at trustees' best estimate market value.

Unrealised and realised gains and losses are shown in the statement of financial activities and represent the difference between the market value and the original purchase cost.

1.6 Structure of Funds

Where there is a legal restriction on the purposes to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as designated funds. The major funds held within these categories are disclosed in note 12.

As at 31 March 2021 the Charity held one endowment fund.

1.7 Pension Contributions

There have been no pension contributions made by the Charity in the financial year ended 31 March 2021.

1.8 Prior Year Adjustments

There have been no changes to the accounts of prior years.

1.9 Pooling Scheme

The General Charitable Fund is a Charitable Fund Umbrella which comprises general and specific purpose funds. As such funds are pooled for investment purposes. The funds included within the General Charitable Fund are as follows,

Essex Partnership University NHS FT General Fund
District Nurses Fund
Mental Health Charity
Primary Care Charity
Continuing Care Services Fund
Psychiatric Research Fund
Primary Care Trust Staff Welfare Fund
Mental Health Research Foundation
Learning Disabilities Psychiatry Academic and Research Foundation
The Margaret Ethel Bolton Fund
Cancer Care General Fund
Child Health Directorate Fund
Cancer Relief Fund

The scheme was registered with the Charity Commission on 18 December 2002.

1.10 Consolidation of Charity Accounts with EPUT Annual Accounts

IAS 27 on Consolidation and Separate Financial Statements, requires consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. The Essex Partnership University NHS Foundation Trust is the corporate Trustee for the Charity and hence controls it. The purpose of the Charity is to assist NHS patients, and hence the Trust benefits from its activities. As such, IAS27 would normally be applicable in the preparation of the Trust's main accounts and the Charity would be consolidated.

However, IAS1 on Presentation of Financial Statements confirms that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity represent 1% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trust's main accounts. The Audit Committee have noted and approved that the Charity Accounts will not be consolidated into the main Trust accounts for 2020/21. This is subject to an annual materiality review.

Note 2 Analysis of donations and legacies

	2020/21				*2019/20*			
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
Donations	25	2	-	**27**	*14*	*17*	*-*	*31*
Legacies	1	-	-	**1**	*-*	*99*	*-*	*99*
Grant income	172	-	-	**172**	*10*	*-*	*-*	*10*
	198	2	-	**200**	*24*	*116*	*-*	*140*

Note 3 Analysis of income from other trading activities

	2020/21				*2019/20*			
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
Raffle tickets sales	-	-	-	**-**	*-*	*-*	*-*	*-*
Income received for courses	-	-	-	**-**	*-*	*10*	*-*	*10*
Income from other fundraising activities	2	-	-	**2**	*8*	*1*	*-*	*9*
Other Income	-	-	-	**-**	*7*	*-*	*-*	*7*
	2	-	-	**2**	*15*	*11*	*-*	*26*

Note 4 Analysis of income from investments

	2020/21				*2019/20*			
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
BlackRock Investment	2	3	-	**5**	*3*	*3*	*-*	*6*
M&G Charities	10	13	-	**23**	*14*	*16*	*-*	*30*
COIF Charities Investment Fund	3	4	-	**7**	*3*	*4*	*-*	*7*
	15	20	-	**35**	*20*	*23*	*-*	*43*

Note 5 Analysis of expenditure on charitable fund activities

	Unrestricted £000	Restricted £000	Endowment £000	**2020/21 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2019/20 Total £000*
Patients Welfare & Amenities	113	14	-	**127**	*89*	*51*	*-*	*140*
Staff Welfare & Amenities	100	-	-	**100**	*6*	*-*	*-*	*6*
Support Cost (see note 5.1)	13	18	-	**31**	*14*	*15*	*-*	*29*
Fundraising Expenditure	1	-	-	**1**	*4*	*-*	*-*	*4*
	227	32	-	**259**	*113*	*66*	*-*	*179*

Note 5.1 Analysis of support cost by type

	Unrestricted £000	Restricted £000	Endowment £000	**2020/21 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2019/20 Total £000*
Audit fee	2	3	-	**5**	*1*	*1*	*-*	*2*
Admin fee	11	15	-	**26**	*13*	*14*	*-*	*27*
	13	18	-	**31**	*14*	*15*	*-*	*29*

Note 5.2 Analysis of support cost by activities

	Unrestricted £000	Restricted £000	Endowment £000	**2020/21 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2019/20 Total £000*
Patients Welfare & Amenities	7	18	-	**25**	*12*	*15*	*-*	*27*
Staff Welfare & Amenities	6	-	-	**6**	*2*	*-*	*-*	*2*
	13	18	-	**31**	*14*	*15*	*-*	*29*

Note 6 Gain/(losses) on investments revaluation

	Unrestricted £000	Restricted £000	Endowment £000	**2020/21 Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*2019/20 Total £000*
BlackRock Investment	18	24	-	**42**	*(14)*	*(19)*	*-*	*(33)*
M&G Charities	43	57	-	**100**	*(55)*	*(70)*	*-*	*(125)*
COIF Charities Investment Fund	18	24	-	**42**	*(2)*	*(4)*	*-*	*(6)*
	79	105	-	**184**	*(71)*	*(93)*	*-*	*(164)*

Note 7 Fixed Asset Investments

Note 7.1 Changes in Fixed Asset Investments

	Unrestricted £000	Restricted £000	Endowment £000	**2020/21 Total £000**	Unrestricted £000	Restricted £000	Endowment £000	2019/20 Total £000
Market Value at 1 April	306	475	27	**808**	378	565	29	972
Transfers/Disposals	-	-	-	**-**	-	-	-	-
Dividends re-invested	-	-	-	**-**	-	-	-	-
Net Gain/(Loss) on Revaluation	79	105	-	**184**	(71)	(93)	-	(164)
Total Market Value of Fixed Asset Investments	**385**	**580**	**27**	**992**	**307**	**472**	**29**	**808**

Note 7.2 Analysis of Fixed Asset Investments by Investment Manager

	Unrestricted	Restricted	Endowment	**2020/21 Total**	Unrestricted	Restricted	Endowment	2019/20 Total
	£000	£000	£000	**£000**	£000	£000	£000	£000
BlackRock Investment Managers (UK) Ltd	83	124	6	**213**	66	100	5	171
M & G Securities Ltd	207	310	15	**532**	163	252	17	432
CCLA Investment Management	96	144	7	**247**	78	120	7	205
Total Market Value of Fixed Asset Investments	**386**	**578**	**28**	**992**	**307**	**472**	**29**	**808**

Note 8 Analysis of recievables due within one year

	2020/21				2019/20			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Sundry Debtors	-	-	-	**-**	*-*	*1*	*-*	*1*
Value as at 31 March	**-**	**-**	**-**	**-**	***-***	***1***	***-***	***1***

Note 9 Short term investments & deposits

	2020/21				2019/20			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
COIF Charities deposits funds	4	7	-	**11**	*4*	*7*	*-*	*11*
Value as at 31 March	**4**	**7**	**-**	**11**	***4***	***7***	***-***	***11***

Note 10 Analysis of cash and cash equivalent

	2020/21				2019/20			
	Unrestricted	Restricted	Endowment	**Total**	*Unrestricted*	*Restricted*	*Endowment*	*Total*
	£000	£000	£000	**£000**	*£000*	*£000*	*£000*	*£000*
Cash at bank and in hand	19	27	1	**47**	*30*	*41*	*0*	*71*
Value as at 31 March	**19**	**27**	**1**	**47**	***30***	***41***	***0***	***71***

Note 10.1 Analysis of cash and cash equivalents

	2020/21
	£000
Cash at bank	44
Cash in hand	3
Value as at 31 March	**47**

Note 10.2 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2020/21 **£000**	***2019/20*** ***£000***
Net income/(expenditure) for the year as per the SoFA	162	*(134)*
(Gain) and losses of investment	(184)	*164*
Dividends, interest from investments	(35)	*(43)*
(increase)/decrease in stocks	-	-
(increase)/decrease in debtors	1	*17*
increase/(decrease) in creditors	(3)	*(3)*
Net cash provided by (used in) operating activities	(59)	*1*

Note 11 Analysis of Creditors

				2020/21				2019/20
	Unrestricted £000	Restricted £000	Endowment £000	**Total £000**	*Unrestricted £000*	*Restricted £000*	*Endowment £000*	*Total £000*
Amounts falling due within 1 year:								
Intercompany creditors	1	1	-	**2**	-	*1*	-	*1*
Accruals	4	6	-	**10**	*5*	*8*	*1*	*14*
Total Creditors	**5**	**7**	**-**	**12**	***5***	***9***	***1***	***15***

Note 12 Reconciliation of fund balance at 31 March 2021

	Balance at 31/03/2020 £000	**Income £000**	**Expenditure £000**	**Unrealise gain(losses) £000**	**Transfers £000**	**Balance at 31/03/2021 £000**
Restricted funds	512	22	(32)	105	-	607
Unrestricted funds	336	215	(227)	79	-	403
Endowment funds	28	-	-	-	-	28
Total funds as per balance sheet	876	237	(259)	184	-	1,038

Note 13 Trustee and Related Party Transaction

Essex Partnership University NHS Foundation Trust is the Corporate Trustee (the Trust) of the Essex Partnership NHS Foundation Trust General Charitable Fund (the Charity). During the year the Charity paid £26,788 to the Trust, to cover costs incurred by the Trust in administering the Charity, on its behalf.

During the year none of the Trustee Board members or parties related to them has undertaken material transaction with the Charity.

Note 14 Trustees Remuneration and Benefits

There was no remuneration or other benefits paid to Trustees during the year.

Note 15 Staff Cost and Other Benefits

The Charity does not directly employ any staff. As such, there were no staff costs or other staff benefits incurred during the year.

Note 16 Contingencies

There are no contingent losses or gains known by the Trustees.

Note 17 Commitments, Liabilities and Provisions

There are no commitments, liabilities or provisions known by the Trustees.

Note 18 Post Balance Sheet Events

There are no post balance sheet events for the reporting period.

Essex Partnership University
NHS Foundation Trust

26 January 2022

The Lodge Trust HQ Runwell
Lodge Approach
Wickford
Essex
SS11 7XX

Tel: 01268 739666

Email:Trevor.Smith9@nhs.net

Ernst & Young
400 Capability Green
Luton
LU1 3LU

Dear Debbie

This letter of representations is provided in connection with your independent examination of the financial statements of Essex Partnership University NHS Foundation Trust Charities ("the Charity") for the year ended 31 March 2021. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your independent examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your independent examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect the requirements:

- to keep accounting records in accordance with section 130 of the Charities Act 2011;
- to prepare accounts which accord with the accounting records; and
- to prepare accounts which comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the engagement letter, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a

true and fair view of the financial position and financial performance of the Charity in accordance with UK GAAP and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic on our system of internal controls.

5. We believe that the effects of any unadjusted differences accumulated by you during the current independent examination and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. The unadjusted difference of £1,949.36 relates mainly to a quarter four dividend not being recorded as income and differences in smaller amounts due to rounding. We have not corrected these differences identified by and brought to the attention by you because the amounts are immaterial within the context of the Charity's financial statements.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected non-compliance with laws or regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

    1. Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

    2. Additional information that you have requested from us for the purpose of the independent examination; and

    3. Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements, including those related to the COVID-19 pandemic.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: 30 November 2021

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the period end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

Signed on behalf of the Trustees

Janet Wood Chair of Audit Committee	Trevor Smith Executive Chief Finance Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 7d
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Update on Charitable Funds Annual Bidding Process**					
Executive/Non-Executive Lead:	Trevor Smith, Executive Chief Finance Officer					
Report Author(s):	Clare Barley, Head of Financial Accounts					
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	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~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		
To note the outcome of the annual general bidding process against Charitable Funds and approve two bids in excess of the Committee's delegated authority.	**Approval**	✓
	Discussion	
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Note the outcome of the annual bidding process for 2021/22
3. Approve the bid totalling £12.5k for Clifton Lodge which is in excess of the Charitable Fund Committees delegated authority
4. Approve the bid to be submitted to NHS Charities Together totalling £68k to be funded via a Stage 3 grant
5. Request any further information or action.

Summary of Key Issues

Annual Bidding Process

As in previous years, the Charitable Funds Committee approved the annual bidding process for general charitable funds with all bids returned by 20th October 2021. These were duly considered at the Charitable Funds Committee meeting held on 30th November 2021.

The Committee received a total of 28 bids totalling £224.2k against available funds of £40.5k, and were pleased to be able to fund 22 of the 28 bids from charitable funds, and to suggest alternative means of funding for a further 4 bids. A summary of the bids is attached at appendix 1 which can be summarised as follows,

- 15 bids approved for funding from designated general funds (of which 2 are proposed to be jointly funded with the services own fund)
- 7 bids approved for funding from the services own fund where sufficient balances exist
- 2 bids are capital in nature, and are therefore to be redirected to the CPPG for future consideration
- 2 bids to be considered for funding from exchequer funds due to them relating to items of medical equipment
- 2 bids were rejected. The first of these relates to pharmacy training for £100k which unfortunately is not affordable from charitable funds, and potentially should be a requirement of exchequer funds to ensure staff are robustly trained. The second rejected bid relates to the provision of outdoor gym equipment to the Linden Centre which does not meet the Trusts Garden Standards as confirmed by the Estates Expert Reference Group.

Of the 22 bids approved by the Charitable Funds Committee, one bid from Clifton Lodge (2021-02) was above the Committee's delegated limit of £10k. The Board are therefore asked to approve this bid to allow the service to purchase additional furnishings to further enhance the environment for patients. This service receives donations on a regular basis and it was therefore agreed that the services own charitable fund should contribute 50% towards the total cost.

NHS Charities Together Bid

Directors may recall that as part of its membership of NHS Charities Together, the Trust was eligible to bid for £110k of Stage 3 grant funding to support recovery. Of the two bids submitted, NHS Charities Together approved one totalling £42k to support the Open Arts Project but unfortunately rejected the second bid.

The Committee have now considered an amended bids totalling £68k which aims to invest in the provision of cycle sheds, development of a self-help/wellbeing library for staff, train-the-trainer sessions to support staffs self-awareness, self-esteem and self-compassion and the purchase of iPads to allow staff who struggle to access technology to more easily take part in staff engagement initiatives. This revised bid will fully utilise all funds available to the Trust via the Stage 3 grant process. Due to the value of this bid being in excess of the Charitable Fund Committees delegated authority, the Board will be asked to approve this at their January meeting ahead of its submission.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	✓
3: We empower	

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
Appendix 1 – Bid Summary

Lead
 Trevor Smith **Executive Chief Finance Officer**

File Reference No	Scheme	Director / Sponsor	Bid Prepared / Submitted by	Estimated Cost	Locality	Approved from General Funds	Own Fund	Capital	NR Revenue	Rejected
2021-01	Wooble Room	Denise Cook	Tasleem Rafiq	4,000	Woodlea Clinic	3,782	218			
2021-02	Clifton Lodge Furnishing	Lynnbritt Gale	Pippa Crocket	12,455	Clifton Lodge	6,228	6,228			
2021-03	Bariatric Couches	Alex Green	Katie Fox	42,870	The Community Wound Care Team / South East Essex	0		42,870		
2021-04	Family Nurse Partnership	Hannah Van Der Puije	Tracey Scanlon / Clare Penn	450		450				
2021-05	Diabetes Build-A-Bear		Dr Katie Hutchin	389	Paediatric Psychology Service	389				
2021-06	ECT Clinic Waiting Room	Lynn McGhee	Yetunde Abiodun	370	ECT Suite, Linden Centre Chelmsford	0	370			
2021-07	The Lakes Staff Room Dishwasher	Elizabeth Wells	Sidick Peeraully	360	The Lakes	360				
2021-08	IT Pool Resources	Denise Cook	Kelly Burgess	1,750	The Specialist Community Forensic Team	1,750				
2021-09	3 x Rempod Cars	Lynnbritt Gale	Cheryl Hill	9,720	Rawreth Court	0	9,720			
2021-10	OT Garden Rochford	Diana Luckie	Bernadette Flynn	257	Rochford	257				
2021-11	Acelerating a Learning Culture in Pharmacy	Hilary Scott	Mona Sood	100,000	All Pharmacies	0				100,000
2021-12	Improving Meadowview Staff Room	Lynn McGhee	Alina Kutraite	330	Meadowview	0	330			
2021-13	Hadleigh Unit Patient Experience Improvement	Lynn McGhee	Jenifer Trowers	2,900	Hadleigh Unit BMHU	2,900				
2021-14	Stabilisation/Calming packs	Greg Wood	Julie Baah	2,786	Transitions, The Linden Centre	2,786				
2021-15	Design and production of the logo for the South East Essex Trauma Alliance	Greg Wood	Kerry Mayers	1,500	South East Essex Trauma Alliance (Psychological Services)	0			1,500	
2021-16	Outdoor Gyms for Ward Gardens	Lynn McGhee	Steven Moxley	17,026	Linden Centre Wards	0				17,026
2021-17	Female and Male gardens on Gloucester ward	Lynnbritt Gale	Thomas Ola	5,580	Gloucester Ward Gardens, Thurrock	0	5,580			
2021-18	Reminiscence Therapy Interactive Activities	Lynn McGhee	Catherine Rothon	5,400	Beech Ward	0		5,400		
2021-19	Female Service Holistic Relaxation Tools	Lynn McGhee	Bethan Simpson	776	Cherrydown Ward	776				
2021-20	Galleywood Ward Ice Machine		Dr Stacy Earl	140	Galleywood Ward, Linden Centre	0	140			
2021-21	Rucksacks/grab bags-UCRT SEE	Kevin McKenny	Sarah Jarratt	704	SEE Urgent Community Response Team	0			704	
2021-22	Mental Health Liaison patient experience and feedback	Lynnbritt Gale	Kerry Turner	1,200	Mental Health Liaison Team	1,200				
2021-23	Gloucester Ward Phlebotomy Ward	Lynnbritt Gale	Thomas Ola	1,078	Gloucester Ward	0	1,078			
2021-24	Assessment Unit Patient Experience Improvement	Lynn McGhee	Mandy McFadyen	1,839	Basildon Mental Health Assessment Unit, Basildon Mental Health Unit	1,839				
2021-25	Brockfield House Fitness Equipment		Kayleigh Reardon	1,654	Secure Services, Brockfield House	1,654				
2021-26	Early Intervention in Psychosis North Essex	Elizabeth Wells	Amy Djordjevic	619	Early Intervention in Psychosis North Essex (Based at Holmer Court)	619				
2021-27	Gloucester ward – Corridor, day area and lounge	Lynnbritt Gale	Thomas Ola	5,974	Gloucester Ward	0	5,974			
2021-28	Cultivating Recovery and Opportunity Project: CRoP	Stephanie Rea	Steve Burrow	2,099	Hennage, Roding Ward, Ruby Ward	2,099				
				224,224		**27,088**	**29,637**	**48,270**	**2,204**	**117,026**

		Agenda Item No: 8a
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Board Assurance Framework 2021/22 January 2022**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Susan Barry, Head of Assurance					
Report discussed previously at:	Executive BAF Sub-Committee December 21 Executive BAF Sub-Committee January 22 Executive Operational Sub-Committee January 22					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	All high level risks included in the EPUT Strategic and Corporate Risk Registers	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber-Attack	✓
Does this report mitigate the Strategic risk(s)?	Yes/ ~~No~~	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~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 the Board of Directors (Part 1) with the January 2022 iteration of a refreshed Board Assurance Framework for noting and approval of recommendations made on behalf of the Executive BAF Sub-Committee	**Approval**	✓
	Discussion	✓
	Information	

Recommendations/Action Required
Recommendations to the Board of Directors (Part 1) are as follows: 1 Note the decisions made by the Executive BAF Sub-Group at its meeting in December 2021 (see section 6.0 for summary list) 2 Note the Board Assurance Framework Dashboards in Section 2 for December 2021 and January 2022 (see section 6.0 for summary list) 3 Note the risks linked to Strategic Objectives in Section 3 4 Note the key risks in Section 4 5 Note the Strategic Risks and Milestones in Section 5

6	Approval of new strategic risk SR6 Cyber-Attack. (Section 2 with further detailed descriptor in Section 4)
7	Approval of increases and decreases in scores on corporate risks (Section 2)
8	Approval of merger of CRR85 and CRR86 (Section 2)
9	Request any further information or action

Summary of Key Issues

Board Assurance Framework

The Board has overall responsibility for ensuring systems and controls are in place and are sufficient to mitigate any significant risks, which may threaten the achievement of the Strategic Objectives. The purpose of the Board Assurance Framework is to assure the organisation that we are on track to achieve strategic and annual objectives for the current year and describe any risks to delivery that have been identified and the actions being taken to control such risks.

The EPUT Board Assurance Framework (BAF) refresh follows changes to the Trust Strategic Objectives approved by the Board of Directors in September 2021. This has also given the opportunity to revise visual presentation of the BAF. This new format will continue to evolve over the next few months.

The Board Assurance Framework is now the overarching report relating to Strategic risks (formerly BAF) and Corporate risks.

Strategic Risks (Section 2.0)

With effect from January 2022, subject to approval by the Board, there are six strategic risks. Risks have been identified following detailed work and discussions with the Executive Team and Development sessions with Board of Directors.

One risk has been escalated from Corporate Risk Register to Strategy Risk Register SR6 Cyber-Attack with risk score of 15. Risks have been reviewed by risk owners and further controls and actions identified.

Corporate Risks (Section 2.0)

No new identified risks added to Corporate Risk Registers. All risks have been reviewed and further controls and actions identified. 5 risks have been de-escalated to Directorate Risk Registers and 3 risks have been closed due to mitigations in place.

Key Risks (Section 4.0)

There are 8 risks identified as key risks (on strategic risk register or on corporate risk register scoring 20 or above)

- SR1 Safety Score of 20
- SR2 People Score of 20
- SR3 Systems and Processes / Infrastructure Score of 16
- SR4 Demand and Capacity Score of 20
- SR5 Independent Inquiry Score of 15
- SR6 Cyber Attack Score of 15
- CRR90 Management of Covid 19 Score of 20
- CRR94 Engagement and Supportive Observations Score of 20

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We Care	✓
2: We Learn	✓
3: We Empower	✓

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	SR	Strategic Risk
SO	Strategic Objective	CRR	Corporate Risk Register
RR	Risk Register	DRR	Directorate Risk Register
ICS	Integrated Care System	F&PC	Finance & Performance Committee
QC	Quality Committee	PECC	People & Culture Committee
IGDSPT	Information Governance Data Security & Protection Toolkit	EOSC	Executive Operational Sub Committee
BOD	Board of Directors	ESOG	Executive Safety Oversight Group
EERG	Estates Expert Reference Group	LRRG	Ligature Reduction Group
TFO	Trust Fire Officer	FSG	Fire Safety Group
P1	Priority 1 sites	FRA	Fire Risk Assessment
MHA	Mental Health Act	HSSC	Health Safety Security Committee
ECC	Essex County Council	CQC	Care Quality Commission
CxL	Consequence x Likelihood	CRS	Current Risk Score
SMT	Senior Management Team	HSE	Health & Safety Executive
CAS	Central Alert System	NHSE/I	NHS England/ Improvement
PMO	Project Management Office	ESR	Electronic Staff Record
EFIN	Electronic Finance Record	TBA	To be advised or agreed
PFI	Private Finance Initiative	NHSPS	NHS property services
CMO	Chief Medical Officer	EDS	Equality and Diversity Standards
A&E	Accident & Emergency	NELFT	North East London FT

Supporting Documents and/or Further Reading
Appendix 1 Board Assurance Framework December 2021 – January 2022

Lead
Paul Scott Chief Executive Officer

EPUT Board Assurance Framework (BAF)
January 2022

Index

1.0 Introduction

The Board has overall responsibility for ensuring systems and controls are in place and are sufficient to mitigate any significant risks, which may threaten the achievement of the Strategic Objectives. The purpose of the Board Assurance Framework is to assure the organisation that we are on track to achieve strategic and annual objectives for the current year and describe any risks to delivery that have been identified and the actions being taken to control such risks.

The EPUT Board Assurance Framework (BAF) refresh follows changes to the Trust Strategic Objectives approved by the Board of Directors in September 2021. This has also given the opportunity to revise visual presentation of the BAF. This new format will continue to evolve over the next few months.

The Board Assurance Framework is now the overarching report relating to Strategic risks (formerly BAF) and Corporate risks.

Following a refinement by the Executive Team of the strategic risk register, the Board Assurance Framework has approval of the Board of Directors with six (subject to approval) key strategic risks, linked to the strategic objectives. All of these risks have/ will have a strategy underpinning them that focus on the scale of the overarching risk as well as the deliverables. The Executive Team is committed to undertaking this by the summer of 2022. The strategic risks will in turn have longer-term actions with deliverables, and expectation on movement is slow burn. The Board of Directors may wish to undertake deep dives on each of the strategic risks in turn at its meetings. The Executive Team may assign Strategic risks to a specific Committee for overview and scrutiny.

With effect from January 2022, subject to approval by the Board, there are six strategic risks.

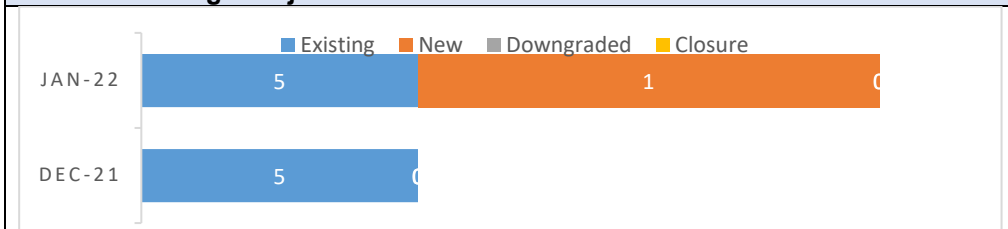
De-escalation of all other former BAF risks to the Corporate Risk Register has taken place. The Executive Team corporate risk review has taken place and as a result, there are some de-escalations and closures as well as one escalation to the Strategic Risk Register.

2.0 BAF Dashboard December 2021/ January 2022

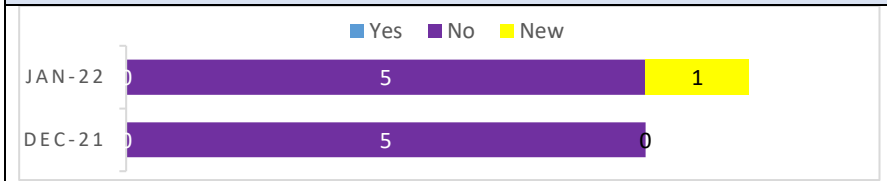
Click here to return to Index

Strategic Risks January 2021

Risks to Strategic Objectives



Risk Score Movement



Risk Score Profile

	RISK RATING Consequence					
		1	2	3	4	5
Likelihood	1					
	2					
	3					SR3 SR5 SR6
	4					SR1 SR2 SR4
	5					

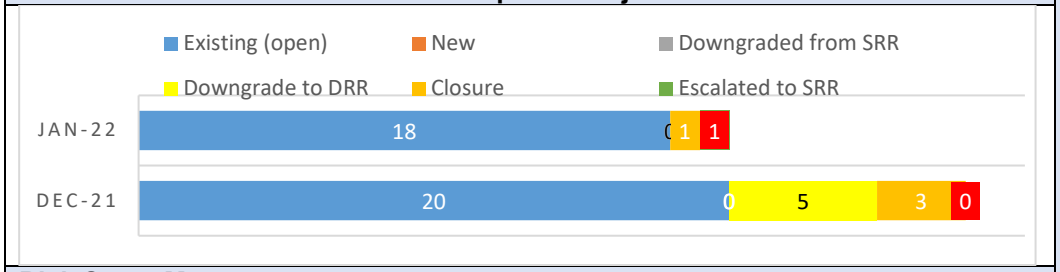
% risks reviewed by risk owners	Number of risks not reviewed	No movement 12 months	On RR more than 12 months	% risks with controls identified	% risks with assurance identified	% risks with actions overdue
83%	1	0	2	100%	100%	0%

ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
Existing risks								
SR1	1	**Safety**	Safety, Compliance, Service Delivery, Experience, Reputation	NH	5x4=20	20 20 20	Rising demand for services; Government MH Recovery Action Plan; Covid-19; Challenges in CAMHS and complexities; Systemic workforce issues in the NHS	Safety First, Safety Always Strategy in place
SR2	2	**People**	Safety, Compliance, Service Delivery, Experience, Reputation	SL	5x4=20	20 20 20	Replaced BAF50 Skills, Resource and Capacity National challenge for recruitment and retention	People Strategy will be in place by March 22 made up of a number of strategies
SR3	All	**Systems and Processes/ Infrastructure**	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	15 15 15	Capacity and adaptability of the support service infrastructure including HR, Facilities, ITT Systems, Estates, Finance, and Corporate Nursing to support frontline services. Recovery from HSE and Covid-19. Need to release clinical time.	Corporate services may not be optimal but are working and have generally supportive and positive internal audit commentary and reporting. Overseen by ESOG.
SR4	All	**Demand and Capacity**	Safety, Compliance, Service Delivery, Experience, Reputation	AG	5x4=20	20 20 20	Covid-19. Long-term plan. White Paper. Transformation and innovation National increase in demand on services Need for credible inpatient clinical model linked to community to drive service flows.	ECOO Service Delivery Model/ Strategy in implementation with clear road map for portfolio service areas

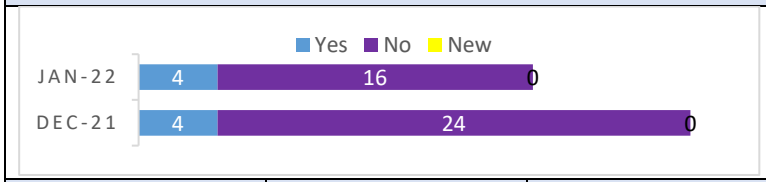
ID	SO	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
SR5	1	**Independent Inquiry**	Compliance, Reputation	NL	5x3=15	15 15 15	Government led independent inquiry into Mental Health services in Essex	Awaiting Memorandum of Understanding. One page strategy to be completed by end January 22
SR6	All	**Cyber Attack**	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	8 8 15 New Risk escalated from CRR	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Escalated to strategic risk register by EBAF January 22 with increased score

Corporate Risks January 2022

Risks to Corporate Objectives



Risk Score Movement



Risk Score Profile

	RISK RATING					
	Consequence					
Likelihood		1	2	3	4	5
	1					
	2					
	3				11 82 83 85↓ 92↓	34 ~~40~~↑ 74 81 84 91 93
	4				45 48 77 79 87	90 94
	5				~~86~~	

% risks reviewed by risk owners	Number of risks not reviewed	No movement 12 months	On a RR more than 12 months
100%●	0●	30% (6)●	50% (10)●

% risks with controls identified	% risks with assurance identified	% risks with actions overdue
100%●	100%●	0%●

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
Existing Risks							
CRR11	Suicide Prevention	Safety	NH	4x3=12	12 12 12	Implementation of suicide prevention strategy	Level 1: Suicide Prevention Group Level 2: Mortality Sub-Committee/ ESOG
CRR34	Suicide Prevention - training	Safety	NH	5x3=15	15 15 15	Implementation of suicide prevention strategy	Level 1: Suicide prevention group Level 2: Mortality Sub-Group and ESOG
CRR45	Mandatory training	Safety	SL	4x4=16	16 16 16	Training frequencies extended over Covid-19 pandemic leaving need for recovery	Level 1: Training Tracker Level 2: Training Reporting via performance report Level 3: IGDSPT
CRR48	Medical & Consultant capacity	Safety, Service Delivery	MK	4x4=16	16 16 16	Recruitment challenges	Level 2: National Fellowship Scheme Currently there are 20 Consultant vacancies, of which Locum posts cover 16.
CRR74	Airlocks	Safety, Compliance	TS	5x3=15	15 15 15	CQC raised concerns following an AWOL from unit without an airlock	Level 2: HSSC / EERG
CRR77	Medical Devices	Safety, Financial, Service Delivery	NH	4x4=16	16 16 16	Number of missing medical devices compared to Trust inventory	Level 1: Medical Device Inventory Level 2: Medical Devices Group
CRR79	Seasonal flu	Service Delivery	NH	4x4=16	16 16 16	Annual Flu vaccination programme	Level 1: Flu project group Level 2: Clinical Governance and Quality
CRR81	Ligature	Safety, Compliance, Reputation	TS	5x3=15	15 15 15	Patient safety incidents	Level 1: Local risk assessment and incident reporting Level 2: Annual Ligature Inspections and LLRG Level 3: Internal Audit BDO 2021/ ELFT Independent Review 2021

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
CRR82	Efficiencies 21/22	Financial	TS	4x3=12	16 12 12	Contract requirements	Level 1: Board Level 2: Regional, ICS and service efficiency groups
CRR83	Covid-19 Financial	Financial	TS	4x3=12	12 12 12	Financial regime during Covid-19	Level 1: F&PC EOSC BOD Level 2: ICS sustainability exercise
CRR84	Purposeful Admissions	Safety, Compliance, Service Delivery	AG	5x3=15	15 15 15	Out of area placements, Mental Health Act Review, effective and timely discharge	Level 1: Steering Group Level 2: Out of area placement at lowest for two years
CRR85	Mass Vaccination	Service Delivery	NL	4x5=20	12 20 12	Covid-19 pandemic	Mass Vaccination project in place CRR85 and CRR86 merged into CRR85 as one mass vaccination programme Recommend decrease in Score
CRR87	12-15 Suffolk Mass Vaccination	Service Delivery	NL	4x4=16	20 16 16	Covid-19 pandemic – potential failure of current contract provider	NHSE/I putting pressure on HPT. EPUT added capacity to support system. Decreased score in December 21.
CRR90	Management of Covid-19	Service Delivery	NL	5x4=20	10 20 20	Covid-19 pandemic	Level 1: Project management board Level 2: Assurance from twice daily project meetings Increased score in December 21.
CRR91	CAMHS Tier 4 System Bed Pressures	Safety, Compliance	AG	5x3=15	20 15 15	CQC S31 System bed pressures/ lack of specialist CAMHS beds	Intensive Support Group and daily escalations Managers Assurance report to ESOG Decreased score in December 21.
CRR92	Addressing Inequalities	Experience	SL	4x4=16	16 16 12	Risk was escalated from Corporate Risk Register to the BAF in March 2021 – de-escalated November 21	Overseen by E&ISC EDS2 2020/21 scored positively by stakeholders, EDS2 2021/22 approved by stakeholder focus group and E&ISC. Positive responses in most recent staff survey. SL recommends decreased score January 22
CRR93	Continuous Learning	Safety, Compliance	NH	5x3=15	15 15 15	HSE and CQC findings highlighting learning not fully embedded across all Trust services	Culture of learning is a key priority project Overseen by ESOG
CRR94	Engagement and supportive observation	Safety, Compliance	AG	5x4=20	16 20 20	CQC found observation learning not embedded	Observation is a key priority project Overseen by ESOG and BSOG Increased score in Dec 21
Closed and Escalated to SRR in January 2022							
CRR40	Cyber Attack	Safety, Compliance, Service Delivery, Experience, Reputation	TS	5x3=15	8 8 15	The risk of cyber-attacks on public services by hackers or hostile agencies. Vulnerabilities to systems and infrastructure.	Increase score and escalate to SRR Jan 22
Closed and De-escalated to DRR(s) in December 2021							
CRR53	Dormitory elimination	Safe, Compliance, Service Delivery	TS	4x3=12	12 12 12	Eliminating mixed sex accommodation	Level 1: Capital Group De-escalated to Estates DRR Dec
CRR68	GWPRA	Safe, Compliance	PS		16 16 16	Delays in reviewing GWPRAs	Level 1: HSSC Level 3: IA commissioned De-escalated to DRR and HSSC Dec 21
CRR72	STaRS IT/ Communication systems	Service Delivery	~~TS~~ AG	4x3=12	12 12 12	STARS and Dual Diagnosis services concerns raised with IT/Communication systems	De-escalated to Specialist Services and IT DRRs Dec 21 Lead changed from TS to AG

ID	Title	Impact	Lead	CRS	Risk Movement (last 3 months)	Context	Comments
CRR80	Fire Safety	Safe, Compliance, Service Delivery	TS	5x3=15	15 15 15	Maintaining fire safety	Level 1: Fire training Level 2: HSSC and Audit Committee Level3: Internal Audit De-escalated to Estates DRR Dec 21
CRR88	Diabetes Service	Safe, Experience, Service Delivery	AG	4x5=20	20 20	Escalated from Directorate Risk Register System pressures	This risk relates to SEECHS – consider the mitigation in place in West Essex De-escalated to Operations DRR Dec 21
Closed risks December 2021							
CRR76	Quality of linen	Safe	TS	5x2=10	10 10 10	Reduction in quality of linen	Level 1: Safety alert to staff via Datix Level 2: Daily quality inspections Closed December 21
CRR78	Supply of blood collection tubes	Service Delivery, Experience	NH	3x2=6	9 9 6	National disruption to supply of bloods collection tubes	Level 1: Cascaded instruction to all staff via command Level 2: Assurance at weekly command meeting Closed December 21
CRR89	Defibrillator pads	Safe, Compliance, Service Delivery	NH	5x3=15	15 15	Shortage in supply chain	Level 1: CAS alert Closed December 21
Closed Due to Merger							
CRR86	12-15s Mass Vaccination	Service Delivery	NL	4x5=20	16 20 Merge	Covid-19 pandemic	Recommend closure and merger into CRR85 January 2022

3.0 Strategic Objectives

Click here to return to Index

OBJECTIVE 1	We will deliver safe, high quality integrated care services	Owner	Natalie Hammond

Risk Summary

There are 15 risks, including CRR risks, currently identified against the achievement of Objective 1:

- SR1 Safety, risk score 5x4=20. No risk score changes in last 3 months.
- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR3 Systems and Processes/ Infrastructure 5x3=15. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- SR5 Independent Inquiry, risk score 5x3=15. No risk score changes in last 3 months. Managed by Special Projects Team
- SR6 Cyber-attack, risk score 5x3=15. Escalated to strategic risk register in December 21 with increased risk score.
- CRR11 Suicide prevention, risk score 4x3=12. Risk score unchanged in last 3 months.
- CRR74 Airlocks, risk score 5x3=15. No risk score changes in last 3 months.
- CRR77 Medical devices, risk score 4x4=16. No risk score changes in last 3 months.
- CRR81 Ligature reduction, risk score 5x3=12. No risk score changes in last 3 months. De-escalated from SRR.
- CRR82 Efficiencies, risk score 4x3=12. Risk score decreased in last 3 months. De-escalated from SRR.
- CRR83 Covid-19 Financial Plan, risk score 4x3=12. No risk score changes in last 3 months.
- CRR84 Purposeful Admissions, risk score 5x3=15. No risk score changes in last 3 months.
- CRR93 Continuous Learning, risk score 5x3=15. No risk score changes in last 3 months. Being managed via key priority project 'Culture of Learning'
- CRR94 Engagement and Supportive Observation, risk score 5x4=20. Risk score increased in last 3 months. Managed via key priority project.

OBJECTIVE 2	We will enable each other to be the best that we can	Owner	Sean Leahy

Risk Summary

There are 7 risks, including CRR risks, currently identified against the achievement of Objective 2:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR34 Suicide prevention – training, risk score 5x3=15. Risk score increased in last 3 months.
- CRR45 Mandatory training, risk score 4x4=16. No risk score changes in last 3 months.
- CRR48 Medical and Consultant vacancies, risk score 4x4=16. No risk score changes in last 3 months.
- CRR79 Seasonal flu, risk score 4x4=16. No risk score changes in last 3 months.
- CRR92 Addressing Inequalities, risk score 4x3=12. Risk score decreased in last 3 months. Being managed by Equality and Inclusion Sub Committee and monitored using EDS2 scores

OBJECTIVE 3	We will work together with our partners to make our services better	Owner	Alex Green

Risk Summary

There are 3 risks currently identified against the achievement of Objective 3:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR91 CAMHS Tier 4 System Bed Pressures, risk score 5x3=15. Risk score decreased in last 3 months. Being managed by CAMHS Intensive Support Group overseen by ESOG

OBJECTIVE 4	We will help our communities to thrive	Owner	Paul Scott

Risk Summary

There are 6 risks, following approval by Board, currently identified against the achievement of Objective 4:

- SR2 People, risk score 5x4=20. No risk score changes in last 3 months.
- SR4 Demand and Capacity, risk score 5x4=20. No risk score changes in last 3 months.
- CRR85 Mass Vaccination Adults, risk score from 3x4=12. Risk score increased and decreased in last 3 months. Managed by Mass Vaccination Project.
- CRR86 Mass Vaccinations 12-15 age group, risk closed and merged January 22 with CRR85. Managed by Mass Vaccination Project.
- CRR87 Mass Vaccinations 12-15 Suffolk, risk score reduced in last 3 months. Managed by Mass Vaccination Project.
- CRR90 Management of Covid-19, risk score increased in last 3 months. Being managed by Command Structure overseen by Executive Team

Potential new emerging risk

- CRR95 Covid-19 Omicron wave, initial risk score 4 x 4 = 16

4.0 Key Risks

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Table 1 – Strategic Risks

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
SR1 SO1 We will deliver safe, high quality integrated care services Lead: Natalie Hammond Standing Committee: Quality Committee	**SAFETY** 20 > 20 > 20 Initial Score C5 x L4 = 20 Interim Target March 22 5 x 4 = 20 Milestones against strategy March 23 5 x 3 = 15 March 24 5 x 2 = 10	If EPUT does not invest in safety or effectively learn lessons from the past then we may not meet our safety ambitions resulting in a possibility of experiencing avoidable harm, loss of confidence and regulatory requirements	Rising demand for services Government Mental Health Recovery Action Plan Covid-19 operational challenges and unknown consequences for future demand on services Challenges in CAMHS and cohort of patients with complex needs Systemic workforce issues in the NHS	PMO Patient Safety Specialist Programme embedded culture of learning, staff training programmes, events, communication briefings, webinars and podcasts Executive Oversight Committee and PMO Prioritising/driving improvements PSIRF early adopter expedite learning from incidents, building change programmes £10m capital investment essential safety improvements and transforming wards Revised Involvement and Engagement Strategy including co-production projects supported by NHSE/I Schwartz rounds insight into wellbeing support for via structured feedback Wellbeing offer including 'Here for you' confidential staff support Innovation EPUT Lab, Quality Academy and partnership initiatives	Dates to be agreed: Establish process to capture, measure and report on new and hard-to-measure key outcomes Establish regular report rhythm for outcomes/ measures Formalise single quality improvement activities programme Complete quality frameworks and actions plans for four priority areas – Reducing restrictive practice framework 2022-25 published Mapping/ streamlining governance for best use of resources while maintaining oversight and accountability Address spike in physical intervention and seclusion Implement involvement and engagement strategy	Safety First, Safety Always Strategy Quality Committee Strategy Progress Report Culture of learning progress report ESOG Minutes	Improve patient safety across all key theme trajectories by March 2023 Deliver the National Zero Suicide Ambition and reduce incidents of self-harm by 2023 Achieve a sustained improvement in physical health outcomes Reduce sexual safety incidents by 20% by March 2023 Reduce the use of restrictive practices by 10% by March 2023 – significant work continues on restrictive practice framework and will align with Safety Strategy work

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
SR2 All SOs Lead SL PECC	**PEOPLE** 20 > 20 > 20 Initial Risk Score 5 x 4 = 20 Interim Target March 22 5 x 4 = 20 Milestones against strategy March 23 5 x 3 = 15 March 24 5 x 2 = 10	If we do not adequately address and manage fluctuating staff supply and demand then we will be unable to deliver high quality care or experience resulting in not attaining our vision, values, safety, quality and compliance ambitions or maintaining high reputation	• National recruitment challenges • Acuity of service users • High level of observations • High number of deep dives • Demand for clinical staff • Establishment vacancies • Staff retention • Releasing time to care • Staff wellbeing and lifestyle • Mandatory vaccinations from 1 April 22 • Recovery from HSE and Covid-19 • NHS People Plan	• Daily Sitrep actions – SafeCare used in sitreps • Health Roster system • Recruitment and Retention policy and process • Safe Staffing Programme – analysis completed • Actions from Staffing Narrative Reviews • Actions from Cultural Reviews – these have commenced with two completed so far and one near completion • ESR/EFIN alignment – increased visibility of vacancies • Leadership structure determined with some business partners in place – recruitment ongoing, offers expected by end December • Recruitment branding design complete • 10 nurses recruited from international recruitment project • Healthcare support workers new initiative with Indeed and ICS to source candidates • Development pathway created for newly qualified nurses • MHost training commenced 13/12 • Safer Staffing Risk Assessment Dec 21 • EPUT is delivering against the People Plan and ahead of target	• Corporate business partnering • Develop action plan (SB/LD by Dec 21) • Develop People Strategy (March 22) themed: **Experience (culture)** Cultural reviews/ shared learning, engagement of flexible workforce - cultural reviews in progress, shared learning – evaluation of outcomes in order to facilitate shared learning across EPUT **Attract staff** Recruitment branding (JB/MG) – in progress, design roll out review incentives, review/ update employee proposition **Recruitment** New qualified nurses, robust strategy, international recruitment and 'onboarding' strategy not in place yet, international recruitment project – aim to get 50 nurses by end March 22. 80 newly qualified nurses placed this year, next year 100 planned and 200 international nurses altogether. 154 apprentices on different programmes as part of 'grow your own' project; help develop staff to registered practitioner status. **Development** Education, pathways and workforce planning (AH). A number of pathways in place. Working on ways to improve the process, early stages. **Retention** Employee proposition, engagement, equity Retention action plan (MC)	• People and Culture Committee (PECC) • Safer staffing data • Patient safety incidents • Project updates to ESOG and BSOG	Delivery of elements of the proposed People Strategy (see gaps in controls) – dates to be agreed

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
				• Patient Engagement Strategy presenting to PECC Jan 22 • Workforce Strategy (Equality Engagement and Experience) presenting to PECC Feb 22 • Marketing and Communications Strategy presenting to PECC Mar 22 • Newton phase 2 'Time to Care' presenting to PECC Jan 22 – includes international recruitment establishment • Retention task and finish group in place • Links to culture of learning project through engagement	**Skill mix/ redesign** Shared learning, establishment review and interim uplifts, new roles - new roles in CAMHS. Interim establishment paper going to ET 14/12. Establishment review Feb 22 **Workforce Technology** Optimisation of workforce systems Digital strategy will inform this **Data/Insight** Staffing narrative review and gap analysis in progress Data/insight work needs defining, with resource allocation **Workforce Planning** R&R strategy, identifying future EPUT needs, talent gaps, population we serve Workforce action plan requires broadening (AH)		

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
SR3 All SOs Lead: TS Standing Committee: F&PC	**SYSTEMS AND PROCESSES/ INFRA-STRUCTURE** 16 16 16 Initial Risk Score 4 x 4 = 16 Target March 22 4 x 3 = 12 Target March 23 4 x 2 = 8	If our systems, processes and infrastructure do not continue to adapt to support clinical services then we may not have the right facilities/ resources to deliver safe, high quality care resulting in not attaining our safety, quality/ experience and compliance ambitions	Capacity and adaptability of the support service system and process infrastructure including HR, Facilities, ITT Systems, Estates, Finance, Corporate Nursing to support frontline services Recovery from HSE and Covid-19 Need to release clinical time Corporate services may not be optimal but are working and have generally supportive and positive internal audit commentary and reporting	Actions from corporate service reviews (Estates and HR baseline reviews) Capital programme in place Internal Audit programme in place Weekly PMT integration meetings with ITT in place Appointment made to Director of Corporate Services and Governance Appointment made to Director of Strategy and Transformation	Corporate business partnering, review support service structures – (progressing and expected completion early 2022) Develop clear enabling strategy - Lead/date TBA Develop/ implement digital strategy (Dec 21 Executive Team then Jan 22 Board meeting for approval with recommendations for an operating model to deliver the strategy through core milestones) Develop Estates transformation programme of work Develop programme of work in PMO to bridge Estates and ITT - PMO will align organisational programmes Ensure staff intake and accommodation match Review tenancy responsibilities/ leased property risks, staff vs property owner accountability, PFI contract deficiencies Operational restructure – progressing Finance, Contracting and Business Development, and Estates structure papers going to F&PC and/or ET Implement electronic risk register Review commercial strategy Mar 22	Project Management Office (PMO) ESOG Audit Committee	To be completed on approval of the Strategy with dates TS to consider how this risk is managed across portfolios

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
SR4 All SO's Lead AG Standing Committee: PECC	**DEMAND/ CAPACITY** 20 > 20 Initial Score C5 x L4 = 20 Target scores to be agreed in line with model/ strategy	If we do not effectively address demands then our resources may be over-stretched resulting in an inability to deliver high quality safe care, transform, innovate and meet our partnership ambitions	Covid-19 Long-term plan White Paper Transformation and innovation – transformation strategy for mental health, and hospital models in West Essex National increase in demand on services Need to form expert areas and centres of excellence to enable culture shift for delivery of outstanding services with empowered operational, clinical, safety and quality leadership and corporate business partnering Need for credible inpatient clinical model linked to community to drive flow through services	First integrated Director appointed in Thurrock (joint appointment across systems) MSE Connect programme has demonstrated the approach that works for system change to transform outcomes for older people and now undertaking diagnostic with Newton Europe to develop the PCN and population health management evidence base that will allow quantification and development of opportunities to deliver improved outcomes EPUT operational structure agreed – to be stood up in January 22 providing leadership stability	**ECOO Service Delivery Model/ Strategy** – **Clear road map for portfolio service areas** using modelling, human system learning and integration of physical/ mental health **Local place based service leadership** and local operating plans for physical/ mental health, with dedicated oversight for inpatients **Key design principles of Service Delivery Model/ Strategy:** Service Group with collective responsibility; business partnership model, CMO/ Doctors providing clinical leadership within services Quality leadership by nursing, Allied Health Professionals and social work **Operational Director** accountable for service delivery through accountability and governance frameworks **Facilitating partnerships** including social care and voluntary sector as well as service user voice **Progressing for Inpatient Adult Mental Health:** Inpatient modelling with bed capacity that supports demand	F&PC Board ESOG System Oversight and Assurance Groups	**Alignment of operating model with Safety First Safety Always Strategy** – safer outcomes evidenced through the implementation of the Safety Strategy **Alignment to the accountability framework** **Alignment with overarching EPUT Five Year Strategy** – partner of choice evidenced through optimised business processes and sustainable partnerships and collaboration **Deliver the safety and quality agenda** through clinical and professional leadership driving excellence **Deliver the strategic objectives and ambitions** through an engaged and capable workforce – great place to work evidenced through staff engagement and cultural surveys, recruitment and retention **Deliver integrated health and social care solutions** through an outward facing and partner focus **Facilitate physical and mental health integration** at a local community level **Co-production** at the core of everything we do evidenced through the service user feedback, reduction in complaints, peer review networks, service user satisfaction surveys and engagement

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
					Sitrep processes Flow project linked to safety ambitions Robust out of area plan Emotionally unstable personality disorder (EUPD) PD inpatient pathways Community flow Purposeful admissions **Integrated Director posts** North East, West, Basildon and Brentwood, South Essex, Mid Essex – all out to advertisement **First inpatient Director** Appointment jointly across all systems in January 2022 **Diagnostics** All systems (EPUT leadership support in place NEE)		

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
SR5 SO1 Lead: NL Standing Committee: Quality Committee	**INDEPENDENT INQUIRY** 15 → 15 → 15 Initial Risk Score 5 x 4 = 20 Current Risk Score 5 x 3 = 15 Interim Target March 22 5 x 3 = 15 Target at end of Inquiry 4 x 2 = 8 No action plan required	If EPUT is not open, transparent or demonstrates learning from or effectively manage the Essex Mental Health Independent Inquiry then it may not deal with the consequences of past failings resulting in not attaining our safety, quality/ experience and compliance ambitions	Government led independent inquiry into Mental Health services in Essex	• Executive Lead identified • Established governance process • Updating stakeholders including NHSE/I • Core team in place including legal, with appropriate skills, and resources required to support EPUT internally • Independent Director and Independent Medical Advisor appointed – will play an advisory role and report into the chair of Audit Committee and Inquiry, and ensure we are transparent in our actions • Inquiry Terms of Reference now published both publically and on EPUT's website • Meetings with the Inquiry Secretariat ongoing to provide information requested • Call for evidence has commenced	Strategy for dealing with the Inquiry in development (end Jan 22)	Major EPUT project EOSC ESOG Audit Committee Board of Directors	**Pick up the historical elements of the HSE investigation** through a dedicated estates work stream under ESOG – ESOG now looking at picking up more of the themes identified from previous action plans and SIs – specifically physical healthcare, care planning and risk assessment **If/ when asked** demonstrate how we are supporting staff through the impact of the HSE investigation; demonstrate how we are improving partner approaches to EPUT through the impact of the HSE investigation; demonstrate actions on fixed ligatures and safety strategy **Awaiting Memorandum of Understanding** **Review the significant number of data requests** and associated governance/ disclosure requirements **Learning** through ET and Audit Committee – include Learning Oversight Group – currently process Later link with Culture of Learning

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
~~CRR40~~ SR6 SO1 Lead TS Quality Committee	**CYBER ATTACK** 8 8 15 Initial Risk Score 4 x 3 = 12 Current Risk Score increased to 5 x 3 = 15 and escalated to Strategic Risk Register Jan 22	If we experience a cyber-attack then we may encounter system failures and downtime resulting in a failure to achieve our safety ambitions, compliance, and consequential financial and reputational damage	Currently an inherent risk within NHS and risk to strategic objectives	• Windows 10 upgrade licences now purchased • Cyber Team in place • Robust updates and patching • Software asset risk log in place • Series of preventative measures in place to protect EPUT networks and scanning all systems, also patching systems with patches released for affected systems • National cyber team in touch with large vendors • Microsoft Defender for endpoints in place with NHS Digital	Mitigation of end of life software Mitigation of gaps in cyber essentials	Level 3: Information Governance Data Security and Protection Toolkit (IG DSPT) compliance and Cyber Essentials Accreditation	• End of life software in EPUT has been identified and placed on the cyber risk log - mitigation options to be presented to IGSSC • Cyber Essentials Accreditation dry run highlighted some expected areas to focus on with mitigation being implemented and date for final certification to be set when ready (dates extended through C19) • Ensure compliance with IG DSPT, which is the measure of EPUT's compliance with cyber standards • EBAF discussion 21/12 CEO reflected that discussion should take place on escalating this to the strategic risk register – agreed with AW Jan 22 • Cyber team gathering information on systems that may be impacted by vulnerability in software package called Log4j

Table 2 – Corporate Risks 20 or above and new risks

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
CRR90 SO4 Lead NL Quality Committee	**Management of Covid-19** 10 → 20 → 20 Initial Risk Score 5 x 3 = 15 Current risk score increased Dec 21 to 5 x 4 = 20 Target March 22 5 x 2 = 10	If EPUT does not manage Covid-19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Covid-19 pandemic	• BCPs • Command structure • Sit rep daily monitoring • Covid-19 intranet page and range of staff training in place • Covid-19 dashboard issued weekly to monitor prevalence • NED and Executive Lead for Emergency Planning agreed (NL) • Demonstrating lessons learnt from Covid-19 through bi-monthly Trust Board reports and EPRR quarterly report • Action Plan completed	• Prepare for Covid-19 Statutory Inquiry • Review emergency planning processes in light of Covid-19 experience • Hold internal emergency planning exercise	Level 1: Action plan completed Level 2: EPRR Team / IPC Team Level 3: EPRR Standards	• Covid-19 IPC risk increased in score and escalated
CRR94 SO1 Lead AG Quality Committee	**Engagement and Supportive Observations** 16 → 20 → 20 **Current Risk Score 5 x 4 = 20** **Initial Risk Score 4 x 4 = 16** **Target March 22 4 x 2 = 8**	If EPUT does not manage supportive observation and engagement then patients may not receive the prescribed levels resulting in undermining our Safety First, Safety Always Strategy	CQC found observation learning not embedded	• Engagement and Supportive Observation project • Observation T&F Group with action plan • Weekly ward huddles and discussing perfect ward reports • ADs undertaking 15 leadership steps each week • New videos implemented in CAMHS • National piece of work to develop CQC standards for inspections in relation to observation and engagement – daily and weekly documentation checks across all MH and specialist services with comprehensive audits using PerfectWard	E-observation work moving forward with trial starting in Feb 22	Level 1: Perfect Ward Audits ESOG BSOG Accountability Framework	• Add dates • Continue with training videos • Link to purposeful admissions work • Enhance with planned staffing improvements enabled by digital tools, engagement with AHPs and improved oversight through the accountability framework • Perfect Ward audit results • Incidence of harm • Task and Finish Workstreams in train – policy refresh, clinical audit, e-observations, training and armbands • Discuss effectiveness and content of documentation used to record engagement and

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
				• Recording forms rolled out to MH and SS through policy revision • Produced short informational films on key elements of observation and engagement with an emphasis on record keeping • Electronic tool trial • Collation of learning • Ongoing task and finish group • Task and finish action plan • Piloting Oxehealth's digital e-observation software (Dec 21) – increase quality and flexibility of observation recording and observation level changes/ approvals to positively impact patient safety events • New policy approved at QC Jan 22			observations when reviewing policy • Annual audit using data from PerfectWard

5.0 Strategic and Corporate Risk Movement and Milestones – two-year period February 2020 to January 2022

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5.1 Strategic Risk Movement

Risk ID	Initial Score	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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Risk ID
SR1	20																					New	20	20↔	20↔	SR1
SR2	20																					New	20	20↔	20↔	SR2
SR3	15																					New	15	15↔	15↔	SR3
SR4	20																					New	20	20↔	20↔	SR4
SR5	20										New	20	20↔	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	SR5
SR6	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	15↑	SR6

5.2 Strategic Risk Milestones

Risk ID	Initial Score	Time on SR/ old BAF	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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Risk ID
SR1	20	<6 months																					New	20			SR1
SR2	20	<6 months																					New	20			SR2
SR3	15	<6 months																					New	15			SR3
SR4	20	<6 months																					New	20			SR4
SR5 (BAF54)	20	>1 year										New	20					15↓						SR			SR5 (BAF54)
SR6 (CRR40)	12	>1 year	8																						CRR	15	SR6 (CRR40)

5.3 Corporate Risk Movement

Risk ID	Initial Score	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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Risk ID
CRR11	16	16↔	16↔	16↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	8↓	12↑	12↔	12↔	12↔	12↔	12↔	CRR11
CRR34	9	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	9↔	15↑	15↔	15↔	15↔	15↔	15↔	CRR34
CRR40	12	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	8↔	SR	CRR40
CRR45	12	12↔	12↔	12↔	12↔	12↔	12↔	16↑	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR45
CRR48	20	20	20	20	20	20	20	20	20	20	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR48
CRR53	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	De-esc		CRR53
CRR68	16						New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	De-esc		CRR68
CRR72	12									New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	De-esc		CRR72
CRR74	15										New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR74
CRR76	20													New	20	20↔	15↓	15↔	15↔	15↔	10↓	10↔	10↔	Closed		CRR76
CRR77	16														New	16	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	16↔	CRR77
CRR78	9																		New	9	9↔	9↔	9↔	6↓closed		CRR78
CRR79	16																			New	16	16↔	16↔	16↔	16↔	CRR79
CRR80	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	De-esc		CRR80
CRR81	12	20↔	20↔	20↔	15↓	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR81
CRR82	16																New	16	16↔	16↔	16↔	16↔	12↓	12↔	12↔	CRR82
CRR83	12			New	12	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	12↔	CRR83
CRR84	15																New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR84
CRR85	20									New	20	20↔	20↔	15↓	15↔	12↓	12↔	12↔	12↔	12↔	12↔	12↔	12↔	20↑	12↓	CRR85
CRR86	16																					New	16	20↑	Merged	CRR86
CRR87	20																					New	20	16↓	16↔	CRR87
CRR88	20																					New	20	De-esc		CRR88
CRR89	15																					New	15	Closed		CRR89
CRR90	15	New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	10↓	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	10↔	20↑	20↔	CRR90
CRR91	20																		New	20	20↔	20↔	20↔	15↓	15↔	CRR91
CRR92	20													New	20	20↔	16↓	16↔	16↔	16↔	16↔	16↔	16↔	16↔	12↓	CRR92
CRR93	15														New	15	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	15↔	CRR93
CRR94	16																		New	16	16↔	16↔	16↔	20↑	20↔	CRR94

5.4 Corporate Risk Milestones

Risk ID	Initial Score	Time on CRR or old BAF	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	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Risk ID
CRR11	16	> 2 years				12														8	12						CRR11
CRR34	9	> 2 years																			15						CRR34
CRR40	12	> 2 years																							Esc	SR	CRR40
CRR45	12	> 2 years							16																		CRR45
CRR48	20	> 2 years										16															CRR48
CRR53	12	> 2 years																									CRR53
CRR68	16	> 1 year							16																DRR		CRR68
CRR72	12	> 1 year										12													DRR		CRR72
CRR74	15	> 1 year											15														CRR74
CRR76	20	>6 months														20		15				10			Closed		CRR76
CRR77	16	>6 months																16									CRR77
CRR78	9	<6 months																			9				Closed	DRR	CRR78
CRR79	16	<6 months																				16					CRR79
CRR80	15	> 2 years																							De-esc	DRR	CRR80
CRR81	12	> 2 years				15↓																					CRR81
CRR82	16	<6 months																	16					12			CRR82
CRR83	12	> 1 year			New	12																					CRR83
CRR84	15	>6 months																	15								CRR84
CRR85	20	> 1 year									New	20			15		12								20	12	CRR85
CRR86	16	<6 months																						16	20	Merged	CRR86
CRR87	20	<6 months																						20	16		CRR87
CRR88	20	<6 months																						20	De-esc	DRR	CRR88
CRR89	15	<6 months																						15	Closed		CRR89
CRR90	15	> 1 year	New	15								10													20		CRR90
CRR91	20	<6 months																			20				15		CRR91
CRR92	20	>6 months													New	20		16								12	CRR92
CRR93	15	>6 months														New	15										CRR93
CRR94	16	<6 months																		New	16				20		CRR94
CRR95	16	<6 months																								16	CRR95

6.0 Recommendations to the Board of Directors

Click here to return to Index

1. Note the decisions made by the Executive BAF Sub-Group at its meeting in December 2021 (See table below)
2. Note the Board Assurance Framework Dashboards in Section 2 for December 2021 and January 2022 (See table below)
3. Note the risks linked to Strategic Objectives in Section 3
4. Note the key risks in Section 4
5. Note the Strategic Risks and Milestones in Section 5
6. Approval of new strategic risk SR6 Cyber-Attack. (Section 2 with further detailed descriptor in Section 4)
7. Approval of increases and decreases in scores on corporate risks (Section 2)
8. Approval of merger of CRR85 and CRR86 (Section 2)
9. Request any further information or action

Please see table below for summary of changes in December 2021 and January 2022:

Dec 2021 Decisions	Jan 2022 Decisions
New Strategic Risks	**New Strategic Risks for Approval**
None	SR6 Cyber-Attack (score increased to 15)
Strategic Risks recommended for de-escalation to Corporate Risk Register	**Strategic Risks recommended for de-escalation to Corporate Risk Register**
None	None
Strategic Risks recommended for closure	**Strategic Risks recommended for closure**
None	None
New Corporate Risks	**New Corporate Risks for Approval**
None	None
Corporate Risks increased in score	**Corporate Risks recommended for increase in score**
CRR85 Mass Vaccinations adults (increased to 20)	None
CRR86 Mass Vaccinations 12-15 (increased to 20)	**Corporate Risks recommended for decrease in score**
CRR90 Management of Covid-19 (increased to 20)	CRR92 Addressing Inequalities (decreased to 12)
CRR94 Engagement and Supportive Observation (increased to 20)	CRR85 Mass Vaccinations (decreased to 12)
Corporate Risks decreased in score	**Corporate Risks recommended for de-escalation**
CRR87 Mass Vaccinations 12-15 Suffolk (decreased to 16)	None
CRR91 CAMHS Tier 4 System bed pressures (decreased to 15)	
Corporate Risks de-escalated to Directorate RR(s)	
CRR53 Dormitory Elimination	
CRR68 GWPRA	
CRR72 STaRS IT/ Communication systems	
CRR80 Fire Safety	
CRR88 Diabetes Service (SEECHS)	
Corporate Risks closed	**Corporate Risks recommended for closure**
CRR76 Quality of Linen	CRR40 Cyber-Attack (increased in score to 15 and escalated to Strategic RR)
CRR78 Supply of blood collection tubes	CRR86 Mass Vaccinations 12-15 (merged into CRR85)
CRR89 Defibrillator pads	

		Agenda Item No: 8bii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	Charitable Funds Committee Assurance Report					
Executive/ Non-Executive Lead:	Amanda Sherlock, Non-Executive Director					
Report Author(s):	Carol Riley, PA to Chief Finance Officer					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of risks highlighted in this report	N/A
Which of the Strategic risk(s) does this report relate to:	N/A SR1 Safety SR2 People (workforce) SR3 Systems and Processes/ Infrastructure SR4 Demand/ Capacity SR5 Essex Mental Health Independent Inquiry SR6 Cyber Attack
Does this report mitigate the Strategic risk(s)?	~~Yes~~/ No
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	~~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 Charitable Funds Committee have been appropriately complied with and adhered to.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 To confirm acceptance of assurance given in respect of risks and actions identified
3 Request any further information or action.

Summary of Key Issues

- IT Equipment Lending Library
- Report of the Financial Trustee
- Update on NHS Charities Together Grants
- Outcome of General Bidding Round 2021/22

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Amanda Sherlock **Chair of Charitable Funds Committee**

Agenda Item: 8bii
Board of Directors
26 January 2022

ASSURANCE REPORT FROM THE CHAIR OF THE CHARITABLE FUNDS COMMITTEE

1. Purpose of Report

This report is provided to the Board of Directors by the Chair of the Charitable Funds Committee. It is designed to provide assurance to the Board of Directors that the duties of the Charitable Funds Committee have been appropriately complied with and risks that may affect the achievement of the organisations objectives are being managed effectively.

2. Executive Summary

The Charitable Funds Committee met on the 30 November 2021 and approved the minutes of the meeting held on the 9 September 2021. These are available to Board members via Content Locker.

At the meeting held on 30 November 2021 the following matters were discussed:

IT Equipment Lending Library - Presentation
The presentation highlighted the success of the above. However, it was noted that a business case may be required to fund the scheme long term.

Report of the Financial Trustee
As at the end of October 2021, the overall charitable fund had a value of £1,152,150, which was an increase of £29,213 from the previously reported value at the end of July 2021.

Funds continue to be held in a mix of long term investments and short term deposits, with outstanding creditors of £7,500. This creditor includes the audit fee for previous and current financial years.

Update on NHS Charities Together Grants
In addition to the Stage 1 grants which the Charity has already allocated to a number of schemes, the Charity has also been able to bid for Stage 2 and Stage 3 grants.

Board approval is required with regards to Stage 3 bids as the total of the bid exceeds the Committees delegated limit of £10k. A separate paper has been prepared for requesting Board approval under agenda item 7d.

Outcome of General Bidding Round 2021/22
At the meeting held in September 2021, the Committee approved the roll out of the bidding process against the general purpose funds. In total, 28 bids were received totalling £224,224. This compares to available funds of £40,553, including the balance of the NHS Charities Together Stage 1 grant.

Out of the 28 bids received, 22 were approved from Charitable Funds, 2 were approved from Trust Capital, 2 were approved from Trust non-recurrent revenue and 2 were rejected. One bid is above the Committee's delegated authority and will require Board approval in respect of the provision of additional furnishings to Clifton Lodge totalling £12,455.

A separate paper has been prepared for requesting Board approval under agenda item 7d.

Management of Risk
This Committee is not responsible for managing any of the Trusts' significant risks (as identified in the Board Assurance Framework).

New Risks
There are no new risks that the committee has identified that require adding to the Trusts' Assurance Framework, nor bringing to the attention of the Board of Directors.

3. Action Required

The Board of Directors is asked to:

1. Note the summary of the meeting held on the 30 November 2021
2. Confirm acceptance of assurance given in respect of risks and actions identified
3. Request any further information or action.

Amanda Sherlock
Non-Executive Director
Chair of Charitable Funds Committee

		Agenda Item No: 8biii
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26th January 2022**

Report Title:	**Finance & Performance Committee Assurance Report**					
Executive/ Non-Executive Lead:	Loy Lobo Chair of the Finance & Performance Committee Paul Scott Chief Executive Officer					
Report Author(s):	Amy Tucker Senior Performance Manager					
Report discussed previously at:						
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	Listed in BAF report	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 assurance that the Finance & 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.	**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

Due to governance-lite arrangements introduced under the Covid-19 level 4 incident arrangements, the Finance & Performance Committee was held as a reduced agenda and reduced membership meeting this month.

Performance Report

The Committee agreed a light touch approach due to the COVID Level 4 incident status.
The Director of Mental Health Inpatients presented the Trusts Surge Plan, which was generated in response to increased pressures over recent weeks.

The current pressures are having an impact on performance for a number of our KPIs, the Surge Planning process monitors these pressures and will help to manage these risks. Services are also working on plans for restoration and recovery of services.

Committee members thanked the Director of Mental Health Inpatients for the exceptional response to these pressures and gave praise to all senior colleagues who have worked hard to maintain services.

Financial Update – Month 9 Results

The Director of Finance updated the Committee on the current financial position at Month 9.
The Chair of the Committee acknowledged the scale and volume of items being covered by the Finance Department and thanked the Director of Finance for their update.

2022-23 Planning Guidance & Budget Setting

The Director of Finance (Commercial) provided the Committee with an update for the external 2022/23 planning guidance and process, and internal budget setting proposals.

The Executive Chief Finance Officer provided reassurance to the Committee that continuous updates in regards to this plan will continue to be made to members and through the standard channels.

The Chair of the Committee thanked the Director of Finance (Commercial) for their update.

IFRS 16 Update

The Director of Finance appraised the Committee of work currently being undertaken on the national implementation of IFRS 16 (Leases), which will be applicable from April 2022.
The Chair of the Committee gave thanks for the information and update provided.

Capital Update

The Director of Finance fed back to the Committee their updates from the Capital Group and advised that draft capital planning guidance, along with allocations for 2022/23 to 2024/25 have been issued.
The Chair of the Committee acknowledged the update provided and gave thanks to the Director of Finance.

Contracts Update

The Director of Contracts informed the Committee that the Trust was successful in its bid for the Essex STaRS Service and is now establishing a mobilisation group working with the Commissioners.
The Committee thanked the Director of Contracts and were please that the Trust had retained the Essex STaRS Service.

Lighthouse Child Development Centre

The Interim Director of Integrated Care South East Essex joined the Committee to give an update on the current position with the Lighthouse Child Assessment Service.

The Committee thanked the Interim Director of Integrated Care South East Essex and requested that there was an update back to the Committee on a quarterly basis for this contract due to the risks around the potential waiting list on transfer of this service.

International Recruitment

The Executive Director of People & Culture and the Executive Chief Finance Officer presented the business case for International Recruitment to the Committee.

The Committee supported the plans in principal on the assumption the appropriate funding could be secured.

Any Risks or Issues

The Committee has agreed to note two risks:

- The Lighthouse project's uncertainty around the waiting list position on transfer of this service.
- The scale of activities the organisation is managing

Policy Extension & Approval Requests

The Committee approved the extension of the policies & procedures listed below:

- Raising Concerns (Whistleblowing) Policy
- Social Media Policy

Any Other Business

There was no other business.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Main Report

Lead
Loy Lobo **Non Executive Director**

Agenda Item 8biii
Board of Directors Meeting Part 1
26th January 2022

FINANCE AND PERFORMANCE COMMITTEE ASSURANCE REPORT

1.0 Purpose of Report

This report is provided by the Chair of the Finance and Performance Committee, Loy Lobo to provide assurance to Board members that the performance operational, financial and governance as at month 9 December 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.

Due to governance-lite arrangements introduced under the Covid-19 level 4 incident arrangements, the Finance & Performance Committee was held as a reduced agenda and reduced membership meeting this month.

2.0 Quality and Performance Report

The Committee agreed a light touch approach due to the COVID Level 4 incident status.

In December 2021 there were 6 areas of inadequate performance (5 in November):

- CPA Reviews
- Inpatient MH Capacity (Adults & PICU)
- Out of Area Placements
- Clients not seen in 12 months
- Psychology
- Sickness Absence

The Committee agreed a light touch approach due to the COVID Level 4 incident status.
The Director of Mental Health Inpatients presented the Trusts Surge Plan, which was generated in response to increased pressures over recent weeks.

The current pressures are having an impact on performance for a number of our KPIs, the Surge Planning process monitors these pressures and will help to manage these risks. Services are also working on plans for restoration and recovery of services.

Committee members thanked the Director of Mental Health Inpatients for the exceptional response to these pressures and gave praise to all senior colleagues who have worked hard to maintain services.

3.0 Financial Position – Month 9

The Director of Finance updated the Committee on the current financial position at Month 9.

The Trust is reporting a YTD surplus of £86k. The Capital annual plan remains £14.4m, YTD spend £6.8m (47% delivery compared to 31% for same period last year).
Cash balances (£85.0m) remain sufficient for trading activities.

FOT outturn remains at breakeven with Trust handling a number of risks, opportunities and uncertainties.

Other key activities include:
National and Local Planning 2022/23. Capital and Revenue allocations have been released. Significant reductions in COVID funding, convergence adjustments and increase in efficiency requirement.
International Financial Reporting Standard Submission (IFRS 16) re leases and licences – Initial assessment is £43m of previous operating leases will transfer onto balance sheet.
Review and update of Efficiency planning and delivery process.
IR business Case – Case remaining subject to CCG support / confirmation of funding

The Chair of the Committee acknowledged the scale and volume of items being covered by the Finance Department and thanked the Director of Finance for their update.

4.0 2022-23 Planning Guidance & Budget Setting

The Director of Finance (Commercial) provided the Committee with an update for the external 2022/23 planning guidance and process, and internal budget setting proposals.
The Director of Finance (Commercial) notified the group that due to the COVID Level 4 incident status planning guidance has been issued in draft, with the national timetable subject to change.

The Executive Chief Finance Officer provided reassurance to the Committee that continuous updates in regards to this plan will continue to be made to members and through the standard channels.

The Chair of the Committee thanked the Director of Finance (Commercial) for their update.

5.0 IFRS 16 Update

The Director of Finance appraised the Committee of work currently being undertaken on the national implementation of IFRS 16 (Leases), which will be applicable from April 2022.

A review of all leases has been undertaken through the assessment process of this however formal confirmation regarding the level of central financial support remains outstanding.

The Director of Finance has confirmed that further updates will be provided to the Committee once additional guidance is received.

The Chair of the Committee gave thanks for the information and update provided.

6.0 Capital Update

The Director of Finance fed back to the Committee their updates from the Capital Group and advised that draft capital planning guidance, along with allocations for 2022/23 to 2024/25 have been issued.

The Chair of the Committee acknowledged the update provided and gave thanks to the Director of Finance.

7.0 Contracts Update

The Director of Contracts informed the Committee that the Trust was successful in its bid for the Essex STaRS Service and is now establishing a mobilisation group working with the Commissioners.

The Committee thanked the Director of Contracts and were please that the Trust had retained the Essex STaRS Service.

8.0 Lighthouse Child Development Centre

The Interim Director of Integrated Care South East Essex joined the Committee to give an update on the current position with the Lighthouse Child Assessment Service.

The Committee thanked the Interim Director of Integrated Care South East Essex and requested an update back to the Committee on a quarterly basis for this contract due to the risks around the potential waiting list on transfer of this service.

9.0 International Recruitment

The Executive Director of People & Culture and the Executive Chief Finance Officer presented the business case for International Recruitment to the Committee. This included rationale as to why the business case is needed and what positive impacts it will have for the organisation, as well as the financial impact.

The Chair of the Committee noted that from the descriptions given; all elements of the case have been considered.

The Committee supported the plans in principal on the assumption the appropriate funding could be secured.

10.0 Policy Extension Requests

The Committee approved the extension of the policies & procedures listed below:

- Raising Concerns (Whistleblowing) Policy
- Social Media Policy

11.0 Any risks or issues

The Committee has agreed to note two risks:

- The Lighthouse project's uncertainty around the waiting list position on transfer of this service.
- The scale of activities the organisation is managing

12.0 Any Other Business

There was no other business.

Report prepared by:

Amy Tucker
Senior Performance Manager

On behalf of:

Loy Lobo
Chair of the Finance and Performance Committee

		Agenda Item No: 8biv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**People Equality and Culture Committee Assurance Report**					
Executive/Non-Executive Lead:	Manny Lewis, Chair of the People Equalities and Culture Committee					
Report Author(s):	James Day Interim Trust Secretary					
Report discussed previously at:	Committee Chair					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report	
Summary of Risks highlighted in this report	People, Capacity and Equality
Which of the Strategic risk(s) does this report relates to:	SR2 - People (Incorporates former BAF 50 Skills Resources and Capacity and former BAF 61 Address inequalities and meet people plan ambitions) SR3 - Systems and Processes/ Infrastructure SR4 – Demand and Capacity
Does this report mitigate the Strategic risk(s)?	No
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 the People Equality and Culture Committee (PECC) is discharging its terms of reference and delegated responsibilities effectively, and that the risks that may affect the achievement of the Trust's objectives are being managed effectively. It also provides assurance to the Board of Directors that PECC is addressing the key items within its remit.	**Approval**	
	Discussion	
	Information	✓

Recommendations/Action Required

The Board of Directors is asked to:

1 Note the contents of the report
2 Accept the Assurance provided
3 Request any further information or action.

Summary of Key Issues

General

Because of the pressures upon staff resulting from the upsurge of the COVID pandemic at the end of 2021 and the beginning of 2022, the PECC did not meet in December 2021 as planned, and met in a shortened form on 20th January 2022. Dates for future meetings in February 2022 onwards have been set, although it remains possible that some of these meetings will also need to be in shortened form.

The confidential and sensitive nature of most of the material considered on 20th January meant that the meeting needed to be held in private as a Part 2 meeting, with attendance limited to Directors and senior staff only. There was no governor observer as a result, although assurance was provided to the observer prior to the meeting that in due course the matters under discussion were likely to progress to enable consideration and report in the open Board in future months.

To aid transparency this report is written as a Part 1 summary so that there is visibility on the items discussed.

In a similar vein to the initial PECC meeting in November 2021, this second PECC meeting agenda covered items of major concern to the Trust, supported by good quality reports. It succeeded in providing substantial assurance to Directors on the continuing and new work underway to address the issues of concern within the People agenda.

The format adopted for this second PECC meeting was that of traditional papers supported by narrative discussion and slide presentations for the key items.

In recognition of the value placed on the high quality rolling slide-set adopted in the initial PECC meeting to give it structure, a similar slide set was employed to introduce and summarise the wider topics being progressed within the People function. This slide set was welcomed as a summary, enabling the limited time available to be concentrated upon the principal agenda items supported by separate papers.

Topics Discussed with summary outcomes

Patient Experience

i) The Committee received detail of current Patient Experience activity including the commencement of the complaints process review, redesign of public forums and a significant increase in volunteer numbers and activity following a recruitment process overhaul. A review of the policy for recompense for lived experience had been initiated with the Coproduction group. EPUT was leading the Coproduction initiative in complex care cases across the five MSE CCG's. A disappointing outcome from the trend analysis of the CQC Community Mental Health Survey indicated a change of approach was required to improve EPUT effectiveness. Following discussion and an outline of future planned Patient Experience work, including the launch of "I Want Great Care", the value of learning from complaints and the triangulated inputs from various forums

was identified as work in progress. The Committee welcomed the report and endorsed the previous and intended Patient Experience work.

ii) Opportunity was taken to outline the current but uncertain and changing position regarding the application of the NHS mandatory COVID vaccination expectation on volunteers. With a caveat that the vaccination element be included, the Committee and Executive Team approved the Volunteer Policy.

iii) The outcome of the NHSEI Patient Experience Improvement Framework Survey was shared in which the "Where are we Now" and "What Good looks Like" position was summarised through the lenses of leadership, organisational culture and the need to drive quality improvement and learning. A roadmap to achieving success was outlined. Following discussion, the risk of patient and lived experience input becoming professionalised was identified. The importance of co-production and involving governors was noted. The committee endorsed the direction of travel proposed and asked that the subject be returned to a Board Development session following scrutiny by the Executive Team.

Leadership Structures

With reference to a shared slide, the committee was introduced to the proposed Target Operating Model. This envisaged flexible care group leadership teams which would be supported by service business units.

The proposals were welcomed and actively supported to be developed and brought to the Board for final approval, following further consultation and engagement.

'Time to Care' Transformation Project

The rationale for the Transformation initiative was shared, which was to deliver improved and streamlined systems and procedures to remove administrative burdens on staff and to release more time to care. It was proposed to build upon past work and to facilitate solutions for the staff from the staff rather than impose a recommended model. The aim was to deliver better patient experience through the creation of an improved staff environment and to improve productivity.

Quick wins were recognised as important to ensure momentum and buy-in, along with releasing staff time to enable meaningful engagement to drive the right outcomes.

The importance of integrating the initiative with the Trust's strategic objectives, mission and values was recognised along with ensuring essential tie-in to the emerging Digital strategy. Any initiative designed to address staffing pressures was likely to find favour externally, including with the CQC.

There was strong PECC support for the initiative which was remitted to the Executive Team to shape and progress.

International Recruitment Business Case

The Trust's international recruitment proposals had been well received and supported at a regional and national level, with the intention to "create the right environment for success" being closely followed.

The intent was to start to address the EPUT nursing vacancy shortfall through an extensive international recruitment campaign.

The key to recruitment and retention was the offer of exemplary and thoughtful class-leading pastoral care and training, along with unfettered and equal opportunity for advancement which fully recognised the value of diversity and was delivered by a diverse team.

The Committee supported the initiative in principle subject to addressing the financial constraints of securing the required external funding and securing commissioner support. This would then be progressed to the Board.

The next PECC would require a report on the lessons already learned from the recruitment and integration of the first cohort of recruits.

Update on PECC Business – Delivering the Future

The committee noted progress on the initiatives within the People and Culture Directorate with reference to a slide deck summarising the same.

Opportunity was taken to explore the impact of the compulsory requirement for front-facing NHS staff to be COVID vaccinated. This included understanding and interpreting complex expectations. Compared to other Trusts, the EPUT position was relatively favourable but it was still estimated that up to 150 staff might ultimately place themselves at risk of dismissal after all options had been explored and encouragement given.

It was recognised that the current position was tense and changing and that the Trust would have to adapt at pace. Additionally, any future annual COVID booster expectation might introduce similar pressures.

The position was noted.

People Strategy

Notwithstanding that this had been long delayed, existing pressures continued to prevent production and delivery. Additional resources had been deployed to provide support at the right level, and it was agreed that the Strategy would therefore be brought to the April PECC.

Policy Extensions and Approval

The committee approved seven extensions and the Study Leave and Medical and Dental Staff Conduct and Capability policies.

The next meeting will follow on 17th February 2022 unless changed to coincide with the re-scheduled F&P meeting, now on 24th February 2022.

Manny Lewis
Chair
People, Equality and Culture Committee
January 2022

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	
3: We empower	

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	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			

Supporting Documents and/or Further Reading

Lead
Manny Lewis **Non-Executive Director** **Chair of the People, Equality & Culture Committee**

ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item No: 8bv
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2021**

Report Title:	**Quality Committee Assurance Report**					
Executive/ Non-Executive Lead:	Rufus Helm, Non-Executive Director					
Report Author(s):	Gill Mordain, Strategic Advisor					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	✓	**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	
	SR3 Systems and Processes/ Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Essex Mental Health Independent Inquiry	
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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 information relating to discussions that have taken place at the Quality Committee, inclusive of assurance given from all accountable sub-committees, performance dashboards inclusive of challenge and mitigation against risks.	**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 actions identified to mitigate against risks
3 Request any further information or action.

Summary of Key Issues

The Quality Committee has reviewed the work of all sub-committees and all performance and quality dashboards accountable to the Quality Committee. This report is provided to give assurance of the review and challenge initiated.

This report confirms that the Quality Committee has been given assurance that all work streams are in place and actions are being taken to mitigate risks.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Main Report

Lead
Rufus Helm **Non-Executive Director (Chair of the Quality Committee)**

Agenda Item 8bv
Board of Directors Meeting Part 1
26 January 2022

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: Minutes of the meetings held on 12 December 2021 and 13 January 2022 were approved as an accurate account of both meetings. .

Assurance from meeting held on 12 December 2021

2.2 Summary of discussions and issues identified as well as assurances provided at the meeting on 12 December 2021

2.2.1 Quality Performance Report: The Committee received the report that gave an updated position based on October 2021. The Committee discussed the three areas of inadequate performance:

- Average length of stay – It was noted that the average length of stay increased in October failing to achieve NHS benchmarks.
- Occupancy – Adult bed occupancy ha increased further to 97.4% in October. Rates have steadily been increasing since February 2021.
- Delayed transfers of care – have shown four consecutive months of increase.

It was noted that currently mental health flow and capacity are experiencing challenges with wait times being affected and the challenges experienced nationally securing appropriate accommodation for young people. Positive trends was noted in relation to seclusions, restraints and ligatures although the committee noted that these areas would continue to be reviewed. The Council of Governors were given an overview of restrictive practice data at their last meeting and steps were being taken to drive continuous improvement. It was noted that the Trust is operating significantly below national benchmarks in relation to restraint data. It was observed that there is a downward trend in relation to active ligatures and harm from ligatures which has been linked to a number of initiatives brought in through the safety strategy.

It was noted that this report was discussed in other Committee structures and it was important to ensure progress was being made against all actions. It was noted that a piece of work was being undertaken to establish accountability arrangements for all actions. The importance of having appropriate RAG ratings was emphasised.

2.2.2 Quality/Patient Safety Update Report: The Committee received and noted the report that showed actions being taken against all themes within the Safety Strategy and the impact work undertaken was having on quality priorities.

2.2.3 CQC Exception Report: The Committee noted that both Poplar and Longview has received approval from the CQC to take limited admissions and work was being undertaken to comply with data requests that will enable the reopening of Larkwood. There is currently one overdue action on the CQC action plan in relation to observation training videos due to the unavailability of the videographer.

It was confirmed that the compliance, nursing and quality teams are continuing to make site visits to support teams and ensure compliance with multiple actions being taken to mitigate risks.

The Committee were alerted that the CQC had reported that all mental health trusts are facing similar challenges with pressure on frontline teams as a result of the pandemic. It was confirmed that a number of work streams were in place internally to improve resourcing and this was supported by engagement with the national teams.

2.2.4 BAF Action Plan: The Committee received and approved the BAF Action Plan

2.2.5 Quarterly EPPR Report: The Committee received and approved the report.

2.2.6 Suicide Prevention Strategy Annual Report: The Committee received a verbal update in relation work being undertaken to develop the annual report and implementation plan. It was agreed that the full report would be considered by the Committee in January 2022.

2.2.7 IPC Board Assurance Framework: The Committee received an update in relation to the assurance framework. It was noted that in some areas there was poor levels of compliance but this was being addressed with ward managers. Improvement has taken place in relation to environmental risk audits and guidance and tools have been developed to reflect the need to assess patients for respiratory tract infections on admissions.

2.2.8 MH Community Service User Survey 2021: The Committee received an update in relation to analysis being undertaken in relation to the annual management report. They were advised that the data demonstrated that previous actions undertaken had not been effective in driving the agenda. It was noted that there had been a downward trend in reporting over the last three years and as a consequence changes are being made to practice working with staff and individuals with lived experience to transform the agenda. A working group has been established that is being supported by NHSE/I and a QI approach was being taken to drive improvement. An action was agreed that the outcomes of the survey should be presented at quality and safety sub-committees and ESOG. The Committee were advised that the outcome of the survey would be triangulated with other data sources.

2.2.9 Research Update Report: The Committee received the report and noted that in 2020/21 research activity and value for money stood out amongst other trusts. It was noted that recruitment to projects was a key benchmark performance indicator and currently significant improvement can be demonstrated. EPUT has been successful in relation to securing additional funding to the value of £37,000.Assurance was given that following audits of the research department an action plan is in place and is being managed through sub-committee arrangements. Further clarification was sought in relation to funding streams and the variable levels shown throughout the year and it was noted that this was impacted by the popularity

of a particular study.

2.2.10 Quality Committee Terms of Reference Annual Review: The Committee noted that minor changes had been made to the terms of reference in relation to membership and gave their approval.

2.2.11 Any Other Business: The Committee was advised that the commissioners had made a request to join future Quality Committee meetings to promote new ways of working as an ICS system and increase alignment across organisations in Essex. The Committee approved the following actions:

1. Review objectives for the Quality Committee and commissioner expectations.
2. Representation to be updated in terms of reference.
3. Consider our governance structures in terms of part 1 & Part 2.

Assurance from meeting held on 13 January 2022

2.3 Summary of discussions and issues identified as well as assurances provided at the meeting on 13 January 2022

2.3.1 Sub-Committee Assurance Report: The Committee received an assurance update from sub-committee structures in place to progress key aspects of the quality and patient safety agenda. It was noted that due to the pandemic resources are under significant pressure and some meetings have been postponed. However assurance was given that all sub-committees have programmes of work in place and these are continuing out with meeting structures.

2.3.2 Restrictive Practice Framework: The Committee received an updated Reducing Restrictive Practice Framework. Sub-Committee structures have reviewed progress against the previous strategy and agreed to follow the principles of 'No-Force First' and Huckshorn's core strategies. It was noted that it was considered that a wider organizational/system approach was now required focusing on the development of care pathways and the development of sensory and seclusion structures. Assurance was given that the Estates team were involved in the development of sensory and seclusion environments.

It was noted that the Trust is working with Human Engine who will align the Framework with the Patient Safety Strategy and work will be undertaken to align dashboards and sub-committee structure. The Committee noted that culture had not been incorporated into the revised framework and assurance was given that this would be amended and the framework and supporting dashboards would be brought back to the committee in two months' time.

2.3.3 CQC Assurance Report: The report provided an update and assurance on key CQC related activities that are being undertaken within the Trust. It was inclusive of details of CQC guidance/updates that have been receives since the previous report received in November 2021.

The Committee noted that EPUT is fully registered with the CQC but continues to have restrictions imposed with regards Child and Adolescent Services. However, the CQC did agree that from 4 January 2022 Larkwood Ward can take admissions up to a maximum of 1 patient per week without seeking further permission. This is now the final CAMHS ward that has been given approval to gradually reopen to admissions.

The trust received a request for an Adult Social Care Provider Information Return (PIR) in respect of Rawreth Court that was completed in line with required deadlines.

It was noted that the same request had just been received for Clifton Lodge. The Committee queried whether receipt of PIR requests meant that an inspection may be imminent and were advised that was not necessarily the case unless a serious incident was reported.

One CQC action plan following the CAMHS inspection remains open and the Committee noted that most actions (88%) were completed with all other actions in timescale.

Assurance was given that the Compliance team continues to test action plans and the opportunity was given to consider gaps.

Information and links were provided in relation to CQC recent guidance and updates as follows:

- A new strategy for the changing world of health and social care – CQC's strategy from 2021
- CQC to postpone inspections of acute hospitals and general practice until New Year to support acceleration of the booster programme
- CQC prioritises activity to help create more capacity in adult social care over winter
- Reply to the Joint Committee on Human Rights in care settings.

2.3.4 High level overview – Q2 2021/22 Mortality Data: The Committee were informed that it has not been possible to compile the full mortality date for Quarter 2 2021/22 to date given the workforce capacity constraints caused by the current increase in Covid-19 and the significant acceleration of the vaccination programme.

The report for review incorporated a high level analysis of the initial data extracted from Datix and clinical systems. Following a query regarding publication of the data the Committee was informed that mortality data was available to the general public through the publication of Board Papers.

2.3.5 Suicide Prevention Annual Report: The Committee received a report containing a summary of relevant performance metrics for October 2021. In addition the Committee received and approved the revision to the strategy noting work being undertaken with partners to build a QI approach to delivery against key objectives and support staff in the utilization of available resources in the prevention of suicide for individual patients and service users.

2.3.6 Patient Story: The Committee received a patient story in which the patient was under the care of the Community Mental Health Services and had taken an overdose. Appropriate actions were taken in response and an After Action Review was commissioned from the Patient Safety Incident Review Group. The review revealed a significant number of good practices by the team involved that incorporated strong engagement with family members and neighbours.

2.3.7 Covid 19 IPC Board Assurance Report: The Committee received an update following the previous report submitted outlining the Trusts position regarding infection, prevention and control during Covid 19 Pandemic. It was noted that further national updates had been received and the framework was operating as a live and dynamic collection of evidence, risks, gaps and mitigation. The Committee acknowledged the extensive work that was being undertaken that was complicated by considerable changes in guidance.

2.3.8 Progress against Learning Disability Standards: The Committee received an update report against implementation of the Learning Disability Standards. Assurance

was given that work was progressing since the last update with project teams and improvement initiatives in place. The Committee agreed to revert to bi-annual updates with quarterly updates to the Clinical Governance sub Committee.

2.3.9 Part 2: The Committee received and noted a paper within part 2 meeting structure

2.4 Policies and Procedures

2.4.1 The Committee approved the following policies and procedures December 2021:

- CLPG13 Safe & Secure Handling of Medicines MH & CHS
- CP9 Records Management Policy
- CP22 Zero Tolerance Policy
- CP29 Registration Authority Policy
- CP61 C.Diff Policy
- RM09 Security Policy
- Rm11 GWPRA Policy
- RM17 Lone Worker Device
- CP74 Password Policy
- CPG50 Information & Sharing Consent Policy
- RM19 Water Safety Management Policy
- RM05 TASID Policy

NH requested that changes to the policies were incorporated into 5 key messages.

2.4.2 Policy extensions were agreed for the following:

- CP41 Dress Code (For Clinical & Non-Clinical Staff) & Uniform Policy
- CP64 Mortality Review Policy
- ICP1 ICP Procedure Section 7 – Infestations
- ICP1 ICP Procedure Sections 8 – Infestations
- ICP1 ICP Procedure 10 – Pets and Pests
- ICP1 ICP Procedure Section 11 – Decontamination of Mattresses

2.4.3 The Committee approved the following policies and procedures January 2022

- CLP8 Engagement and Supportive Observations Policy and Procedure

2.4.4 Policy extensions were agreed for the following:

- CLP19 Research Conduct and Processes Policy
- CPG50A IT&T Security Procedure
- CPG9F Transfer/ Transportation of Records and Information/ Data Policy
- HR21 Induction, Mandatory and Essential Training Policy
- ICP Procedure Section 5 – Management of MRSA – MH & CHS Procedure
- RM12 Assured Safe Catering Policy

2.4.5 Risks/Hotspots:

The Committee identified:

- Patient engagement as a risk to be added 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

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Report prepared by:
Gill Mordain, Strategic Advisor

On behalf of:
Rufus Helm, Non-Executive Director
Chair of the Quality Committee

		Agenda Item No: 9ai
SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Covid-19 Assurance Report**					
Executive/Non-Executive Lead:	Paul Scott, Chief Executive Officer					
Report Author(s):	Jane Cheeseman, Head of Compliance and Emergency Planning					
Report discussed previously at:	Executive Team					
Level of Assurance:	**Level 1**	✓	**Level 2**		**Level 3**	

Risk Assessment of Report – *mandatory section*		
Summary of risks highlighted in this report	High number of outbreaks and staff sickness due to Omicron Variant. Fast pace of changes to guidance and need to enact surge plans	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	✓
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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	Risk Register monitored through governance processes.	

Purpose of the Report		
This report provides 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 risk register 2021/22 and summary mitigations (Appendix 1)
4 Request any further information and or action

Summary of Key Issues

Background / Current Context

- The country continues to deal with the corona virus pandemic and the emergence of additional variants such as Omicron.
- The NHS has returned to its highest level of emergency preparedness and declared an Incident Level 4.
- All organisations were asked to prioritise key activities in response to the level 4 increase:

- Mass vaccination
- Availability of Covid 19 treatments
- Maximise capacity across acute and community settings
- Support patient safety in urgent care pathways and ask for MH and LD services are retained throughout surge and face to face care retained as far as possible
- Support staff and maximise their availability
- Revisit staff wellbeing offers
- Prepare surge plans

- Covid-19 restrictions remain in place and as such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

Command Structure

- The Gold/Silver and Bronze Command meetings continue to be held with frequency depending on current risk.
- The (virtual) Incident Control room operational times continue to run 8am until 6pm 7 days a week
- The Covid Risk Register is regularly reviewed and updated by Gold and Silver Command.
- National daily / regular sit reps remain in place.

Current Impact

- There have been 27 reported outbreaks within the trust, since the last report, 2 of which have since been closed from outbreak status
- There have been 2 further reported patient or staff deaths as a result of Covid-19 since last reporting
- At time of writing we have a total of 197 staff off sick due to Covid-19 and there are 58 Covid-19 confirmed in-patients
- Considerable national guidance changes have been received since increase to incident level 4 with in excess of 133 formal guidance documents received, reviewed and where required implemented/actioned.
- New legislation Vaccination as a Condition of Deployment (VCOD) for Healthcare workers will come into force 1st April 2022. Work is underway to scope staff affected and to support staff in ensuring they have been vaccinated by the cut-off date of 3rd February 2022

Trustwide Response

Due to the rapid spread of the Omicron variant and the declaration of the level 4 National incident a number of Trustwide changes have taken place

- Significant changes to IPC Guidance in response to national changes
- Review of EPUT wide surge plan and development of service specific surge plans
- Redeployment of staff to support inpatient ward and Mass Vaccination
- Incentives offered to reward and encourage flexibility of the workforce
- Suspension of Mandatory training (face to face)
- Focus on discharge planning
- Immediate focus to support patients to be home for Christmas
- Full refresh of the IPC Board Assurance Framework
- Re-establishment of the oxygen working group
- Re-instated the Ethics Committee
- Ramp-up of the vaccination programme
- Opening of an additional community health ward
- Pause of Services to release staff to support inpatient areas
- Plane Ward designated as a Covid ward for non-acute patients

Communication

Decisions made by the Command meetings and any changes in guidance continue to be communicated to all staff through the regular production of the Live briefings and the Wednesday Weekly publication

Risks

The Trust's Covid Risk Register (Covid RR), attached as Appendix 1, remains a live document with monthly updates that reflect the changing environment. There is one extreme risk open on the Covid Risk Register being a new risk as of December 2021 with key controls and assurance in place

- If the Trust is unable to manage staff absence and availability of flexible (bank) and corporate clinical workforce during the Omicron wave then BCPs and surge plans are significantly affected resulting in compromised service delivery and breaches in working time regulations.

Learning

Learning continues to be a key part of the Trust response to Covid 19 and reflection will again be undertaken once the level 4 incident is stepped down.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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			
NHSE/I	NHS England and Improvement	IPC	Infection Prevention and Control
COVID RR	Covid Risk Register	CCG	Clinical Commissioning Group
CPNS	Covid-19 Patient Notification System	UKHSA	UK Health Security Agency
Sitrep	Situation Report		

Supporting Documents and/or Further Reading
Covid Assurance Report Gold Command Covid Risk Register Summary (Appendix 1)

Lead
Paul Scott **Chief Executive Officer**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COVID 19 ASSURANCE REPORT

1. Purpose of Report

The purpose of this report is to provide 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.

2. Background

As the country continues to deal with the corona virus pandemic and the emergence of additional variants such as Omicron, the NHS has returned to its highest level of emergency preparedness and declared an Incident Level 4.

All organisations were asked to prioritise key activities in response to the level 4 increase:

- Mass vaccination
- Availability of Covid 19 treatments
- Maximise capacity across acute and community settings
- Support patient safety in urgent care pathways and ask for MH and LD services are retained throughout surge and face to face care retained as far as possible
- Support staff and maximise their availability
- Revisit staff wellbeing offers
- Prepare surge plans

Considerable national guidance changes have been received since increase to incident level 4. These have all been considered through the EPUT Command structure and changes made to local guidance where necessary.

Since last reporting the national growth rate rapidly increased although we are starting to see signs of a plateau. The Trust's arrangements continue to be in place, regularly reviewed in line with national guidance and working effectively. Covid-19 restrictions remain in place and as such we continue to monitor prevalence amongst our patients and staff and respond promptly to guidance as and when provided.

3. Command Structure

The command structures remain in place and have increased in frequency over the past month along with the change to revert to holding daily separate Silver and Gold command meetings during the week and a joint Silver and Gold command meeting at the weekends. The command frequency remains flexible in regards to reducing/ increasing meetings for COVID-19 activity in addition to the winter pressures over the coming months. Bronze command meetings continue to mirror the Silver and Gold commands to ensure decisions made and information received continues to cascade through the organisation at pace, and that we are responsive to changes required.

The (virtual) Incident Control room remains operational 7 days a week 8am until 6pm in line with the East of England Operational Centre. This is mainly covered by the Compliance and Assurance Directorate with the additional help of other corporate staff on a rota at the weekends buddied by the EPRR leads for support and on call should there be any areas for escalation or Covid-19 Patient Notification System (CPNS) death reporting required.

The regular sit rep submissions required by the Centre continue, namely the National Covid-19 daily sitrep, Community discharge daily sit rep, (both also required at weekends) the regular Lateral Flow

Testing numbers and Long Covid activity.

The incident control inbox continues to receive the national and regional information/guidance alongside a more wider remit of information sharing. The continued monitoring of the inbox ensures that should anything of urgency come through we are able to remain responsive. Any national/ regional guidance, information and/or requests are cascaded to the appropriate Directors and through discussion at the Command meeting for information and consideration of the actions required with a timely response.

Since the beginning of December 2021 there has been 133 formal guidance documents received via the C19 email system in addition to the large number and range of general information that comes through. Each piece of information received requires a significant piece of work to ensure it is appropriately reviewed, circulated and where required implemented/actioned.

The equalities network leads continue to have a presence at 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.

We have reconvened the ethics committee with a Non-Executive Director as Chair for oversight of any ethical decisions that may be required as a result of our response to dealing with the current challenges being faced and ability to review the impact of these decisions.

4. Impact to Date

Since last reporting in November 2021 there has been a significant increase in our reporting of Covid-19 positive cases. At time of writing, we currently have 58 Covid-19 confirmed patients within our services (previously 12) and a total of 197 staff off sick not working due to Covid-19 related illness which is a momentous increase from 42 at last report.

Sadly, we have recently had to report two deaths onto the Covid-19 Patient Notification System (CPNS) (one in November 2021 and one in January 2022) due to the patients having tested positive in the proceeding 28 days prior to their death.

Since last reporting, we have now had 27 outbreaks declared to UK Health Security Agency (UKHSA) formerly known as Public Health England, two of which have since passed the 28 day period and therefore has now been closed from outbreak status. The remaining 25 open outbreaks (2 CHS and 23 MHS) continue with ongoing monitoring and reporting. To note an outbreak is classified when there are 2 or more cases in one area at a period of time, which was the threshold met in each of the teams where the outbreaks have occurred. All processes for an outbreak are followed as advised through joint meetings with NHSE/I, CCG's and UKHSA.

The regular lateral flow testing of both our patients and asymptomatic staff continues across the trust.

Parliament has passed new legislation that extends the scope of mandatory vaccination requirements for staff beyond registered care homes. The new requirements will come into force on 1st April 2022 with a 2 phased implementation process. We are currently scoping roles for identification and assessment of individuals that must be vaccinated, unless exempt or those that there is no requirement. If patient facing staff working in CQC regulated services (including those not directly involved in patient care but may have incidental contact) are not vaccinated, then redeployment or dismissal may be required. Work is underway to support staff in ensuring they have been vaccinated by the cut-off date of 3rd February 2022 being the last date for staff to get their first dose to ensure they are fully vaccinated by the time the regulations come into force.

5. Trustwide Response

Due to the rapid spread of the Omicron variant and the declaration of the level 4 National incident a number of key changes have taken place including the following;

Ramp-up of Vaccination Programme

- Ramp-up of the vaccination programme with a redeployment of staff to support the opening of additional sites and extended opening hours that were required following the Prime Ministers announcement to increase the vaccination programme
- Have opened up more appointments across all vaccination centres
- Increased throughput and opening hours across centres
- Opened up two new centres: Chelmsford County Hall and Chelmsford race course increasing capacity to c. 3,500 per day
- Running specific clinics for 12-15 year olds and for the hard to reach groups
- Staff identified to support ramp up of the Covid-19 vaccination programme and current being redeployed.
- Call to action for staff to work additional hours in vaccination centres
- Enhanced training access to support on Covid-19 vaccination centres

Maximise availability of covid 19 treatments for people at highest risk

- Each ICS setting up CMDUs through acute trusts (MSE, Colchester Hospital and PAH)

Maximise capacity across acute and community settings to enable discharge

- Ensuring a focus on discharge planning to improve capacity and reduction of bed occupancy where possible
- Immediate focus to support patients to be home for Christmas
- Plane Ward designated as a Covid ward for non-acute patient
- SE CHS: Improved coordination via ICC 24/7 including over Christmas and new year; Population health management targeting high risk patients; Strengthening recovery at home service to support discharge; Dedicated pathway navigator for flow through CICC
- WE CHS : Redeploying staff to support discharge and flow; Daily operational calls taking place to identify any blocks/ issues for discharges; Increased care at home capacity in light of lack of social care provision; Daily board rounds taking place to ensure those that can are able to be discharged home before Christmas

Support patient safety in urgent care pathways and ask for MH and LD services are retained throughout surge and face to face care retained as far as possible

- The opening of an additional ward (Gibbard) to support Princess Alexander Hospital
- Principle of face to face contact as default agreed at Command

Support staff and maximise their availability

- Redeployment of staff to support inpatient wards due to the high proportion of staff absent from work due to illness
- Incentives offered to reward and encourage flexibility of the workforce
- Suspension of Mandatory training, a reduction of non-essential meetings and other corporate functions
- Leaner recruitment processes driving down our time to hire.
- The international recruitment programme accelerating the arrival of nurses

Revisited staff wellbeing offers

- A number of support services are in place for staff through employee assistance programmes and occupational health, as well as mental health first aiders. Here for You, run by MH experts, prioritises staff needs, signposts to the right help at the right time, provides a priority referral if needed and helps rebuild resilience levels. The Employee Assistance Programme provides free 24/7 independent and confidential advice on a range of topics that may affect physical, mental, social or financial wellbeing. Optimise, a wellbeing assessment app providing content and an extensive library of wellbeing information, is offered to all staff and their families.
- A new Wellbeing Support website has been developed: COVID-19 Wellbeing Support Service (covidwellbeingsupport.com) Alongside this, a number of toolkits have been allocated to staff.

Prepare surge plans and Incident Control Centre (ICC) processes

- A revisit and implementation of the EPUT wide surge plan and service specific surge plans to ensure processes are ready to be enacted to protect the safety of the patients in our care
- Pause of the Cardiac Rehabilitation and Pulmonary Rehabilitation service in West Essex to support discharge/ Virtual wards
- Review of Incident Control Centre SOP
- Review of supplies and stock levels

Response to national guidance changes

- Significant changes to IPC Guidance that have been regularly reviewed and taken through command structures to ensure inclusion of the updated covid-19 control measures and changes to isolation periods
- A full refresh of the IPC Board Assurance Framework
- Re-establishment of the oxygen working group
- Re-instatement of the Ethics Committee to oversee decisions that create ethical dilemmas

6. Communication

Decisions made through Command meetings and any changes in guidance continue to be communicated to all staff through bronze command, the regular production of the Live briefings, the Wednesday Weekly publication and on the intranet.

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 frequent virtual events made available to support staff and their wellbeing.

7. Risks

The Trust's Covid Risk Register (Covid RR), attached as Appendix 1, remains a live document with monthly updates that reflect the changing environment. There are currently 7 stand-alone Covid risks made up of 1 extreme, 5 high and 1 medium. The extreme risk is new as of December 2021 relating to staffing pressures arising from staff absences during the Omicron variant wave. If the Trust is unable to manage staff absence and availability of flexible (bank) and corporate clinical workforce during the Omicron wave then BCPs and surge plans are significantly affected resulting in compromised service delivery and breaches in working time regulations. Key controls and assurances are in place for this risk. 11 risks have been closed following review by Command.

In addition there are 5 risks on the Corporate Risk Register (CRR) relevant to Covid-19, made up of 1 extreme and 4 high risks. The extreme risk is management of Covid-19 (emergency planning risk) increased in December 2021 in light of level 4 status, Omicron variant wave and the faster pace on mass vaccinations and boosters. Key controls and assurances are in place. Two mass vaccination risks are now merged into one to reflect the 'one programme' approach with a reduced score. The Board Assurance Framework paper to the Board recommends approval of a new Corporate risk related to the Omicron wave and our recovery from it. This will be formally added to the Covid Risk Register following approval.

8. Learning

Learning continues to be a key part of the Trust response to Covid 19 and a number of activities as reported previously are continuing to take place, alongside some new initiatives and incentives to support our staff.

As we are currently still in the Omicron variant wave and at a level 4 incident we are currently developing our recovery plans follow which a reflective piece of learning will be undertaken; taking into account the learning from previous waves.

9. 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 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 Officer

Table 1 – COVID RISK REGISTER 2021/22 Summary of Risks as at January 2022

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

Note: SR1 Safety SR2 People SR3 Systems and Processes/ Infrastructure and SR4 Demand and Capacity all have Covid-19 as part of their context

Note: Closed risks this months crossed through and shaded grey

Stand-alone Covid-19 risks

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
Strategic Objective 1 We will deliver safe, high quality integrated care services					
CVG19 SO1 Lead: NH Committee: Quality	**Infection and Prevention Control** 12 → 12 → 12 Current Risk score 4 x 3 = 12 Risk score Target 4 x 2 = 8 Ongoing	If EPUT does not manage Infection and Prevention Control (IPC) during COVID19 then infections may increase resulting in a negative impact on the pandemic	• 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 • Live event w/c 18 October to mitigate risk • Undertaking patient risk assessment and follow isolation flow chart on inpatient areas	Level 1: assurance visits Command meetings Level 2: Covid Dashboard	• Monitor increase in outbreaks • Reiterate compliance with current guidance • Not doing monthly assurance audits on Perfect Ward in a timely manner • Not swabbing patients as per the frequency guidelines • Escalate within the EBAF report • Staff not following guidance • Shortage of staff, wards swamped and a lot of agency staff • Avocet – recent issue • Included question about risk assessments on admission

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
CVG37 SO1 Lead: DG Committee: Quality	**Covid Secure Risk Assessments**  Current risk score 4 x 3 = 12 ~~December 21~~ March 22 Target 4 x 2 = 8	If EPUT does not maintain Covid-19 secure risk assessments then premises may not conform to guidance resulting in a possible spread of infection	• Covid19 Secure risk assessments completed locally and reviewed by a member of risk team before approval • Datix is monitored in order to pick up any risks • Identification of buildings where assessments complete • Developed process for managing the out of date secure risk assessments	Level 1: Bronze Command Level 2: Silver Command	• This is being reviewed at the moment to scope any gaps – will go into health and safety inspections from January 22 and will then be business as usual • Certificates no longer need to be on display – discussed in Silver 12/01/22. Agreed we must have Covid Secure risk assessments. Buildings that incorporate wards will have an over-arching risk assessment. Incorporate into health and safety inspections in the longer-term but in the interim period they will be separate. Workstream for all areas that do not have one or are going out of date. H&S inspections should include checking it is complete – include in template. • Produce list of buildings that have them and list of places that have them with dates

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
CVG10 SO1 Lead: TS Committee: F&PC	**Capital Programme** 9 9 9 Current risk score 3 x 3 = 9 Ongoing Target 3 x 2 = 6	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	• Capital projects continuously under review • Building contractors have returned to BAU • No delay identified and no significant risk to future programme • Situation continues to be managed • Meeting took place 5 October around managing contractors on care home sites	Level 1: Capital Group ESOG Level 2: F&P	• Contractors working within social distancing guidelines still an issue
CVG55 SO1 Lead: AG Committee: Quality	**Outbreaks** 10 10 15 Score increased to 5 x 3 = 15 by Silver Jan 22 Risk score 5 x 2 = 10 at threshold ~~June 21~~ March 22 Target 5 x 2 = 10	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	• 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 • Extend completion date in line with national lockdown easing	Level 1: Bronze Command and Surge Plans Ward Assurance Level 2: Silver Command and IPC function	• Continue to revisit this risk following lifting of restrictions • Silver command Jan 22 increased to 15 with the potential to increase again
CVG59 SO1 Lead: SL Committee: PECC	**Mandatory Vaccinations** 16 16 16 Risk score 4 x 4 = 16	If EPUT does not manage implementation of the mandatory vaccination for front line staff then recruitment and retention may be impacted resulting in sub-optimal service delivery	• HR already planning for mandatory vaccinations	Level 1: Bronze Command Ward Assurance Level 2: Silver Command and HR function	• Further targeted communications to unvaccinated staff • Review mandatory vaccination announcement • Currently 700 bank/ mass vaccination staff with no vaccination details held (no

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
	Target April 22 4 x 2 = 8				response to disclosure request) • Plan for 5-10% of front line workers not yet vaccinated • National data for EPUT boosters is skewed and low
Strategic Objective 2 We will enable each other to be the best that we can					
CVS30 SO2 Lead: SL Committee: PECC	**Fatigue and burnout** 12 → 12 → 16 Risk score increased Dec 21 to 4 x 4 = 16 Ongoing Target 4 x 2 = 8	If EPUT does not manage the levels of fatigue within the organisation then burnout and sickness levels may rise resulting in a failure to deliver services in a safe way and compromised wellbeing of staff	• Wobble rooms where practicable • Take a break initiative promoted • Annual leave guidance updated • Wellbeing events and mindfulness • Wellbeing Festival Summer 21 • Rest nest sessions • PULSE survey to be reinitiated August 21 • Discussions at Senior Leadership Team • Refocus on the environmental factors that are affecting staff stress levels e.g. excessive workloads and demands	Level 1: Command	• Continue to encourage staff to take up offers of online support • Senior and local leaders to address environmental factors affecting staff morale and wellbeing through discussion focus • Commitment to transfer bank and agency staff to permanent posts • Full establishment review • Silver Command Jan 22 approved increased score to 16 – seeing increases in staff sickness plus change in self-certification process
CVS32 SO2 Lead: SL Committee: PECC	**Staffing Pressures** 20 New risk Dec 21 Initial risk score	If EPUT is unable to manage staff absence and availability of flexible and corporate clinical workforce during Omicron wave then BCPs and surge plans are significantly affected resulting in compromised service delivery	• Incentives being offered to bank staff – undertake three shifts and receive pay for a fourth shift • Incentives offered to substantive staff over New Year period	Level 1: Bronze Command / ward staffing sit reps and oversight huddle Level 2: Silver Command and ESOG	• Breaches in working time regulations by staff working additional hours to cover absentees • Approved at Silver Command Jan 22

Risk and Objective ID	Summary	Potential Risk	Key Controls	Key Assurances	Key Gaps/Actions
	5 x 4 = 20 Target date and score March 22 5 x 2 = 10	and breaches in working time regulations	• Corporate clinical staff redeployments to clinical areas • Surge Plans in place		
Strategic Objective 4 We will help our communities to thrive					

The following is an extract from the current Corporate Risk Register including all Covid-19 related risks.
Notes: any recommendations from Silver Command may receive approval at Gold Command and the EBAF report will reflect any changes. Format matches Board Assurance Framework report. Seasonal flu updated with Angela Wade 11/01/22. Mass vaccination risks discussed with Nigel Leonard 12/01/22 and approved at ET 18 January

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
CRR79 SO2 Lead NH Quality Committee	Seasonal flu 16 → 16 → 16 Initial Risk Score 4 x 4 = 16 Target March 22 4 x 2 = 8	If EPUT's alternative approach to seasonal flu is unsuccessful then it may suffer outbreaks in the workforce resulting in failure to meet national programme of expectations	Annual Flu vaccination programme	• Project management in place • Clinical oversight in place • Plan in place to commence flu programme in September in conjunction with Covid-19 boosters • Weekly task and finish group in place • Ensure local measures are ready prior to programme starting • Encourage uptake of flu vaccinations in conjunction with offer of Covid-19 boosters	• Performance, mass vaccs and HR are triangulating information as far as possible – will know the position shortly – estimated at 50% • Lack of mandated flu vaccinations • ET instigated an incentive programme to reward people that had vaccine	Level 1: Clinical Governance and Quality Level 2: Level 3:	• Awaiting national and regional communications about approach • No data process. Combined with mass vaccs and goes onto national vaccs system with no opportunity for local data capture. • NIVS and NIMS cannot be filtered • ESR/NIMS do not have same data points so there are variabilities • Competing with Covid vaccination programme without the same national push for flu

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
							• GDPR – holding medical record in HR system is an issue
CRR83 SO1 Lead TS Quality Committee	**Covid-19 Financial Plan** 12 → 12 → 12 Initial Risk Score 4 x 3 = 12 Target March 22 4 x 2 = 8 No action plan required	If the Covid-19 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	Financial regime during Covid-19	• The Trust's 21/22 financial plan has been set to deliver a breakeven position. Continuous monitoring of the financial position through reporting to F&PC, EOSC finance and performance meetings and the Board. • Efficiency requirements are included in the financial plan and schemes under development. • H2 (second half-year) plan has now been approved and has reduced any uncertainty over the financial envelope	None	Level 1: F&PC EOSC BOD Audit Committee Level 2: ICS sustainability exercise	None identified
CRR85 SO4 Lead NL Quality Committee	**Mass Vaccination Adults** 12 → 20 → 12 Current risk score recommended to decrease to 4x3=12 Jan 22 Initial Risk Score 5 x 4 = 20 Target Ongoing 4 x 2 = 8 January 22 – risk merged with CRR86 to reflect	If EPUT does not effectively direct and implement the ~~adult~~ entire mass vaccination programme during challenging times then it may not meet ~~its~~ level 4 deliverables and timescales resulting in a ~~failure of~~ compromise to the programme ~~in MSE and SNEE~~	Covid-19 pandemic	• A risk register set up specifically related to the Mass Vaccination programme to strengthen governance around the project • New BCPs developed for vaccination centres • Working in partnership, with Local Resilience Forums, Local Authorities and other providers to deliver the programme • Clinical oversight and governance in place at all vaccination centres discussed daily • All costs passing through NHSE and laptop costs	• Maintain watching brief on variable vaccine supply and impact on programme • Assessment of recently published national security guidance to draw out any actions • Maintain watching brief with national uncertainty about extension of vaccination programme • Monitor situation in relation to further cohorts coming on	Level 1: Programme Board and Risk Register Level 2: Level 3: over 1,000,000 vaccinations delivered	• MSE have lost GP practices for vaccination purposes • Following above update the level 4 announcement poses further challenges to the mass vaccination programme so EBAF approved the increase to 20 • No action plan in place – managed through project board • Reduction in people coming forward for boosters • BLMK have written to region regarding the 12-

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
	'one programme' from the same hub			supported by skill mix work • Robust communication in place with vaccination centres • Pre-assessment model developed by EPUT now approved by Region • Managing alternative models for vaccination delivery including pop ups and large trailer, drive through pilot and buses • Maintaining workforce at vaccination centres (and other delivery centres) with forward planning to identify workforce challenges • Maintaining vigilance and awareness on security and potential criminal activity at vaccine sites • Mirrored on Covid-19 and Mass Vaccs risk register • 12-15 age group School Immunisation Teams now delivering vaccines mainly through school environments • Delivery of phase 3 booster programme commenced on 20 September via a range of delivery models including GP led, Community pharmacies and large scale vaccination centres • Standing up temporary vaccination centre in Chelmsford and working with system to maximise resources	stream due to the Omicron variant • JCVI Directive is that all over 18's to receive boosters by 31 Jan 22 • Project team working on covering off pre-assessments on behalf of other systems •		15 age group programme changes – leaves uncertainty as to how we deliver the contract • Main areas of concern are the 5-11 age group, 12-15 age group and 16-17 age groups

Risk and Objective ID Lead Standing Committee	Summary	Potential Risk	Context	Key Controls that mitigate the risk (Evidenced)	Gaps in Controls	Key Assurances (Evidenced)	Gaps in Assurance
				• Expanded 12-15 age group appointments			
CRR87 SO4 Lead NL Quality Committee	**Mass Vaccinations 12-15 age group Suffolk** 20 16 16 Current risk score reduced Dec 21 to 4 x 4 = 16 Initial risk score 4 x 5 = 20 Target date and score Feb 22 4 x 2 = 8	If EPUT is asked at short notice to support the Suffolk 12-15 age group programme then it may be unable to meet the required timescale resulting in an impact on existing targets	Covid-19 pandemic – potential failure of current contract provider	• None at this stage • New risk reviewed by NL 04/11 • Agreed with NHSE/I that recovery of any costs to EPUT are made • EPUT has additional capacity to support the system	• Deliver additional sessions in Suffolk • Discussions taking place with NHSE/I and existing contract holder HCT • Develop a plan to support the Suffolk programme • Ensure Essex programme has sufficient school nursing staff before staff are taken or redeployed to help with Suffolk programme	Level 1: Project Board Level 2: Level 3: NHSE/I	
CRR90 SO4 Lead NL Quality Committee	**Management of Covid-19** 10 20 20 Initial Risk Score 5 x 3 = 15 Current risk score increased Dec 21 to 5 x 4 = 20 Target March 22 5 x 2 = 10	If EPUT does not manage Covid-19 through effective emergency planning then containment of the pandemic is compromised resulting in a failure to follow national and local requirements	Covid-19 pandemic	• BCPs • Command structure • Sit rep daily monitoring • Covid-19 intranet page and range of staff training in place • Covid-19 dashboard issued weekly to monitor prevalence • NED and Executive Lead for Emergency Planning agreed (NL) • Demonstrating lessons learnt from Covid-19 through bi-monthly Trust Board reports and EPRR quarterly report • Action Plan completed	• Prepare for Covid-19 Statutory Inquiry • Review emergency planning processes in light of Covid-19 experience • Hold internal emergency planning exercise	Level 1: Action plan completed Level 2: EPRR Team / IPC Team Level 3: EPRR Standards	• Covid-19 IPC risk increased in score and escalated

Table 2 – Heat Map against 5 x 5 scoring matrix

		RISK RATING				
		Consequence				
		1	2	3	4	5
Likelihood	1					
	2					
	3			CVG10	CRR83 CVG37 CVS30 CVG19	CVG55 CRR85
	4				CVG59 CRR79 CRR87	CRR90 CVS32
	5					

	Agenda Item No: 10a

SUMMARY REPORT	**BOARD OF DIRECTORS PART 1**	**26 January 2022**

Report Title:	**Safety First, Safety Always: 12 Month Update Report**					
Executive/ Non-Executive Lead:	Natalie Hammond, Executive Nurse					
Report Author(s):	Jonathan Noble, Human Engine					
Report discussed previously at:	Executive Committee					
Level of Assurance:	**Level 1**		**Level 2**		**Level 3**	✓

Risk Assessment of Report		
Summary of risks highlighted in this report	Patient safety is the number one priority for the Trust and touches all areas of the organisation. Therefore, all of the strategic risks facing the Trust relate to patient safety, including: • Demand for mental health services, locally and nationally (21% increase since 2016) • Impacts of the pandemic on population mental health – for every 1% increase in long-term unemployment, the suicide rate of a population increases by 0.83% • The increasing complexity of patients' needs alongside the increasing volume of demand • Impact of both the pandemic and running of the largest vaccination programmes on staff • Systemic workforce shortages, with the most significant shortages being in mental health, learning disability and community nursing • The specific impact of the pandemic on some of our safety measures, such as restraint and seclusion	
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	✓
	SR2 People (workforce)	✓
	SR3 Systems and Processes/ Infrastructure	✓
	SR4 Demand/ Capacity	✓
	SR5 Essex Mental Health Independent Inquiry	✓
	SR6 Cyber Attack	
Does this report mitigate the Strategic risk(s)?	Yes	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register? *Note: Strategic risks are underpinned by a Strategy and are longer-term*	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	Delivery against patient safety outcomes as set out in the report, organisational sub-committees, audit and regulator review of performance, learning from incidents, feedback, complaints and compliments.	

Purpose of the Report		
This report provides the Board of Directors with an update on the implementation of the Trust's strategy for patient safety 12 months after consultation with partners and approval by the Trust Board.	**Approval**	
	Discussion	✓
	Information	

Recommendations/Action Required

The Board of Directors is asked to:

1. Note the contents of the report
2. Discuss our priorities for 2022 (summarised on page 13: Safety Never Stops) and how we can best work together to achieve these
3. Discuss how our data collection and reporting processes may need to evolve to give us the insight we need for assurance and to continue to drive improvement in safety and quality
4. Request any further information or action.

Summary of Key Issues

Board Members are asked to note:

- That significant progress that has been made across almost all indicators of patient safety, even against a challenging backdrop of exceptional influencing factors
- The particular successes within physical health and restrictive practice, against a backdrop of demand and operational challenges that continues to be very challenging
- The innovations that are being rolled out across the Trust, from use of new technologies such as Oxehealth vital signs monitoring to co-production with service users
- The major, strategic changes underway that will transform the way EPUT operates as an organisation and as part of the system, through a new operating model, Accountability Framework and cultural shift.

Board members are asked to discuss:

- Our priorities for 2022 (summarised on page 13: Safety Never Stops) and how we can best work together to achieve these
- How our data collection and reporting processes may need to evolve to give us the insight we need for assurance and to continue to drive improvement in safety and quality

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	✓
SO2: We will enable each other to be the best that we can	✓
SO3: We will work together with our partners to make our services better	✓
SO4: We will help our communities to thrive	✓

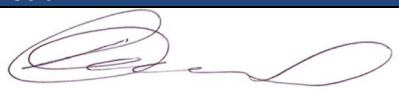
Which of the Trust Values are Being Delivered	
1: We care	✓
2: We learn	✓
3: We empower	✓

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
Safety First, Safety Always: 12 Month Progress Report

Lead



Natalie Hammond
Executive Nurse

NHS
Essex Partnership University
NHS Foundation Trust

Safety First. Safety Always.

Our strategy for ensuring inpatient safety

12 Month Progress Report

Contents

Executive Summary

- The *Safety First, Safety Always* strategy was agreed by Trust Board in February 2021, following widespread engagement with staff, NEDs, Governors and partners (including commissioners and NHSE/I).

- The strategy introduced **seven themes for improvement**, as an overarching framework for improvement in safety across the Trust. We shaped our strategy around cross-cutting themes to make it relevant to all staff, whatever their role, and to emphasise the importance of driving safety in a collaborative, systematic way that cuts across organisational boundaries.

- We said we would measure the success of the strategy using **five key outcomes.** Not all of these outcomes are easy to measure or exclusively within our control. They might rely, for example, on patient co-operation or engagement from partners. To reflect this complexity, we developed a set of **key measures** (which are quantitative) and **proxy measures** (which include qualitative information and evidence from supporting actions that have been taken).

- The five key outcomes are supported by a set of **supporting outcomes and measures**, which are more detailed, make use of the Trust's existing datasets and directly reflect the core safety and quality activities in clinical practice.

- **Patient safety is improving.** We have seen improvement in safety indicators in the majority of areas. Even in those areas where we have maintained the previous position, this has been done against a backdrop of unprecedented demand, huge pressures on staff and both a very challenging external environment and a cohort of patients with some very complex needs.

- We have made **good progress on the six urgent actions** that were set out as part of the strategy. Four of six are complete and two are substantially underway.

- We have made **good progress towards the five key outcomes**, with zero preventable deaths in the reporting period and a reduction in instances of self-harm. National guidance around patient safety planning has changed, so we need to update our metrics and data capture mechanisms for some indicators.

- We have made **good progress towards improved outcomes in physical health**, with a reduction in falls, pressure ulcers and early signs of deterioration. We have maintained levels of physical intervention and seclusion, despite very challenging circumstances and have **dramatically reduced use of prone restraint even in these circumstances**.

Recap: Safety First, Safety Always

Recap

- The *Safety First, Safety Always* strategy was agreed by Trust Board in February 2021, following widespread engagement with staff, NEDs, Governors (including service user and carer representation) and partners, including safeguarding partners, commissioners, local authorities and NHSE/I.

- The strategy introduced **seven themes for improvement**, as an overarching framework for improvement in safety across the Trust. We shaped our strategy around cross-cutting themes to make it relevant to all staff, whatever their role, and to emphasise the importance of driving safety in a collaborative, systematic way that cuts across organisational boundaries.

- We said we would measure the success of the strategy using **five key outcomes.** Not all of these outcomes are easy to measure or exclusively within our control. They might rely, for example, on patient co-operation or engagement from partners. To reflect this complexity, we developed a set of **key measures** (which are quantitative) and **proxy measures** (which include qualitative information and evidence from supporting actions that have been taken).

- The five key outcomes are supported by a set of **supporting outcomes and measures**, which are more detailed, make use of the Trust's existing datasets and directly reflect the core safety and quality activities in clinical practice.

Recap: 7 Strategic Themes

Leadership

Ensuring there is buy-in, ownership and accountability across the Trust for putting *Safety First, Safety Always* and delivery this through leadership at all levels – from ward to board

Culture

Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility

Continuous Learning

Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff

Wellbeing

Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care

Innovation

Facilitating and inspiring patient safety initiatives through new ways of working

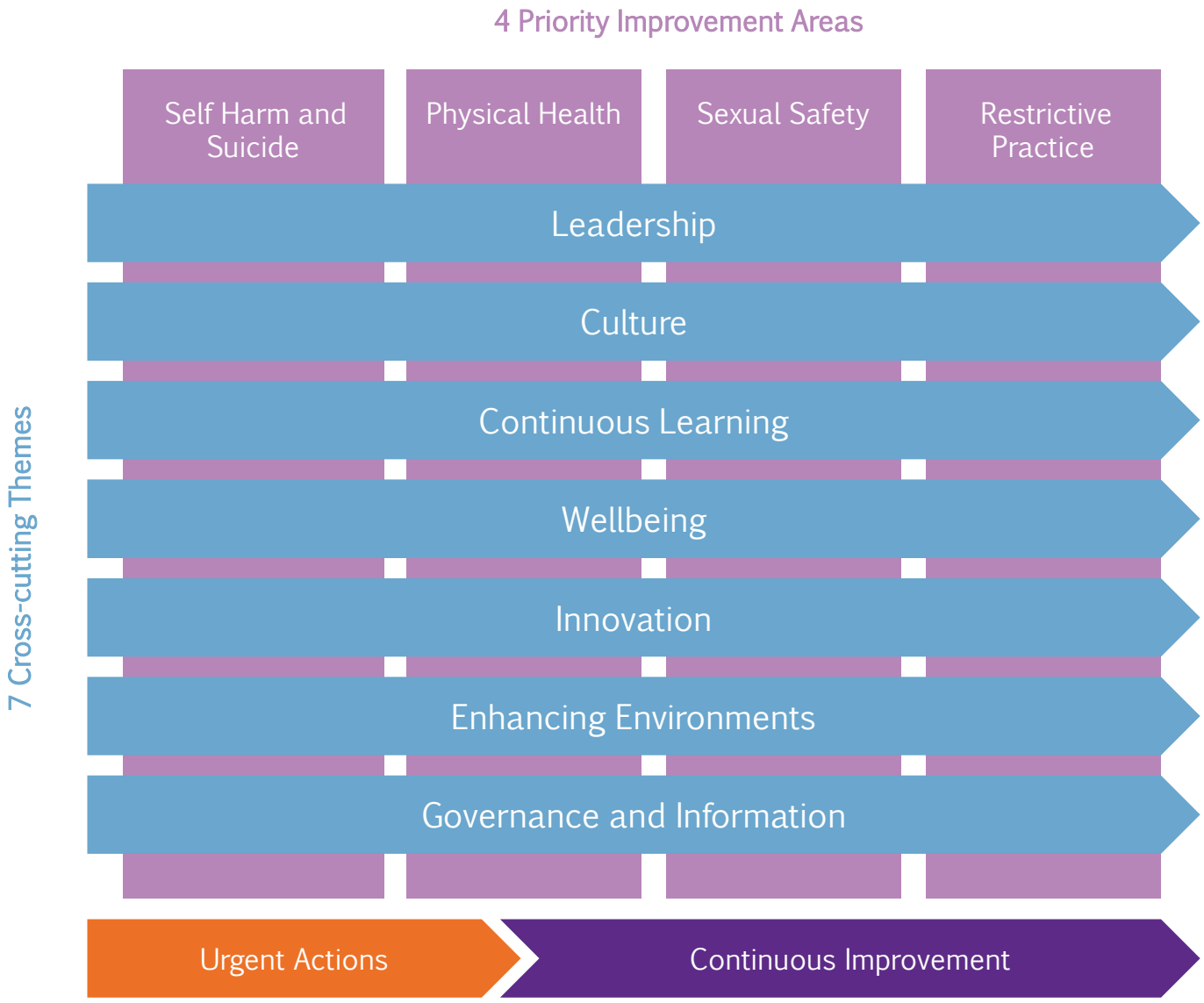
Enhancing Environments

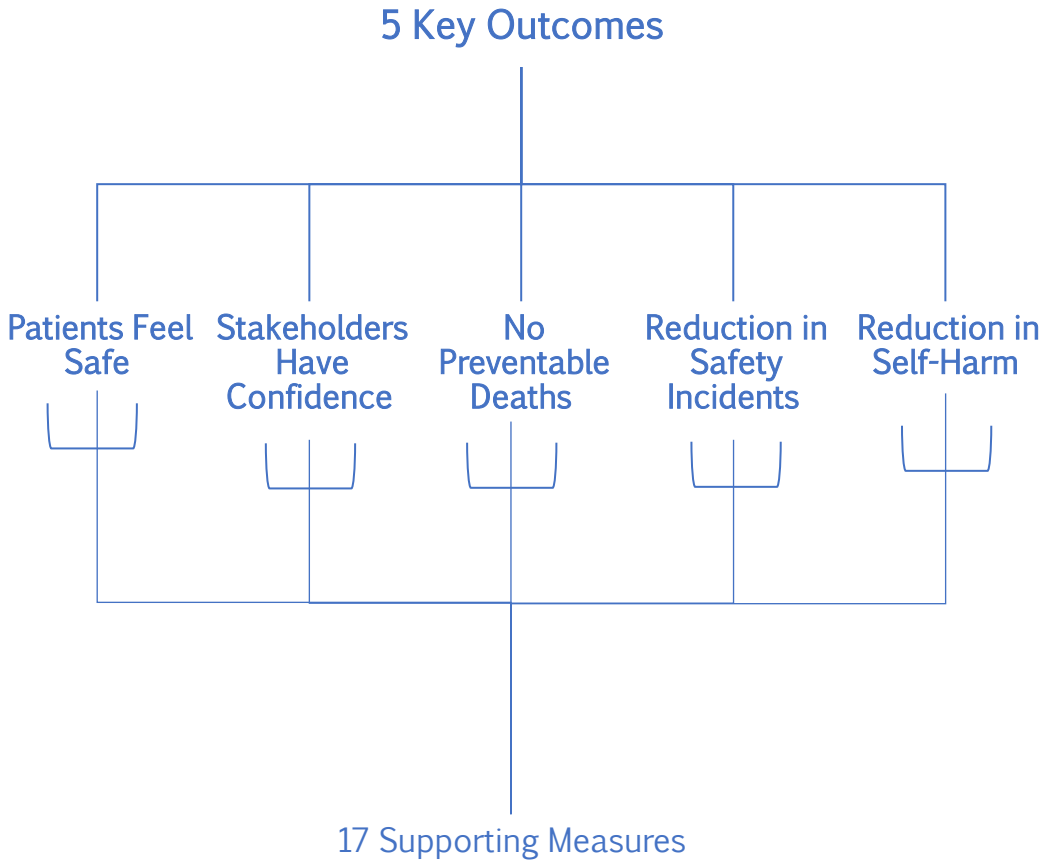
Ensuring our buildings and estates support the *Safety First, Safety Always* agenda

Governance and Information

Building the foundations for safety through governance, processes and availability of information that put safety first

Recap: The Anatomy of our Strategy



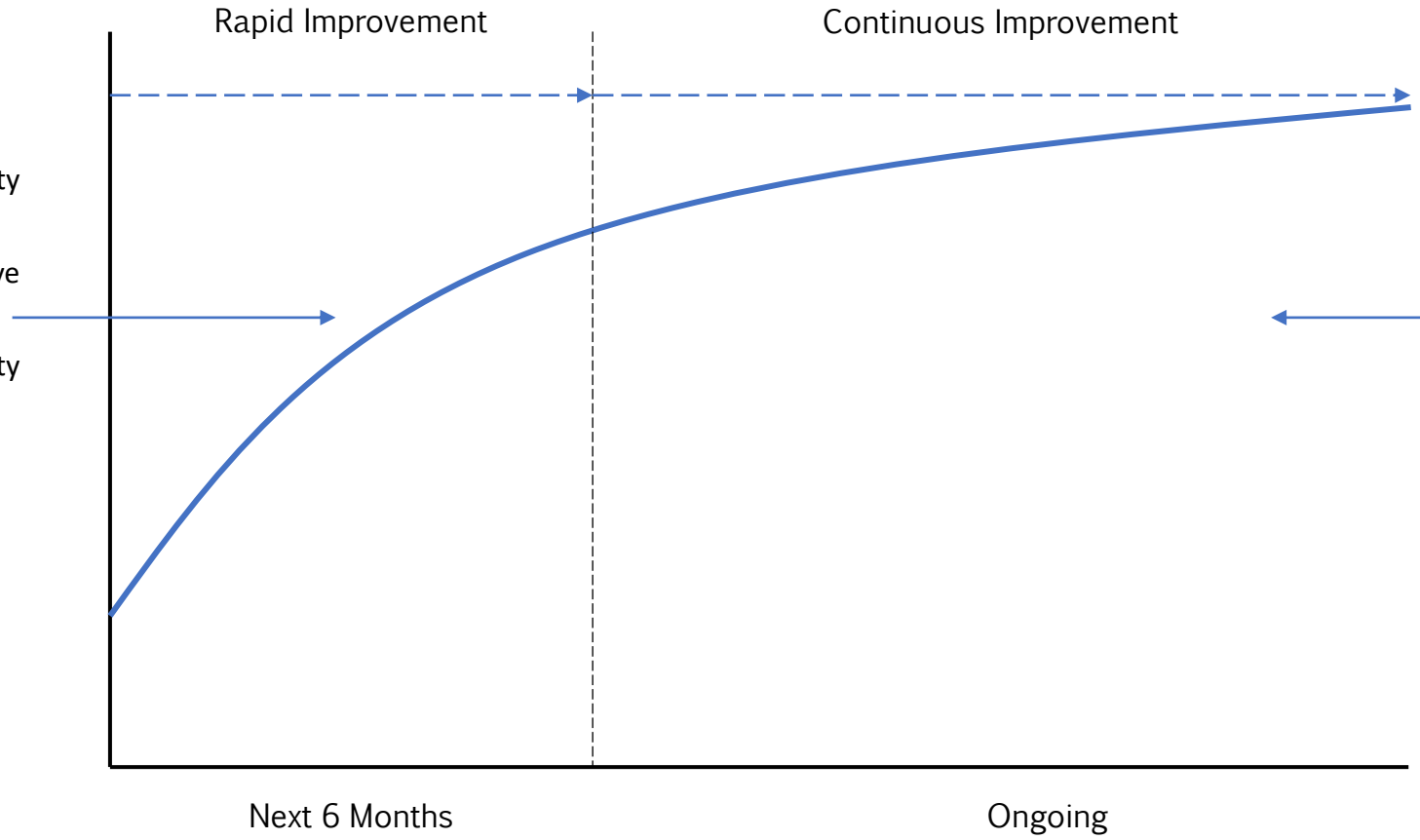


Recap: Improvement Journey

We recognised that there would be a journey of improvement. Some actions needed to be taken urgently, some would take longer to embed in the organisation and others would continue beyond the duration of the strategy, because safety never stops.

Urgent Actions

- Appointment of Senior Safety Specialist
- Establish Safety Executive Committee
- Selection of external quality improvement partner
- Implementation of PSIRF
- Improvements in record keeping
- Communications with other agencies
- Urgent estate and security issues



Continuous Improvement

- Embedding and sustaining a just culture
- Culture of continuous learning
- Modern estate
- Improving safety through technology
- Innovation
- Co-production
- Partnership working

Actions Since Approval

- We set out a roadmap for improvement as part of the strategy, which had 55 actions organised by theme. Some of these actions have since come under the governance of the Trust PMO and others are being implemented locally by teams, with support from a small team working to the Executive Nurse.

- 6 actions were identified as urgent. Good progress has been made against these, with further detail on page 11 of this report.

- Following approval of the strategy, four areas of priority were identified for **quality improvement** activities, using the 7 themes of the strategy for consistency. These areas are:

    1. Self Harm and Suicide Prevention
    2. Restrictive Practice
    3. Sexual Safety
    4. Physical Health

- Sub-Committees and working groups have been established for these activities to ensure clinical leadership of improvement. Quality Committee oversees all activity related to safety across the Trust.

- Each priority area has a Quality Framework and supporting action plan, either complete or in development. These documents reflect the themes of the Trust's overarching *Safety First, Safety Always* strategy and aspects of quality improvement that are specific to each specialist area, including alignment to national priorities and indicators.

Progress Against Measures

Local and National Context

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

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

- Research shows that a 1% increase in long-term unemployment increases the suicide rate of a population by 0.83%. While the **long-term effects of COVID on population mental health** are not yet quantified, the evidence points to an increase in demand on services that could last up to 18 years.

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

- Staff at EPUT and across the NHS have made extraordinary efforts throughout the pandemic and have given more than could have been asked of them. But putting more pressure on staff is not a sustainable solution and there are **systemic workforce issues to be addressed in the NHS**. There is a national nursing shortage, with the most significant shortages in mental health, learning disabilities and community nursing. The Interim NHS People Plan identifies this as a national challenge to be addressed, but there is not yet a clear action plan and there is unlikely to be a 'silver bullet' solution. Locally, we are taking action through initiatives such as the Safe Staffing project, a refreshed pipeline of graduate talent and creating new Clinical Assistant Psychologist roles.

- This report has been made against the backdrop of this context, which has presented significant challenges to providing consistent, good quality, safe care. But the outlook is optimistic – despite these challenges, good progress has been made in a number of areas of patient safety.

Celebrating Successes

- **Patient safety is improving.** We have seen improvement in safety indicators in the majority of areas. Even in those areas where we have maintained a position, this has been done against a backdrop of unprecedented demand, huge pressures on staff and both a very challenging external environment and a cohort of patients with some very complex needs.

- **We've moved in the dial even in the most challenging circumstances**. We have seen improvements across the majority of areas, despite the ongoing impact of COVID and the operational impact of running one of the largest vaccination schemes in the country. Some of our indicators, such as physical intervention, have moved in the right direction despite the direct pressure of COVID driving against them.

- **The message is getting clearer.** We have seen an increase in reporting of incidents, even where these resulted in little or no harm. This reflects the commitment of staff to the *safety first, safety always* ethos – no matter how small a risk, patient safety comes first and there is always an opportunity to incorporate learning into practice improvement. Our absolute focus on safety means that we may be over-reporting in some areas (such as physical intervention) and this is causing our progress indicators to look cautious – but it is the right thing to do to ensure we place patient safety at the heart of everything we do.

- **Patients are having more of a say.** We have launched a new Engagement and Involvement strategy and programme and are making sure that patients, their carers and families are involved in planning their care. Having begun research into family involvement in suicide and incident prevention in 2021, we are now ready to conduct focus groups with patients and families. We are also leveraging the lived experience of our service users, for example by co-producing advice on how to stay safe online with our CAMHS patients.

- **Lessons are being learned.** We are capturing more learning and disseminating this more widely in the organisation and across the system. The implementation of PSIRF is changing our focus to learning from incidents and applying that learning to future prevention. Data on incident reporting indicates that staff are reporting more no-harm and low-harm incidents than before, so that we can learn from near-misses and prevent more serious incidents occurring.

- **Things are more joined up.** We are seeing greater levels of collaboration than ever before, both internally and with partners. This is taking the form of QI Hubs, collaboratives of learning and improved communications between agencies.

Safety Never Stops…

- **We are one year in to our three-year strategy.** While good progress has been made in circumstances that continue to be very challenging for our patients and staff, we want to go even further to make care at EPUT the safest available and the safest it can be. We are headed into a period of transformational change, including the launch of our Accountability Framework and the development of a new Target Operating Model.

- **We're becoming more agile and responsive.** Our organisational focus is shifting from observation and engagement to flow and capacity, embedding the best of what we have learned from our response to COVID-19. Public sector organisations have responded to the pandemic with a new pace and agility and we intend to capitalise on this. We have formed an Executive Safety Oversight Group (ESOG) which meets weekly, giving us real-time oversight and the ability to make decisions quickly to ensure that patients receive the right care at the right time from the right people in the right environment.

- **We're planning for the future** while managing the present. We're developing our workforce of the future, drawing on national best practice to meet local needs. We have new workforce strategies that blend growing our own talent with innovative international recruitment and training plans. Our new Nursing and AHPs Workforce Strategy is one of the first integrated strategies in the country, putting us ahead of expected best practice in the new NHS People Plan.

- **We want to see even greater clinical leadership.** The Accountability Framework will devolve maximum autonomy and decision making to those on the frontline who are responsible for patient safety and care. We are also considering how best to organise our services in the future to provide a leadership structure which is clinically-led, delivering patient-centric care in inpatients, specialist and locality settings.

- **We're focusing even more on people, place and pathways**. System-wide working throughout Essex and across the public sector has seen a step-change during COVID. We want to capitalise on this change and embed the best of our pandemic working practices with partners going forward. We are finalising our strategy for safety in community settings, which complements this strategy, joins up pathways and seeks to improve outcomes for people through greater prevention and early intervention.

- **We're continually improving** both our working practices and our ability to measure and evidence what works. In year 2 of the strategy, we are focused on continually increasing the sophistication of our data collection and measurement techniques so that we can evidence some of the 'hard to measure' improvements in the strategy and ensure that decision making is based on data, evidence and insight.

Progress Against Urgent Actions (1/2)

Urgent Action	RAG Rating	Notes
1. Appointment of Senior Safety Specialist	Complete	• Director of Patient Safety post has been created and appointed • Priority improvement plan in place based on national indicators
2. Establish Safety Executive Committee	Complete	• ESOG has been established and providing specific governance in relation to safety since November 2020 • This oversight is now supplemented by BSOG, which meets monthly
3. Selection of external quality improvement partner	Complete	• We are working with UCL Partners on a Mental Health Safety Improvement programme, the CAMHS National Team and the provider collaborative led by local commissioners to drive forward quality improvement initiatives • We are identifying QI opportunities jointly with the local ICSs • Culture of learning being introduced in association with Military of Defence • Newton Europe's diagnostic report has identified further improvements

Progress Against Urgent Actions (2/2)

Urgent Action	RAG Rating	Notes
4A. Implementation of PSIRF 4B. Improvements in record keeping	**Complete**	• PSIRF has been implemented and signed off by commissioners; new practices are being embedded and PSII reporting is taking place, including the incorporation of lessons learned into practice • Improvements in record keeping have been made and progress is reflected in audits, with actions incorporated in QI programmes • High level of investment with families and coroners • Improvement trajectories being development in line with learning
5. Communications with other agencies	**In Progress**	• We have improved communications with partners across the local system, including commissioners, system partners and provider collaboratives, including a number of joint appointments with local government partners • Strategic objectives have been developed with partner agencies and agreed at September Trust Board • Mid & South Essex Community Collaborative in place, driving system wide improvements • Conferences and learning events delivered in relation to safeguarding and patient safety
6. Urgent estate and security issues	**In Progress**	• Risk stratification has been undertaken to identify priorities • Additional funding of £10m allocated for estates modernisation • Estates have appointed Patient Safety Co-ordinators

Progress Against Key Outcomes

Outcome	Key Measure	RAG Rating	Notes
Patients and families feel safe in EPUT's care	An upward trend in the number of patients and families that say they feel safe in EPUT's care	Metrics Under Development	• The Trust received 275 complaints and 1,000 compliments • We have documented positive feedback from patients • We have developed a new Involvement and Engagement Roadmap as part of our Patient Experience Strategy
Stakeholders have confidence that EPUT is a safe organisation	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	Metrics Under Development	• We have documented positive feedback from commissioners and partners • There was an increase in MP enquiries in 2020/21 compared with 2019/20, although most of these related to COVID-19 vaccinations
No preventable deaths	Zero instances of preventable deaths	Zero	• As of March 2021, 0% of patient deaths for Q1-Q3 have been judged more likely than not to have occurred due to problems with the care patients received • 72 reviews are still awaiting judgement.
A reduction in patient safety incidents for investigation	A downward trend in the number of serious incidents	Trend = Variable	• It is difficult to compare SI information directly against incident information from PSIRF because of the change in focus to learning and future risk mitigation • There was a rise in instances of death or catastrophic harm to May 2021, but this has since dramatically reduced
A reduction in self-harm	A downward trend in instances of self-harm	Trend = Down	• There was a sharp rise in instances of self-harm between April and June 2021. This has since reduced to below the average, but is higher than when the strategy was approved in January. • This is due to specific incidents in CAMHS and is related to the increase in use of physical intervention. Trend is representative of the national picture due to the affect of the pandemic.

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Progress Against Supporting Indicators (1/2)

Outcome	Key Measures	RAG Rating	Notes
Reduction in instances of physical intervention	• Reduction the number of all episodes of physical intervention • Maintain reduction in prone restraints	Trend = Same	• Instances of physical interventions increased significantly between January and July 2021, but has decreased slightly over the last 24 months. • The number of prone restraint incidents has also increased since January 2021, but is significantly lower than 18 months ago. • The increase is attributable to the admission of a complex CAMHS cohort during the reporting period. There has been a sharp decline since August 2021.
Reduction in episodes of seclusion	• Reduction in all episodes of seclusion • Reduction in episodes of long-term segregation	Trend = Up	• Instances of seclusion have fluctuated significantly in 2021, with sharp dips and increases, followed by a steady increase since May. • August 2021 figures are above the mean average for the last 24 months and higher than in January 2021. • Instances of long-term segregation have gradually increased since January 2021.
Reduction in inpatient falls	• Continued reduction in the overall rate of inpatient falls • % Reduction in people who fall more than once • % Reduction in falls resulting in moderate and severe harm	Trend = Down	• The number of inpatient falls has fluctuated in 2021, with dips and increases. • Figures have stayed below the mean average for the last 24 months and August 2021 figures are below January 2021 figures.

Progress Against Supporting Indicators (2/2)

Outcome	Key Measures	RAG Rating	Notes
An improved experience of care at the end of life	• Patients and families experience an improvement in care at the end of life • % Increase in number of Do Not Attempt CPR for people at end of life • % Increase in preferred places of death	Trend = Up	• 100% of DNACPRs were in place at time of death for in-patients services. • There is documented evidence that next of kin had been involved in discussions 80% of the time • Patients offered PPD has decreased from 61.8% to 57.7% over the last 12 months.
Reduction in pressure ulcers	• A reduction in instances of pressure ulcers acquired in care • % Reduction in all ulcers • % Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings • Zero category 3, 4 and unstageable ulcers on mental health wards	Trend = Down	• Trust-wide pressure ulcers have declined steadily since January 2021 and are at the lowest in at least 24 months. • There is variation between inpatients and community figures but both show a downward trend overall. • There have been zero category 3, 4 and unstageable pressure ulcers reported in inpatients settings.
Improvement in clinical response to signs of deterioration	• An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards • Improvement in rate of raised early warning scores being escalated appropriately	Trend = Up	• On average across all services, 88% of patients had MEWS charts in place as of January 2020. This average is made up of 5 services with 93% or more of MEWS charts in place and 1 service (LD Services) with 40%. • 82% of cases with raised MEWS were escalated in Q3 2019/20, compared to 43% in 2018/19. There was also an increase in appropriate action being taken, from 43% in Q3 2018/19 to 68% in 2019/20. • The 2020/21 audit is pending.

Progress Against Priority Areas

1. Suicide and Self-Harm
2. Sexual Safety
3. Physical Health
4. Physical Intervention

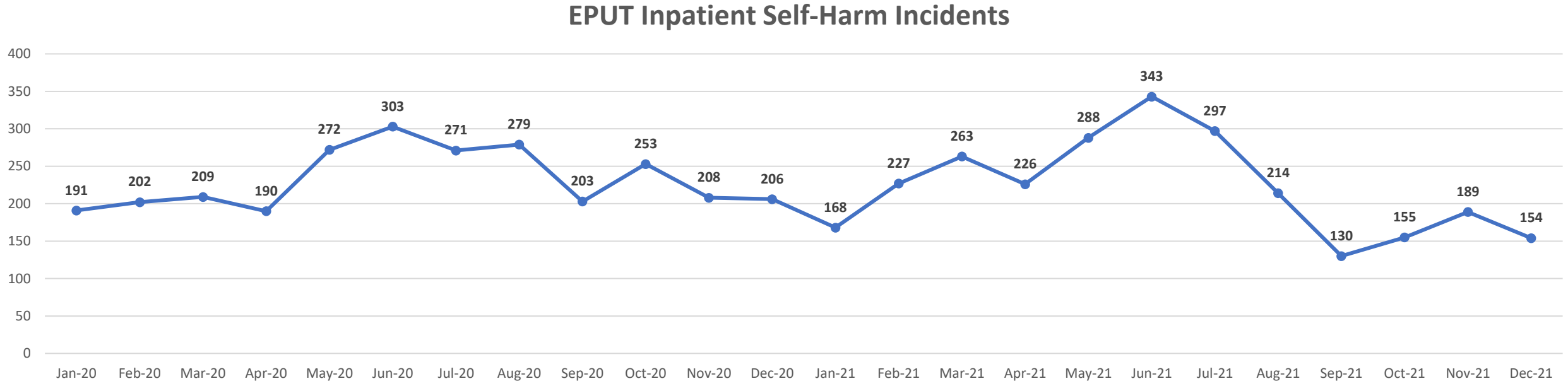
Self-Harm and Suicide Prevention

Self-Harm and Suicide Prevention: Overview

Outcome	Indicator	Result
A reduction in suicide, self-harm and serious incidents	Zero instances of preventable deaths	Zero
	A downward trend in the number of serious incidents	Variable
	A downward trend in instances of self-harm	19.3% down

0% of patient deaths in 2020/21 have been judged more likely than not to have occurred due to problems with the care patients received (72 are awaiting judgement). This data is based on our mandated mortality review process which we report on as part of the Trust's annual Quality Accounts in line with NHS England requirements.

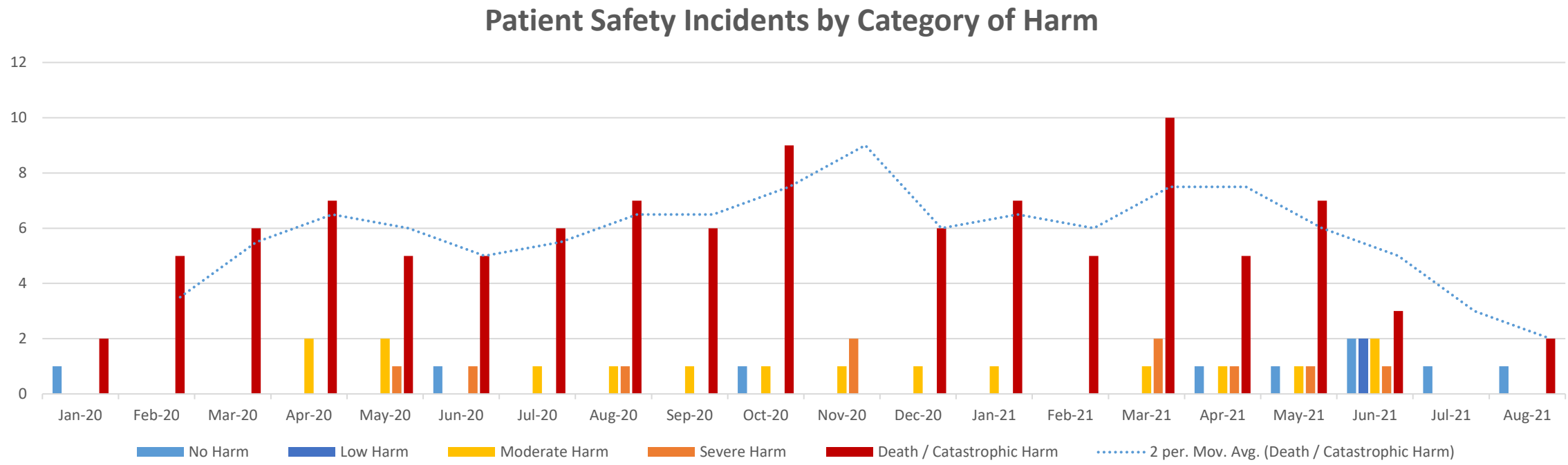
Self Harm and Suicide Prevention: Key Trends and Insights



High levels of reporting were recorded during May, June and July 2021. The rest of the year saw a reduction, with September, October and December incidents falling below the level set in January 2021 when the strategy was approved and the most recent month's data representing a 19.3% reduction since January 2020.

The CAMHS Inpatient Units admission restrictions had a direct impact on the number of reported incidents and accounts for the reduction.

Self Harm and Suicide Prevention: Key Trends and Insights



The number of patient safety incidents has fluctuated over the reporting period but we have started to see a downward trend since March 2021, with the number of incidents resulting in death or catastrophic harm reaching a two-year low in August 2021.

There has also been a reduction in incidents causing moderate and severe harm.

There has been an increase in the number of incidents recorded that resulted in no harm or low harm, which is positive as it indicates there is a good culture of reporting and learning from near-miss incidents can be captured and applied to prevent incidents of greater harm taking place.

Self Harm and Suicide Prevention: Initiatives and Interventions

- We have rolled out STORM training and an accompanying train-the-trainer programme. STORM is the first fully evaluated suicide prevention and self-harm mitigation training for frontline workers, supported by over 20 years of academic and clinical research.
- We have rolled out *Breaking the Silence* Trust-wide, patient groups which explore suicidality, coping and management.
- We are establishing a patient group to explore the role social media plays in suicide attempts on the wards.
- We have rolled out safety plans across the Trust, which have now been added to the patient electronic record.
- We are using reflective practice sessions to discuss recent case studies in small groups, allowing staff to reflect on their experience of managing suicidality in patients and sharing learning with and from others.
- We are undertaking more regular safety huddles, prioritised by level of risk and used to agree the level of observation required for patients presenting warning signals
- We are researching family involvement in suicide and incident prevention. Having conducted the literature review in 2021, we are now ready to conduct focus groups with patients, carers and families.

- We have rolled out 10 Ways to Improve Safety from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Our suicide prevention workstream monitors delivery and an annual assessment is undertaken against the NCISH toolkit.
- We have introduced new regular risk review calls for patients waiting for intervention.

Sexual Safety

Sexual Safety: Overview

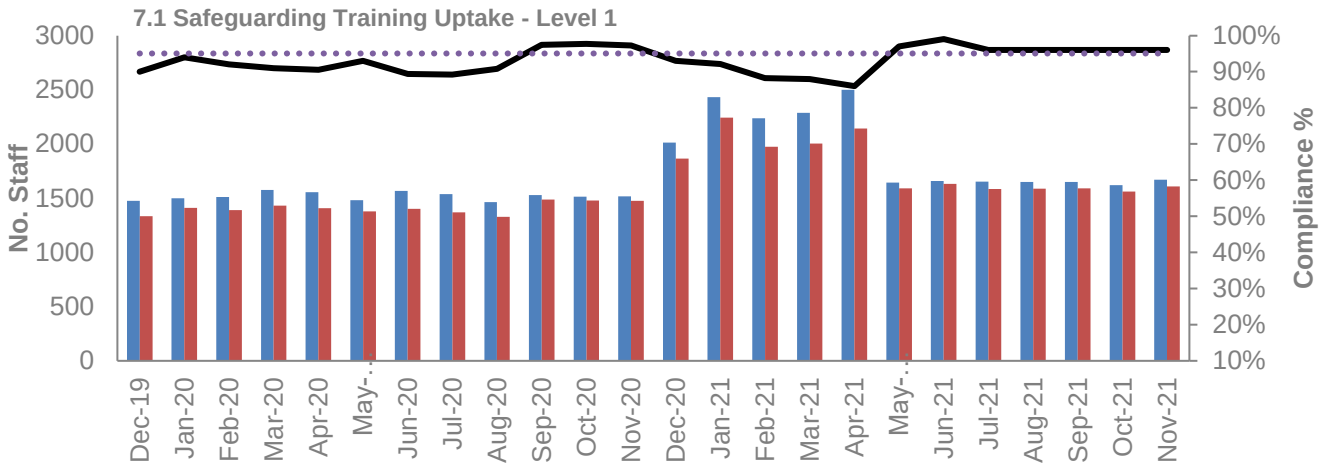
Outcome	Indicator	Result
Our wards are free from sexual harm	Number of enquiries raised to ensure safeguarding of patients across the Trust	**37% increase**
	A downward trend in the number of substantiated enquiries	**40% decrease**
	Level of uptake of level 1 safeguarding training compliance	**95%**

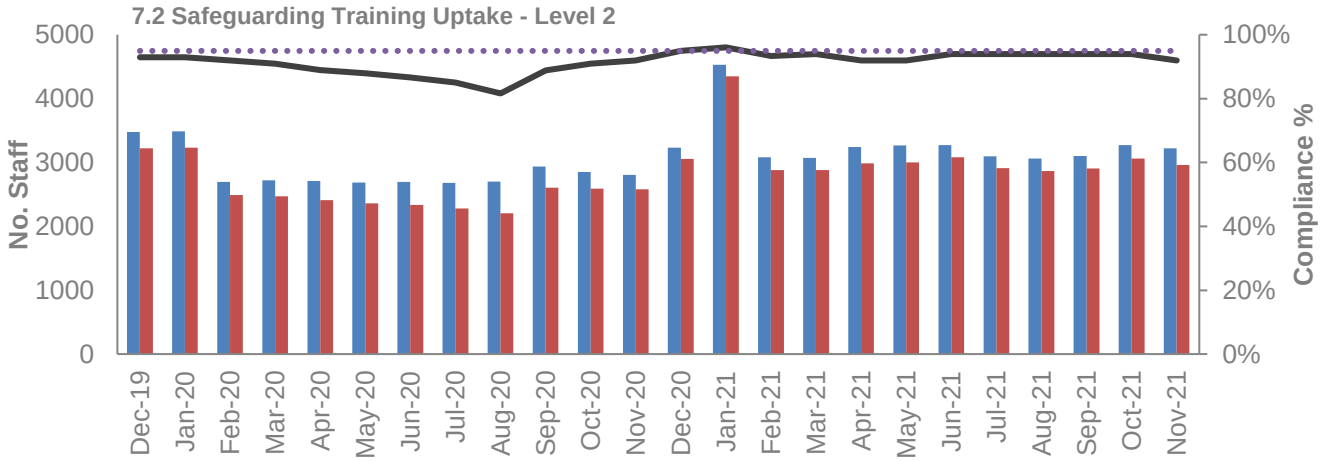
There has been an increase the number of safeguarding referrals, rising by 37% from 2020/21 to 2021/22. This includes all cases, including allegations against staff and allegations against other patients. Our ambition was to see an increase in the number of enquiries that support the protection and safeguarding of our patient population – an increased level of activity indicates heightened awareness of safeguarding issues and an increased willingness for people to speak out.

There has been a decline in enquiries from acute inpatient settings, indicating that our interventions to maintain and improve patient safety are having a positive effect. The move to more single-sex accommodation is expected to further influence these figures.

Substantiated cases from enquiries have decreased by 40% over the 24 month reporting period.

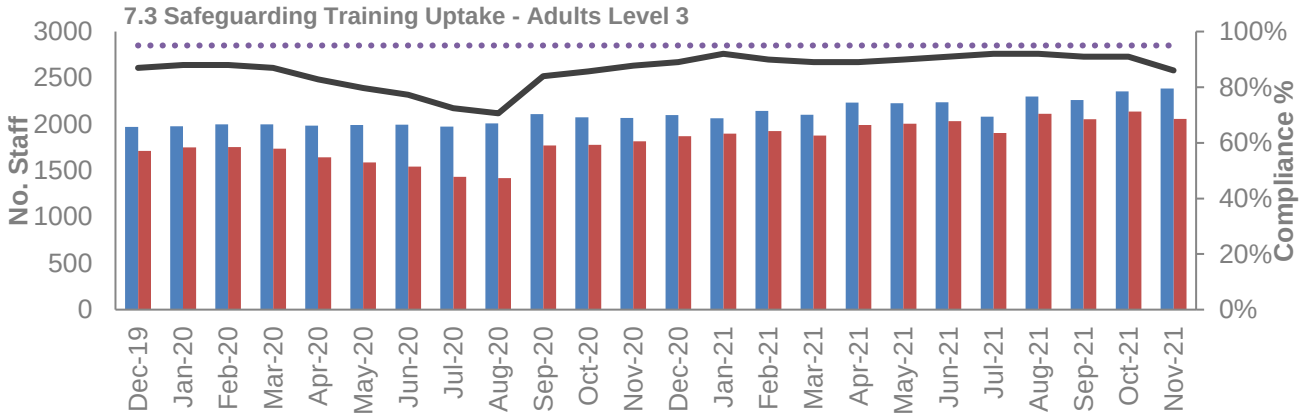
Safeguarding Training Compliance

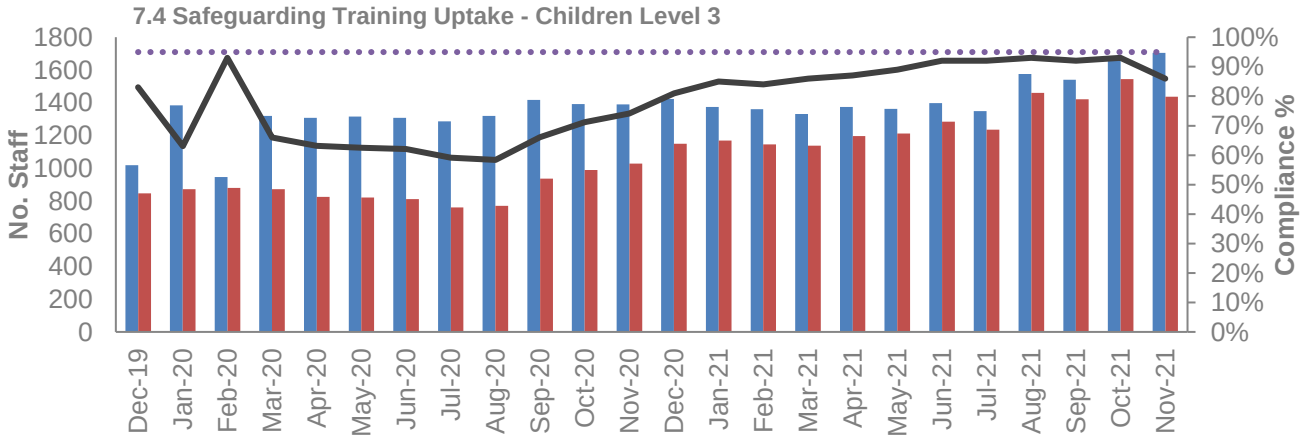




Safeguarding is one component of our work on sexual safety. Our latest training uptake figures show 95% compliance with level 1 safeguarding training and 92% compliance with level 2 training.

Safeguarding Training Compliance





Our latest training uptake figures show 86% compliance with safeguarding training specific to Adults and 86% compliance with training specific to Children.

These figures fall slightly below target but are still very good, against the backdrop of operational pressures from the pandemic and vaccination programme. We stood down all training during the peak of COVID in March and August 2020 and our targets have increased as a result of needing to train huge additional numbers of staff and volunteers to work at vaccination sites.

Sexual Safety: Initiatives and Interventions

- Sexual safety is becoming embedded in the fabric of the organisation – it is discussed in all team meetings and safeguarding practitioners attend to provide expert advice and communicate the importance of raising all concerns, no matter how small.

- Sexual safety forms a major component of our safeguarding training, including the risks of sexual abuse for both adults and children. The training deals both prevention and intervention.

- We have co-produced information for young people on sexual safety and staying safe online with patients in our CAMHS wards.

- We have opened more single-sex wards, which has been shown to dramatically reduce the risk of sexual harm. In line with NHS England guidance on eliminating mixed-sex accommodation, we have opened single-sex accommodation at Cedar, Willow, Cherrydown and Kelvedon Wards.

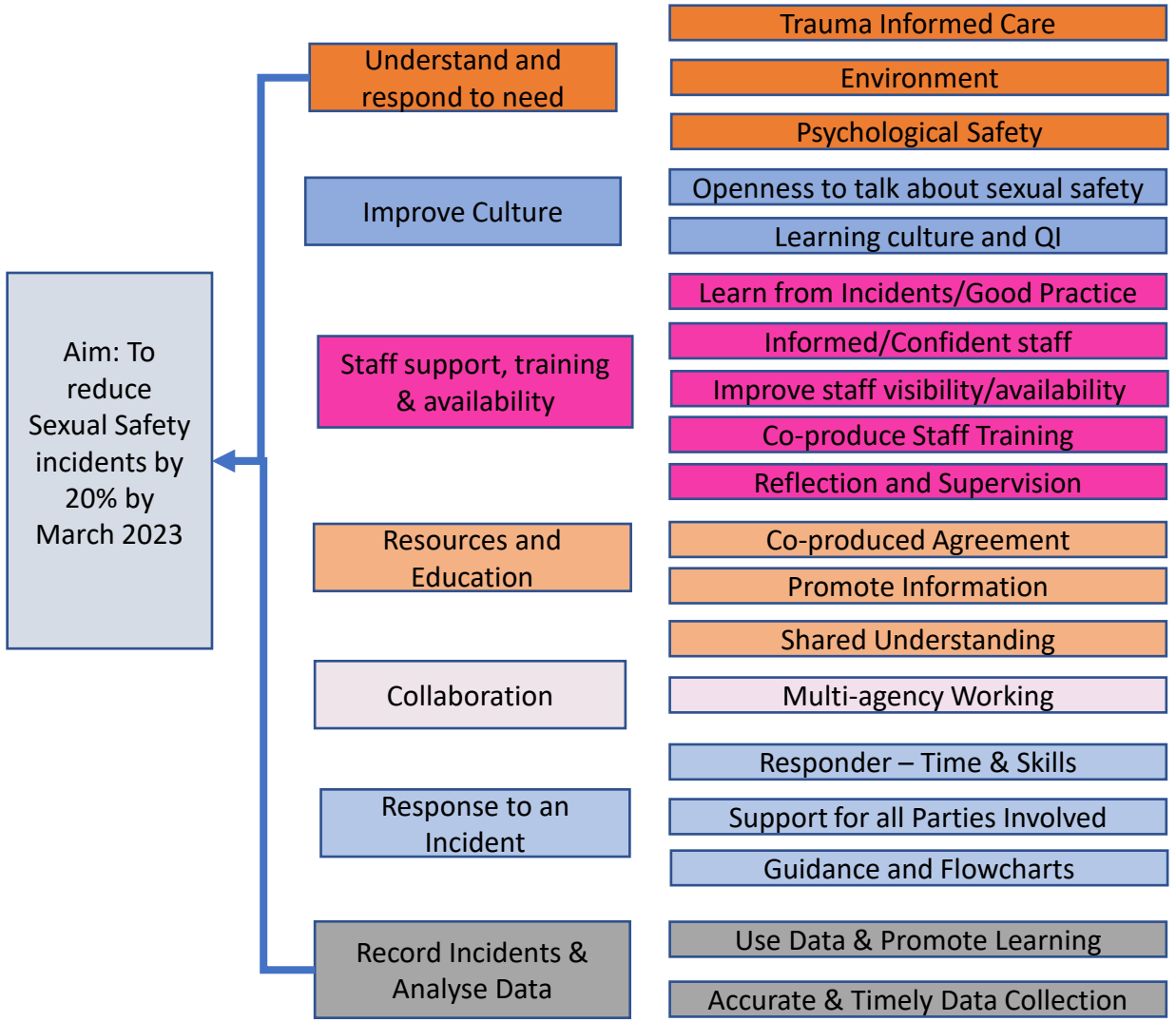
- We are participating in multi-disciplinary Quality Improvement hubs with NHS England & Improvement and the Royal College of Psychiatrists.

- We are improving information and communication for patients on how to keep themselves safe and when and how to speak up if they have any concerns. We have communicated the same messages to staff as part of our *Speak Out Safely* campaign.

- We are working closely with partner agencies on initiatives such as the Sexual Violence Scrutiny Panel and tackling street prostitution in Southend.

- We have a new sexual safety framework under development with a new set of outcomes, indicators and measures that will help us track how well initiatives are being embedded, what impact they are having and how safe people feel on the wards.

Sexual Safety: Key Workstreams Underway



Physical Health

Physical Health: Overview (1/2)

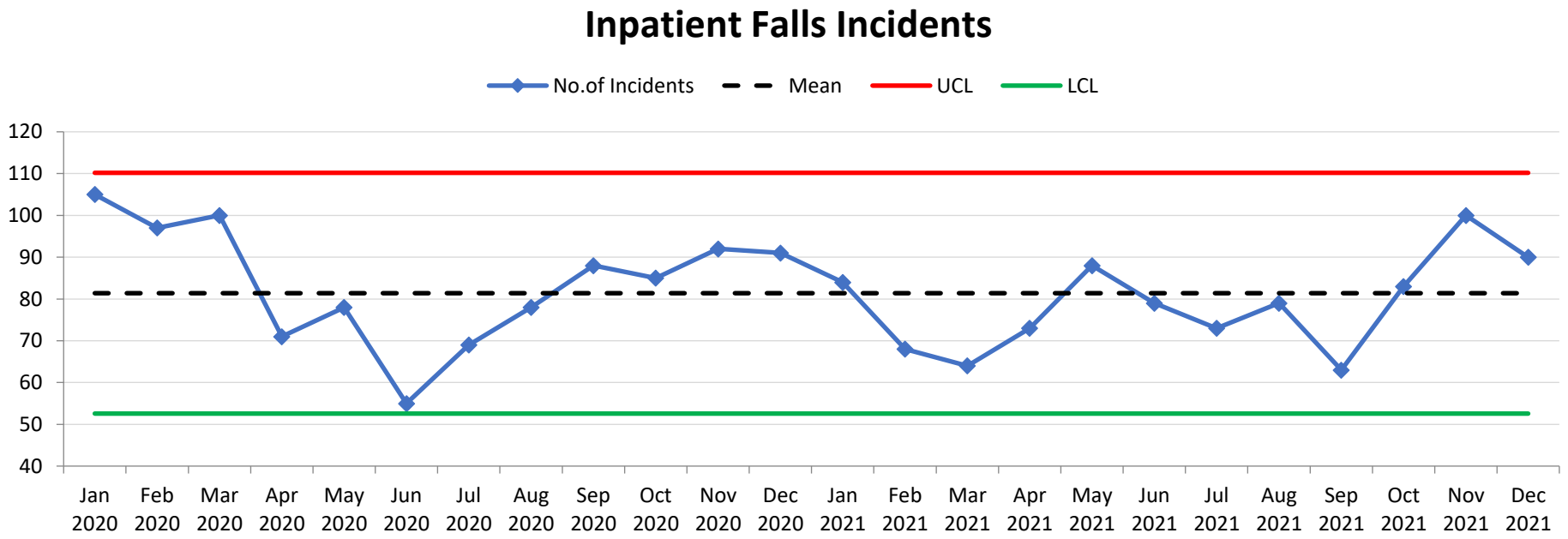
Outcome	Indicator	Result
Reduction in falls in inpatient settings	Continued reduction in the overall rate of inpatient falls	**14.3% down**
	% Reduction in people who fall more than once	**9.6% down**
	% Reduction in falls resulting in moderate and severe harm	**16% down**
Reduction in pressure ulcers in all settings	A reduction in instances of pressure ulcers acquired in care	**32.7% down**
	% Reduction in all ulcers	**21.8% down**
	% Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings	**Zero**
	Zero category 3, 4 and unstageable ulcers on mental health wards	**Zero**

Physical Health: Overview (2/2)

Outcome	Indicator	Result
An improved experience of care at end of life	Patients and families experience an improvement in care at the end of life	Up
	% Increase in number of Do Not Attempt CPR for people at end of life	100%
	% Increase in preferred places of death	4 % points down
Improvement in clinical response to signs of deterioration	An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards	25 % points up
	Improvement in rate of raised early warning scores being escalated appropriately	39 % points up

Physical health indicators are green across the board with the exception of preferred place of death, which has seen a minor decrease. This is attributable to the demands of COVID and the complexities of controlling infection rates in healthcare settings.

Inpatient Falls: Key Activities and Trends

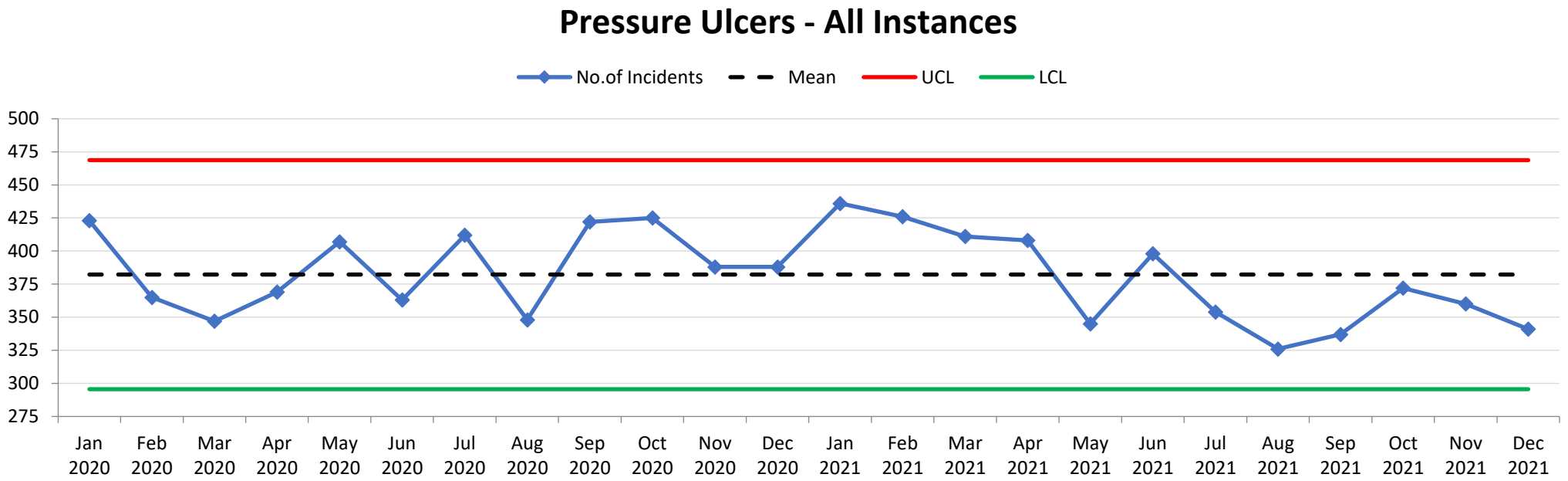


Falls in inpatient settings have had peaks and troughs over the last 24 months, but have seen an overall decline.

A sharp increase was observed in November and December 2021, with Meadowview Ward reporting 29 incidents across the period involving 12 separate patients, 10 of which were involved in 2 or more falls.

The number of falls resulting in moderate, severe or catastrophic harm has reduced from 50 to 42 between 2020 and 2021.
The number of repeat falls has also reduced by 9.6% over the same period.

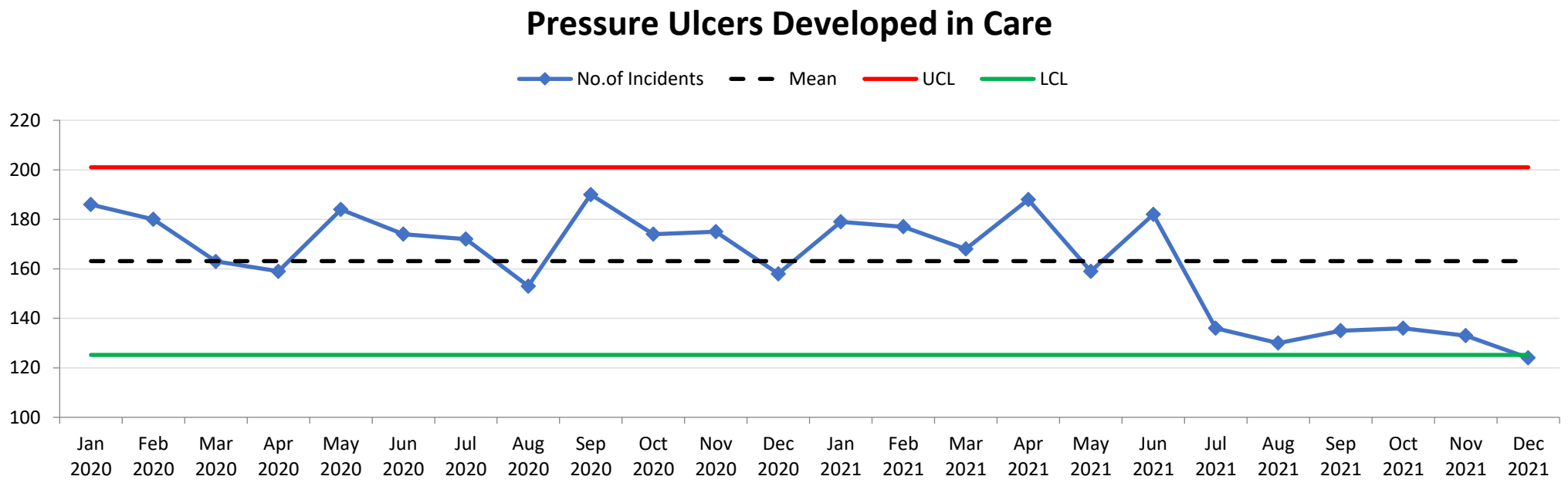
Inpatient Falls: Key Activities and Trends



Instances of pressure ulcers have fluctuated over the last 24 months, but have seen an overall decrease of 19%.

This data represents pressure ulcers in all settings, including community settings, where prevention is more challenging.

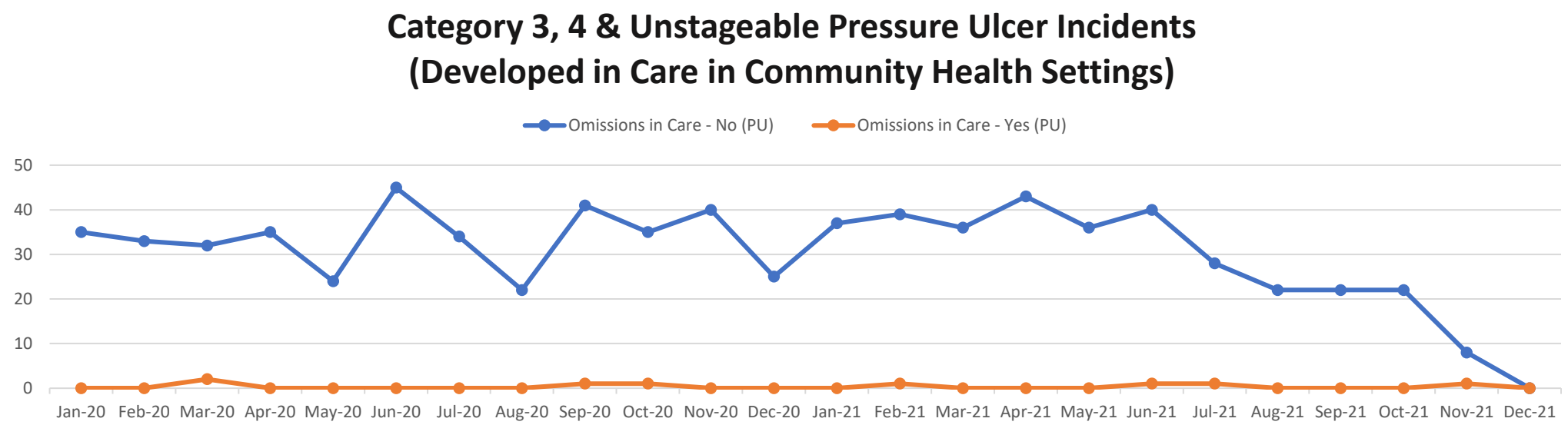
Pressure Ulcers: Key Activities and Trends



The total number of pressure ulcers developed in care has reduced by 32.7%, with December 2021 being at the lowest level for 24 months.

There have been **zero instances of Category 3, 4 & Unstageable pressure ulcers** developed in our care reported by Mental Health inpatient units since April 2020.

Pressure Ulcers: Key Activities and Trends



The majority of pressure ulcer incidents recorded have occurred in community health settings (as opposed to inpatients settings, where there have been zero category 3, 4 or unstageable ulcers).

Ulcers developed in community settings are harder to identify early and prevent than in inpatients settings, but the number of ulcers that have developed as a result of omissions in care has remained low and is currently at zero.

Physical Health: Initiatives and Interventions

- We have rolled out Oxehealth to digitally monitor patients' vital signs, which improves safety across a broad range of measures including self harm and attempted suicide, falls and early signs of deterioration in a patient's physical health.
- We are increasing use of hydration jellies across the wards to prevent dehydration – these have been successfully piloted on Ruby Ward for patients with physical frailty and have now been introduced at Clifton Lodge dementia care home.
- Alongside essential safety improvements, the estate is being brought up to date to reflect modern healthcare needs. This includes transforming wards in line with National Building Standards and ensuring accessibility for patients and visitors with disabilities and bariatric patients.
- Training compliance is at 94% across all essential courses, including falls prevention and pressure care. We are working to train more staff on specialist processes like transfusion.
- We have rolled out FloJac inflatable lifting devices to assist patients who have fallen while minimizing risk of further injury from moving them.
- We are implementing a new wound care app, which allows nurses to share information with other staff involved in a patient's care and produces a visual timeline of development and healing.

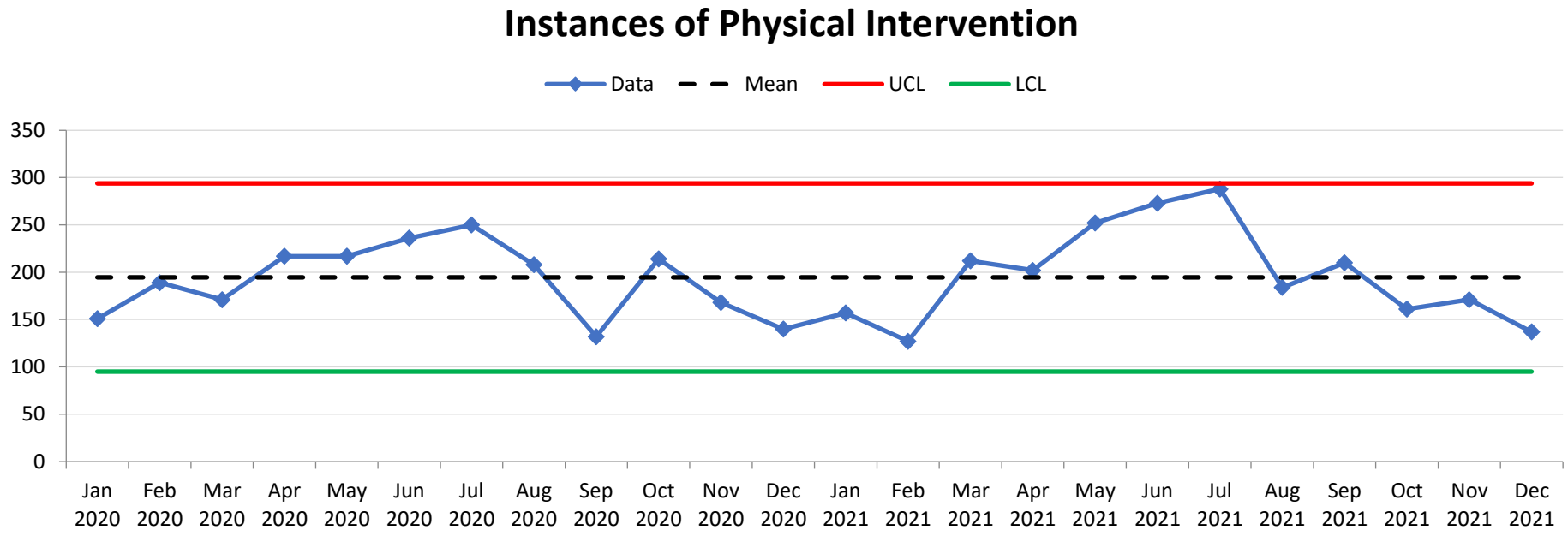
- We have developed a new framework for physical health with five priority areas. Progress is being measured and monitored by a refreshed Physical Health Sub-Committee, with representation from across the Trust.
- We are working to join up our data to promote whole-patient care, looking to create a single view of all data from physical health checks, no matter which system it sits in.

Physical Intervention and Seclusion

Physical Intervention and Seclusion: Overview

Outcome	Indicator	Result
Reduction in physical intervention	Reduction in the number of episodes of physical intervention	**9.2% down**
	Maintain the reduction in prone restraints	**88% down**
Reduction in seclusion	Reduction in all episodes of seclusion	**Same**
	Reduction in episodes of long-term segregation	**+2 incidents**

Physical Intervention: Key Activities and Trends



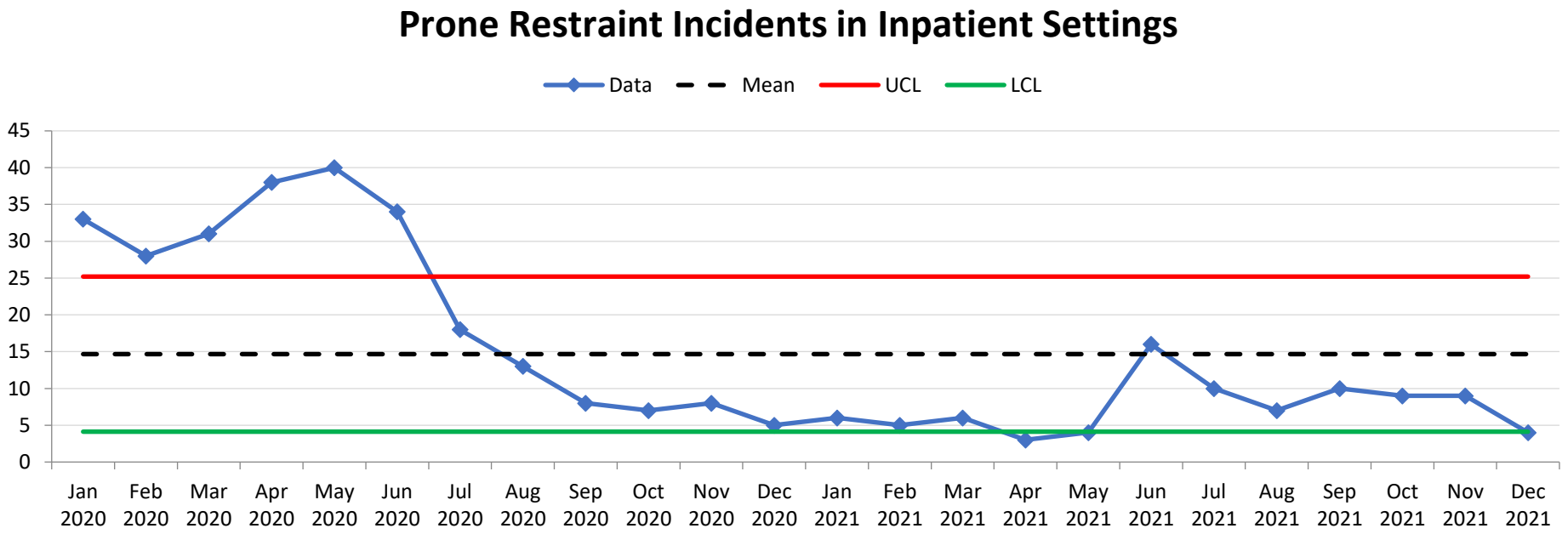
Instances of physical intervention in inpatient settings have fluctuated considerably over the last 24 months, due to a wide range of factors including both the complex needs of some of our patients and the need to move patients to maintain their safety during COVID.

Staff have erred on the side of caution and have been recorded each instance of physically assisting a patient between locations as a 'physical intervention', but the majority of these are not restraints in the usual sense. This is reflected in the significant decline in the number of prone restraints (see next page).

The admission of a CAMHS cohort with particularly complex needs accounts for the sharp rise in physical interventions between May and July 2021. The closure of inpatient admissions to CAMHS units resulted in a significant decrease in August, which has continued to fall.

Physical interventions recorded on the Christopher Unit for psychiatric intensive care increased from 147 in 2020 to 370 in 2021, where one patient with particularly complex needs accounted for 62% of all restraints.

Seclusion: Key Activities and Trends

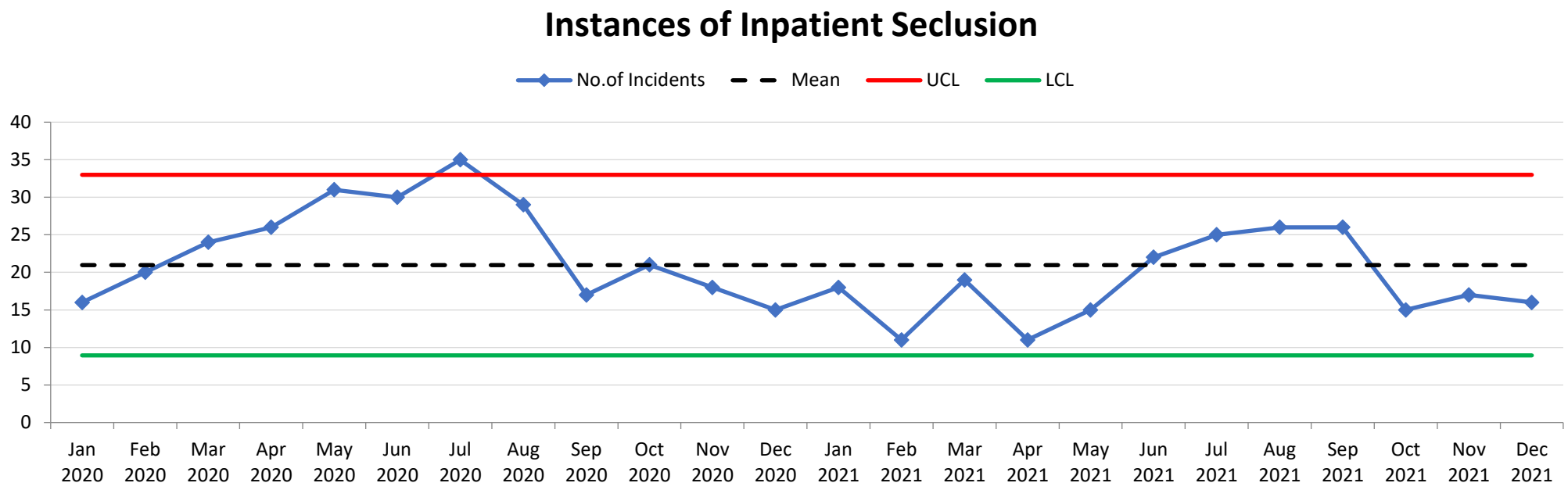


Use of the prone restraint has declined dramatically over time, since a peak in May 2020.

We saw an increase earlier in 2021, attributable to a single patient on Christopher Unit for psychiatric intensive care, who was restrained in the prone position on 26 occasions between June and November. 24 of these incidents involved the patient being placed into seclusion or long-term segregation to ensure their safety and the safety of others; the prone position was used to allow staff to safely exit the area.

Despite this increase due to complex patient needs, use of the prone restraint has continued to decline over time and is well below both the upper control limit (tolerance) and average for the 24 month reporting period.

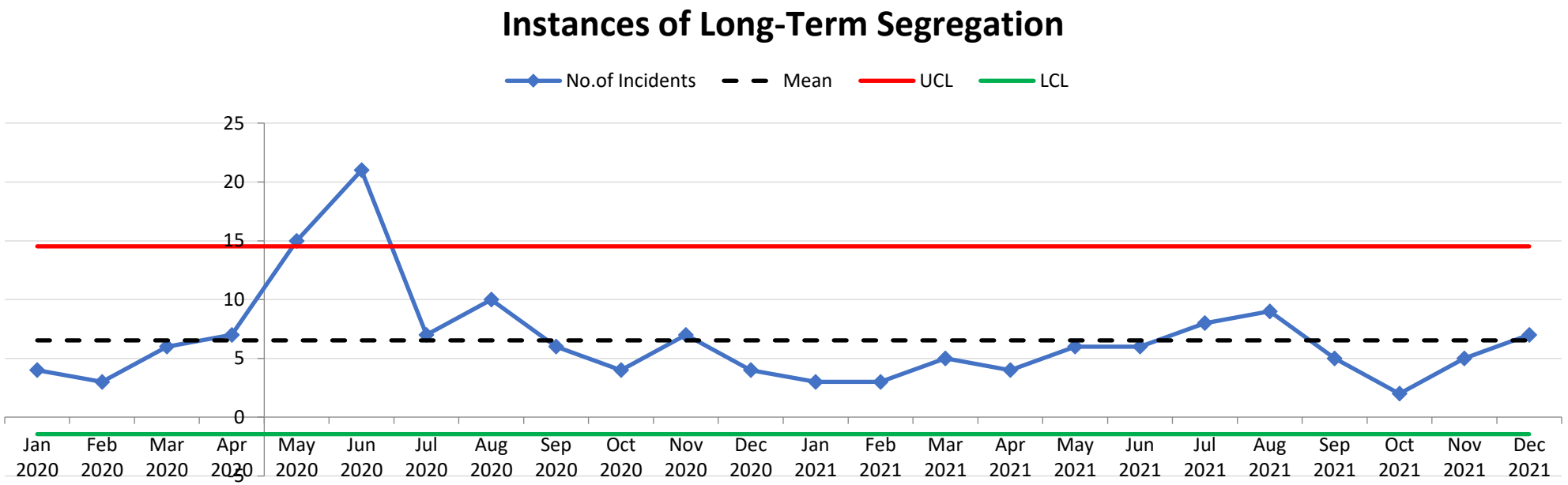
Seclusion: Key Activities and Trends



Instances of patients being placed into seclusion remain within control limits across the 24 month period, following a peak in July 2020 that has since been managed down.

The period between June and September 2021 saw increases in the use of seclusion to ensure safety, specifically at Christopher Unit, Longview Ward and Larkwood Ward. This corresponds to the increase in use of prone restraint explained on the previous page.

Seclusion: Key Activities and Trends



Instances of patients being placed into long-term segregation remain within control limits across the 24 month period, following a peak in June 2020 that has since been managed down.

Physical Intervention and Seclusion: Initiatives and Interventions

- We have adopted a *No Force* First policy, the effects of which are being seen in practice – we have consistently reduced use of the prone restraint, virtually eliminating its use except in circumstances where it is necessary to prevent a patient from harming themselves, other patients or staff.

- We are undertaking an audit of use of physical interventions and a programme of training and communications that reflects changes to the national guidance around reducing restrictive practice.

- We are undertaking a project to look at alternative techniques for existing seclusion environments that could reduce the use of prone restraint, including use of safety pods.

- We have produced accessible guidance, including *Why Am I Being Held?* Information in child-friendly formats for use on CAMHS wards.

- We have agreed a new policy for Therapeutic and Safe Interventions and De-escalations, which was approved by Quality Committee in April 2021. This refreshes our previous policy to reflect national guidance and best practice. The policy has been communicated to staff through Teams Live events and our *5 Key Messages* bulletins.

- We have incorporated national learning and development objectives on restrictive practice into the preceptorship programme, which welcomes, inducts and integrates newly registered professionals to the organisation.

Transforming the Trust's Approach to Safety

7 Themes for Improvement

Alongside our 4 key areas for quality improvement, we developed 7 pan-organisational themes as part of our strategy which will transform the Trust's operating model, way of working and culture. These are helping us to achieve a transformational and sustainable cultural shift in attitudes and approaches to patient safety.

Leadership

Ensuring there is buy-in, ownership and accountability across the Trust for putting *Safety First, Safety Always* and delivery this through leadership at all levels – from ward to board

Culture

Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility

Continuous Learning

Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff

Wellbeing

Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care

Innovation

Facilitating and inspiring patient safety initiatives through new ways of working

Enhancing Environments

Ensuring our buildings and estates support the *Safety First, Safety Always* agenda

Governance and Information

Building the foundations for safety through governance, processes and availability of information that put safety first

Leadership

Building Effective Communication	PS Embedded in Leadership Programmes
	Weekly Communications and Briefings
	Governance arrangements agreed
	Lunchtime Learning Events
Quality Improvement Partnerships	Mental Health Safety Programme
	CAMHS Collaboratives
	Provider Board Joint Working
	Staff/Service User involvement in QI Hubs
Patient Safety Specialists	Director of Patient Safety in Post
	Multi Professional Patient Safety Specialists
	Work Programme in place
	PMO in place
Patient Safety Incident Response Framework (PSIRF)	Achievement of Early Adopter Status
	New Working Practices Introduced
	Structure in Place for Learning Lessons

Summary

All Executive Directors are firmly engaged in leading improvements in patient safety across the Trust. Patient Safety is recognised by the Executive Committee as the key priority across the EPUT. To this end, the Executive Oversight Committee is now in place and supported by our new Programme Management Office to help prioritise and drive improvements across the trust.

The PMO has established a Patient Safety Specialist Programme and through this we have embedded a culture of learning, which offers our staff training programmes, events, communication briefings, webinars and podcasts.

Our leadership and management programmes have been reviewed and developed to enhance a culture of learning and focus on patient safety. Team away days have also been reviewed to embrace the wellbeing of staff and embed a 'Just Culture', promoting multi-disciplinary working to drive improvements in the provision of safe, effective and person-centered care.

EPUT is an early adopter of PSIRF and have commenced our transformation journey by engaging with the wider system's partners including CCGs and local coroners. We now have a system in place to expedite the learning from incidents, ensuring we build programmes of change.

We have formed Quality Improvement Hubs across EPUT Directorates to identify and drive safety improvements locally.

Culture

Alignment of Culture	Just Culture Framework
	Values and Behaviours development
	Cultural barometer at team level
	Review of leadership and management programmes
Ensure Culture of Co-Production	Strategy under review – update due autumn
	Service users and carers QI induction
	NHSE/I Co-production projects
Instil Culture of Reflective Practice	Staff completing Professional Nurse Advocate training
	Review of supervision policy underway
	Data incident reviews taking place
	Facilitators trained for 360 appraisal process
Embed a Just Culture	Just Culture embedded in MDP
	Steering Group to be established
	Culture project commissioned
	HR policies and procedures aligned

Summary

Culture change is underway at all levels in the organisation, from ward to board. This shows on the ground in initiatives such as our efforts to minimize restrictive practice, the introduction of safety huddles and an increase in reporting low-harm and no-harm incidents. Learning is being taken from data, patient safety incidents and best practice and are being shared through a wide range of communications and engagement structures.

At a strategic level, the new Accountability Framework is flipping the organisation's culture on its head – devolving maximum autonomy, responsibility and accountability to those on the frontline who understand patients' needs best. A revised Involvement and Engagement Strategy was approved by the Executive Team in Sept 2021 that has now moved into implementation with a 6-month plan being led by the Director of Patient Experience. As part of this, a series of Co-Production projects will take place with the support of NHSE/I to define the EPUT CoPro way.

Across services a number of our nurses have undertaken the Patient Nurse Advocate programme to take steps to preserve human dignity and promote equality. Learning from the programme will be embedded within practice and drive through supervision arrangements.

Continuous Learning

EPUT Culture of Learning	Arrangements in place to learn from incidents
	Working groups responding to learning
	Lunchtime learning events in place
Collaboratives of Learning	QI Hubs in place
	Collaborative Priorities Agreed
	Involvement of national and CAMHS
	Lunchtime learning events
Schwartz Rounds	Steering group in place
	Facilitator team trained
	Schedule of rounds in place
Structured feedback programme	Lunchtime learning events in place
	Individual and team level programmes

Summary

EPUT is dedicated to creating a culture of individual and organisational learning that will drive quality improvement and innovation throughout the whole system. We want to incorporate accountability and lessons learned without creating a culture of blame. To this end, a 'Just Culture' is being embedded and is shown in the response to incidents and the HR processes applied. The fundamentals are being embedded into systems, processes and actions taken.

Empowerment and engagement is at the heart of the Patient Safety strategy. Directorates have formed QI Hubs that are open to all staff welcoming their ideas and their involvement in making improvements across all services.

Schwartz rounds have been introduced with a range of staff being trained as facilitators. We want to engage our workforce in conversations about the emotional impact of their work. This promotes learning and is giving insight to further steps that could be taken to support to support the wellbeing of our workforce.

Structured feedback programmes have been put in place at a range of levels. Feedback and support programmes are provided at an individual level but also at a team and organisational level to share learning and develop new ways of working.

Wellbeing

Workforce	Safer staffing steering group in place
	Team building / wellness packages
	Group coaching
	Wobble rooms and rest nest
	Equality networks
	Engagement / 'Freedom to Speak' Champions
	'Here for you' Psychological Service
Delivery of Whole Person Care	Whole Person Framework and steering group
	QI Collaborative
	Directorate QI Hubs leading delivery
	Equally Well Programme
Staff Support	Occupational Health, screening and health services
	Menopause support group
	Long covid awareness group
	Chaplaincy service
	Online support for mental wellbeing

Summary

The Executive Team is driving delivery of a workforce strategy that aims to build and retain a strategy in line with organisational need. Bank workers have been offered substantive posts and students have been successfully appointed.

A range of networks and engagement forums have been established with staff positively engaging to drive improvement in relation to wellbeing. This includes staff support networks and engagement champions in teams.

A series of live events on wellbeing has taken place.

Here for You confidential staff support scheme has been rolled out by EPUT and HPFT.

The wellbeing of those that use services is fundamental and to drive improvements in physical and mental health. To enhance delivery of the whole person agenda QI Hubs are supporting the Physical Health sub-committee deliver against agreed priorities.

The last 22 months have been particularly challenging for staff and a range of support systems have been put in place. The engagement and wellbeing team are actively working across the Trust to identify and put in place support systems requested by staff.

Innovation

EPUT LAB	Strong Clinical Engagement
	Provision of digital innovations
	Digital Dementia Neighbourhood
	Oxehealth rollout to all MH wards
	Smart Dashboards
Quality Academy	Life QI Procured to support learning
	Engaged as part of national collaboratives
	Ongoing training of Quality Champions
	QI Hubs across all Directorates
	Collaboratives supporting patient safety priorities
Partnerships and Learning from Others	Electronic observation recording
	Mindfulness therapy
	Hydration jellies
	Collaboratives and Networks

Summary

- Oxehealth continues to be installed on all Mental Health wards, monitoring patients at risk of self harm or suicide in addition to the engagement and supportive observations.
- Wound care app has been procured there is a working group to ensure staff have the latest devices to be able to use the app.
- Digital Dementia Neighbourhood in North-East Essex (Cognitive Stimulation Therapy for people with Dementia helps to slow down progression) is reducing isolation and building a social network for people with Dementia.
- We are making more use of dashboards and whiteboards, ward status and patient information. This gives us vital information when managing the risks on the wards based on what is recorded for patients.
- We are part of national collaboratives for Reducing Restrictive Practices, Sexual Safety and Suicide Prevention.
- The number of Quality Champions is steadily increasing, supported by the Quality Hubs and led by Quality Leads locally.
- Electronic Observation recording, developed by Oxehealth to support the recording of information on the wards with engagement and supportive observations. This is about to be piloted on CAMHS and other wards.
- Mindfulness Therapy in Southend, supporting patients with mild to moderate depression as suggested in NICE guidance, run by the Occupational Therapists groups.

Enhancing Environments

Compliance with National Standards	Appointment of Patient Safety Coordinators
	Allocation of Patient Safety resources
	Risk Stratification processes
	Governance structures in place
	Triage and prioritisation schedules
	National Building Standards
Learning from People with Lived Experience	Learning from incidents/events
	Co-production approach
	Frontline engagement in improvements
	Governor/champion roles
	Recompense
Relational Security	Transformation programmes
	Development of therapy/sensory areas
	Improvements to physical environments
	Governance processes

Summary

£10m capital investment has been committed to modernizing the estate and ensuring it is fit for purpose for modern healthcare needs. This includes addressing the basics of making secure that facilities are safe and secure, and transforming them into places that promote wellness and support patients with both their physical and mental health.

A Ligature Risk Reduction Group is in place which has oversight of the inspection process, standard setting and incident monitoring. There were 13 secured ligature incidents to the end of August 21/22, against a year-end total of 34 for 20/21. This indicates a possible downward trend, although it is likely to be too early to make an accurate projection to year-end for 21/22. No incidents this year have resulted in death or catastrophic harm.

Alongside essential safety improvements, the estate is being brought up to date to reflect modern healthcare needs. This includes transforming wards in line with National Building Standards and ensuring accessibility for patients and visitors with disabilities and bariatric patients.

Governance and Information

Governance Structures	Reset of Organisational Values and Strategic Objectives
	Accountability Framework
	Corporate PMO
	ESOG established
	Sub-Committees for Quality priorities
Dashboards	Dashboards in development for Quality Priorities
	PMO safety projects dashboard
	Complaints and Compliments dashboard
External Oversight and Involvement	MerseyCare
	Provider Collaboratives in East London
	Collaboration with NHSE/I
	Newton Europe diagnostic

Summary

A refresh of the trust's organisational values and strategic objectives is underway. These will place safety at the heart of the everything the organisation does and be supported by the trust's new Accountability Framework. The Accountability Framework will deliver a change in the way the organisation operates, devolving maximum autonomy and empowerment to staff on the frontline who are responsible for delivering safe, good quality care to our patients.

PSIRF has now been implemented and is changing the approach the trust takes to safety incidents, focusing on learning as well as reporting.

The Trust PMO is managing delivery of the organisation's top strategic projects in a more coordinated way than before. This includes projects vital to patient safety such as the Safe Staffing project and estates programme.

A consolidated programme plan and dashboard for the quality areas in this report is under development, which will give central visibility of progress against key outcome and measures across our four priority areas of quality improvement.

Appendix:

Explanation of Outcomes and Measures

Five Key Outcomes

Outcome	Key Measure	Risks/Challenges	Proxy Measures
Patients and families feel safe in EPUT's care	An upward trend in the number of patients and families that say they feel safe in EPUT's care	• Facts do not always change perceptions • Each experience will be individual and personal	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans • Compliments and complaints • Anecdotal feedback
Stakeholders have confidence that EPUT is a safe organisation	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	• Facts do not always change perceptions • Baseline to be established	• Anecdotal feedback • Increase in contracts awarded or extended • Nature of media coverage
No preventable deaths	Zero instances of preventable deaths	• Lack of patient co-operation • No standard definition of a preventable death	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans • Suicide awareness training targets achieved
A reduction in patient safety incidents for investigation	A downward trend in the number of serious incidents	• We must not achieve this outcome as a consequence of under-reporting	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans
A reduction in self-harm	A downward trend in instances of self-harm	• Lack of patient co-operation • We must not achieve this outcome as a consequence of under-reporting	• 100% of patients have safety plans • 100% of inpatients have been involved in completing their safety plans

Explanation of Supporting Indicators (1/2)

Outcome	Key Measures	Risks/Challenges	Proxy Measures
Reduction in restrictive practice	• Reduction the number of all episodes of restrictive practice • Reduction in restraint incidents • Maintain reduction in prone restraints	• Restrictive practice may be necessary to prevent harm • We must not achieve this outcome as a consequence of under-reporting	• Mental Health Data Services benchmarking • Compliance with learning disability improvement standards • Increased awareness of blanket rules and global restrictions • Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in episodes of seclusion	• Reduction in all episodes of seclusion • Reduction in episodes of long-term segregation	• Seclusion may be necessary to prevent harm and as an alternative to restrictive practice	• Mental Health Data Services benchmarking • Compliance with learning disability improvement standards • Increased awareness of blanket rules and global restrictions • Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in inpatient falls	• Continued reduction in the overall rate of inpatient falls • % Reduction in people who fall more than once • % Reduction in falls resulting in moderate and severe harm	• Up to 60% of falls are unwitnessed • We must not achieve this outcome as a consequence of under-reporting	• Weekly reviews take place • Audit of recurrent fallers • Analysis of unwitnessed falls • Lessons learned are disseminated

Explanation of Supporting Indicators (2/2)

Outcome	Key Measures	Risks/Challenges	Proxy Measures
An improved experience of care at the end of life	• Patients and families experience an improvement in care at the end of life • % Increase in number of Do Not Attempt CPR for people at end of life • % Increase in preferred places of death	• Dependency on other agencies • The experience of each patient and family will be individual and personal	• Workforce competencies • Frequency and quality of debriefings • Involvement of patients and families
Reduction in pressure ulcers	• A reduction in instances of pressure ulcers acquired in care • % Reduction in all ulcers • % Reduction in category 3, 4 and unstageable ulcers with omissions in care in community health settings • Zero category 3, 4 and unstageable ulcers on mental health wards	• Identification of ulcers in community health settings • Prevention of ulcers in community health settings	• Roll-out of training against targets and schedule • Lessons learned are disseminated
Improvement in clinical response to signs of deterioration	• An improved clinical response against where patients show signs of deterioration against National Early Warning Score (NEWS2) and Modified Early Warning Score (MEWS) standards • Improvement in rate of raised early warning scores being escalated appropriately	• Completeness and accuracy of information	• Roll-out of training against targets and schedule • Improvement in completeness, accuracy and quality of information • Lessons learned are disseminated